CREDENTIALING INFORMATION SHEET

PERSONAL INFORMATION (all information is required)		
Last Name:	**First Name:**	**Middle Initial:**
DOB:	**City of Birth:**	**Country of Birth:**
SS#:	**Home Address:**	
City:	**State:**	**Zip:**
Email:	**PH:**	**Cell:**
I approve Elite Medical to electronically sign applications/contracts on my behalf: (initial) _____		

PROFESSIONAL INFORMATION (* are required)			
Practice Name:			
Physical Address:		**City, State & Zip:**	
Practice PH#:	**Fax:**	**Billing PH#:**	**Fax:**
Date Incorporated:	**Group NPI#:**	**IND NPI#:**	**Tax ID#:**
Owner/ Managing Member Full Name:		**DOB:**	**SS#:**
Home Address of Owner/ Managing Member:			
Medical School:		**Month/YR Started:**	**Month/YR Grad:**
Internship:	**Location**	**Month/YR Started:**	**Month/YR Grad:**
License #:	**State:**	**Eff Date:**	**Exp Date:**
DEA #:	**State:**	**Eff Date:**	**Exp Date:**
Certification # (if mid-level):	**State:**	**Eff Date**	**Exp Date:**
Board Cert #: **Yes No**	**Board through:**	**Date Cert:**	**Exp Date:**
Hospital Privileges: **Yes No**	**Name:**	**Name:**	**Name:**
If no, to above, who do you us to admit PTs:		**Specialty (must match your specialty):**	**Admitting MD NPI#:**
Other Languages Spoken:		**Any Adverse HX:** **Yes No**	***CAQH #:**
***NPPES Username:**	***NPPES Password:**	***CAQH Username:**	***CAQH Password:**

*If you have any questions, please contact us. If any changes need to be made, please contact us right away. **Please Note**: Any inaccurate information may slow down the credentialing process.

CREDENTIALING INFORMATION SHEET

LIST THREE PROFESSIONAL REFERENCES (If you are ARPN, you must list ARPNs)		
Name & Specialty:	**Address:**	**City/ State/ Zip:**
PH:	**Cell:**	**Email:**
Name & Specialty:	**Address:**	**City/ State/ Zip:**
PH:	**Cell:**	**Email:**
Name & Specialty:	**Address:**	**City/ State/ Zip:**
PH:	**Cell:**	**Email:**

Please be sure to attach the following documents:

- **Degree**
- **Certifications**- applicable for ARNP
- **Board Certification Certificates** and renewal dates
- **State of Utah Division of Occupational and Professional License**
- **Controlled Substance (DEA) Registration Certificate**
- **CV** (including all degrees, institutions, CEU's, CEC's, and years) Dates must be in MM/YY format.
- **W-9**; if not with an already established group working with Elite Medical
- **Proof of Medical Liability Coverage** and Letter describing any Case(s) (if applicable)
- **Voided Business Bank Account Check**, if not with an already established group working with Elite Medical
- **Copy of IRS generated document** confirming the applicant's Legal Business Name and Tax ID number (Tax payment voucher, or the form can be requested from IRS) *Needed if starting a new group/practice (Required by Medicare)

Please email all information to mstevens@e-medonline.com or fax to 801-784-2767.