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## PRACTITIONER APPLICATION

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### Checklist of Materials to submit with Application

- A completed application
- Official College/University Transcripts sent directly to LifeWays (initial credentialing only)
- A copy of licensure
- A current Curriculum Vitae/Resume (initial credentialing only)
- A copy of current and adequate malpractice insurance and professional liability insurance in the amount required by LifeWays (minimum \$1,000,000 per occurrence and \$3,000,000 aggregate)
- List of continuing education programs attended over the past twenty-four (24) months and CMEs/CEUs/Clock Hours received (for re-credentialing only)
- Signed attestation form (page 10)
- Signed Criminal Background Check form (Page 11)
- Malpractice Information Form, if applicable (See Page 7 Disciplinary Actions; Page 12)

Reference: LifeWays Provider Manual, Section II: Provider Network, A. Credentialing/Re-Credentialing Process.  
On the web at: <http://www.lifewaysmco.com/default.aspx?pageid=5077>



**APPLICATION FOR PRIVATE PRACTITIONER  
PROVIDER NETWORK PARTICIPATION AND PRIVILEGED STAFF MEMBERSHIP**

**General Instructions:**

- Please TYPE OR PRINT all responses.
- Attach additional sheets if necessary.
- Submission of evidence of appropriate education/degree completion is required *for initial application*. Official transcripts must be sent directly from the educational facility.
- Application must be complete, including attachment of all requested supporting documentation.

**PERSONAL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Country: \_\_\_\_\_  
City/County/State

Email: \_\_\_\_\_

DBA (Doing Business As), if applicable: \_\_\_\_\_

Check Appropriate Status:  Sole Proprietorship  Partnership  Corporation  LLC

Main Office: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Office: \_\_\_\_\_ Emergency: \_\_\_\_\_ FAX: \_\_\_\_\_

Office/Location #2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Office: \_\_\_\_\_ Emergency: \_\_\_\_\_ FAX: \_\_\_\_\_

Office/Location #3: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Office: \_\_\_\_\_ Emergency: \_\_\_\_\_ FAX: \_\_\_\_\_

**BILLING INFORMATION:**

*Under what number(s) do you bill? (Please check applicable and provide #s. **SSN and NPI are required.**)*:

- Social Security Number (SSN): \_\_\_\_\_
- Taxpayer Identification Number (ITIN, Tax ID #): \_\_\_\_\_
- Unique Physician Identification Number (UPIN): \_\_\_\_\_
- National Provider Identifier (NPI): \_\_\_\_\_
- Federal Employer Identification Number (FEIN): \_\_\_\_\_

- Medicaid #: \_\_\_\_\_
- Medicare #: \_\_\_\_\_
- Other Insurer(s) #: \_\_\_\_\_

Please indicate all insurance companies and/or managed care plans you currently participate with or have provider agreements with (i.e. PPO, BCBS, PHP, Aetna, etc.):  None

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

( ) Employer Groups Please, specify: \_\_\_\_\_

**CREDENTIALS**

Licensure - Please indicate all licenses/certifications held. Physicians - Please include Board Certifications. **Attach copies.** (Required for initial credentialing and re-credentialing.)

License/Certification	License #	Expiration Date

If you are a Licensed Independent Practitioner, who is providing your supervision per the Licensing requirement?

\_\_\_\_\_  
 Name Credentials

Education - Please indicate all degrees held, name of educational institution and year degree granted. **Attach copies of degree(s) if initial credentialing.** Official transcripts are also required for initial credentialing only.

Degree	Educational Institution	Year Degree Granted

Residency - Please indicate all residencies, fellowships, or internships held. **Attach copies of residency certificates if initial credentialing.**

Institution/Address	Specialty	Months/Years Attended

Hospital Privileges - Please indicate all hospitals/outpatient settings at which privileges are held and the type of privileges (active/full, courtesy, provisional, etc.).

Institution/Address	Privilege Type	Departments

**CONTINUING EDUCATION**

Please indicate all continuing education obtained in the past two (2) years. **Copies must be attached.** (Section is for re-credentialing only.)

Continuing Ed Subject	Credits/Hours Earned	Sponsoring Institution

**MALPRACTICE AND PROFESSIONAL LIABILITY INSURANCE**

Please complete the following information for all malpractice insurance carriers for the past five years, starting with the most recent: ***Attach Copy of Insurance Certificate Indicating Limits and Expiration***

Name/Address of Carrier	Policy No.	Expiration Date	Amount of Coverage

**PROFESSIONAL REFERENCES**

**INITIAL CREDENTIALING ONLY.** Please name three (3) individuals who **have personal knowledge of your current clinical abilities, ethical character, and ability to work cooperatively with others** and who will provide specific written comments on these matters upon request. For re-credentialing, peer recommendations must be from licensed independent practitioners actively practicing in the network or from outside practitioners within the same scope of practice. ***Please provide references that have specific knowledge of the services you are requesting.***

1. Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone: \_\_\_\_\_
2. Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone: \_\_\_\_\_
3. Name: \_\_\_\_\_  
Organization: \_\_\_\_\_  
Address: \_\_\_\_\_  
Title: \_\_\_\_\_ Phone: \_\_\_\_\_

**WORK HISTORY**

Starting with the most recent, please list your previous employment over the past five years. ***For initial credentialing, LifeWays is required to contact your former employer(s) to verify position and dates of employment.*** Attach additional sheets if necessary. You may reference an attached resume is desired.

EMPLOYER NAME	POSITION	CONTACT PERSON AND TELEPHONE	DATES OF EMPLOYMENT

**DISCIPLINARY ACTIONS**

Have you ever had any of the following denied, revoked, suspended, reduced, limited, or placed on probation, or have you voluntarily relinquished any of the following in anticipation of any of these actions, or are any of these actions now pending? **IF YES, PROVIDE FULL EXPLANATION ON A SEPARATE SHEET.**

License, in any State	( ) YES	( ) NO
1. DEA Registration	( ) YES	( ) NO
2. Other professional Registration/License	( ) YES	( ) NO
3. Medical/Hospital Staff Membership	( ) YES	( ) NO
4. Clinical Privileges	( ) YES	( ) NO
5. Professional Liability Insurance	( ) YES	( ) NO
6. Have you had malpractice suits settled against you in the past five (5) years, or currently pending? (Attachment 2)	( ) YES	( ) NO
7. Have you had any other professional sanction?	( ) YES	( ) NO
8. Have you had any professional action against you which was resolved by monetary settlement? (Attachment 2)	( ) YES	( ) NO
9. Are there any medical incidents for which you have been contacted by an attorney regarding potential malpractice liability (settlement request, writ of	( ) YES	( ) NO

summons, etc.)?		
10. Within the past ten (10) years, have you ever been convicted of, or pleaded guilty to, a criminal offense, including a verdict of guilty following a plea of nolo contendere? (Attachment 1)	( ) YES	( ) NO
11. Have you had any Medicaid, Medicare, or other governmental or third-party payor sanctions?	( ) YES	( ) NO
12. Have you ever been excluded from the Medicare program? If yes, specify date: Date of Reinstatement:	( ) YES	( ) NO
13. Have civil and monetary penalties been levied against you by Medicare or Medicaid programs?	( ) YES	( ) NO

**Statement of Ability to Perform**

Do you now, or have you had any physical condition, mental condition, or substance abuse condition (alcohol, illegal or prescription drugs) that has interfered with your ability to practice or perform clinical duties, or led to suspension, termination, or any other disciplinary action(s) toward privileges or employment?	( ) YES	( ) NO
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**SERVICE CONTINUUM**

Please indicate population groups and services you are seeking approval to provide.

**Population Group (✓):**

- Adults w/Mental Illness  
 Adults w/Developmental Disabilities  
 Children w/Mental Illness  
 Children w/Developmental Disabilities  
 Elderly & Disabled  
 Substance Abuse  
 Employee Assistance  
 Co-Occurring Mental Health and Substance Abuse Disorders

**Specialty Areas (i.e. outreach, Christian Counseling, etc.) that you would like listed on the Provider Directory:**

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**Services (✓):**

Applied Behavioral Services
Assessments <i>Please specify, if desired:</i>
Authorize Admission/Referral to Services
Certification of Inpatient Services
Certified Peer Support Specialist Services
Crisis Interventions
Dialectical Behavioral Therapy (DBT) for Borderline Personality Disorder
Family Training
Family Therapy
Fiscal Intermediary Services
Health Services and Health Assessment Services (Dietary, RN)
Housing Assistance
Group Therapy
Individual Therapy
Medication Administration



**CULTURAL COMPETENCE**

Please list date and title of Cultural Diversity Training(s): **Required for Practitioner Re-credentialing**

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Please specify all fluent communicable languages (including sign language): \_\_\_\_\_

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**OPTIONAL:**

Provider network applicants are considered without regard to race, religion, sex, national origin, or handicap. LifeWays is interested in providing consumers with sufficient information on which they can base their provider selection and in assuring that the network provider reflects the diversity of our membership.

The information provided below is *optional*. It will not be used to discriminate in referrals; however, it would be available to members when they are making a choice of provider, if requested.

*Check All That Apply:*

Male

Female

Caucasian

African American

Hispanic

Other:

Asian

American Indian

Multiracial - having parents of a different race

Religious Affiliation: \_\_\_\_\_

Other Cultural Affiliations: \_\_\_\_\_

**PRIVILEGED STAFF ORGANIZATION  
STATEMENT OF PRIVATE PRACTITIONER APPLICANT**

I fully understand that any significant misstatement in or omission from this application constitutes cause for denial of appointment or cause for summary dismissal from the organization of privileged staff, loss of clinical privileges, and termination of employment or contract. All information submitted by me in this application is true to my best knowledge and belief.

In making this application for appointment or reappointment to the LifeWays provider network and privileged staff, I acknowledge that I have received and read the standards and rules and regulations of the organized, credentialed and privileged staff of this organization, and that I am familiar with the standards and ethics of the national, state, and local associations that apply to and govern my specialty and/or profession, and I agree to be bound by the terms thereof if I am granted clinical privileges, and I further agree to be bound by the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for appointment to the organized privileged staff or clinical privileges, and I further agree to abide by the organization and staff rules and regulations as may be from time to time enacted.

By applying for appointment or reappointment of membership and applicable clinical privileges, I hereby signify my willingness to appear for interviews in connection with my application. I hereby authorize the Agency, its staff, and their representatives to contact administrators and members or staffs of other facilities or institutions with which I have been associated, and with any person, organization, or others, including past and present malpractice liability insurance carriers, who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection, by the Agency, its Privileged Staff Organization, and its representatives, of all documents, including consumer records and other facilities, that may be material to an evaluation of my qualifications and competence to continue as a member of the Privileged Staff Organization and to maintain applicable privileges.

I hereby release from liability all representatives of the Agency and its staff, including, without limitation, its officers, directors, agents, and employees, for all their acts performed in good faith and without malicious intent in connection with evaluating my application, my credentials, and qualifications. I also hereby release from liability any and all individuals and organizations who provide information to the Agency or its staff in good faith and without malicious intent concerning my competence, ethics, character, and other qualifications for membership in the Privileged Staff Organization or applicable privileges, and I hereby consent to the release of such information.

I understand and agree that I, as an applicant for organized privileged staff membership or clinical privileges, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications.

I have not requested privileges for any procedures for which I am not qualified. Furthermore, I realize that certification or licensure does not necessarily qualify me to perform certain privileges. However, I believe that I am qualified to perform all clinical activities for which I have requested privileges.

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Signature of Applicant

Date

CRIMINAL BACKGROUND CHECK AUTHORIZATION

In connection with my provider network application, I hereby authorize LifeWays to investigate and obtain a record of my criminal convictions and any pending felony charges from official law enforcement agencies.

**\*Required Fields**

\*Last Name: \_\_\_\_\_ \*First Name: \_\_\_\_\_ MI: \_\_\_\_\_

Alias (Previous Name): \_\_\_\_\_

\*Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Sex: \_\_\_\_\_ M \_\_\_\_\_ F

\*Race: \_\_\_\_\_

My signature below indicates that the information that I have furnished is true and correct to the best of my knowledge.

\_\_\_\_\_  
Applicant's Signature Date

The Credentialing Reviewer has verified the accuracy of the above information to the best of his/her ability.

\_\_\_\_\_  
Signature Date

**MALPRACTICE SUIT INFORMATION FORM**

Please submit one sheet for each case settled and/or pending in the past ten years. You may use a separate form if the following elements are covered in such form.

Name of Case: \_\_\_\_\_

Case Number: \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_ Payment Due: \_\_\_\_\_

Allegations which are basis for the claim: \_\_\_\_\_

Description of circumstances in the case: \_\_\_\_\_

Disposition of Claim: \_\_\_\_\_

Date of Disposition: \_\_\_\_\_

Amount of judgment or settlement: \_\_\_\_\_

Insurance Company(s) involved (if any): \_\_\_\_\_

I hereby certify that the above information is true and accurate and that this form will be kept confidential and will only be used for credentialing or re-credentialing determination.

\_\_\_\_\_  
Name/Credentials Date