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**Pathways to SmartCare
HealthMart**

Credentialing Application Instruction Form

We would like to invite you to credential with Pathways to *SmartCare* HealthMart network. Please fill out the credentialing application completely. If a question does not apply to you, draw a line or write N/A so that every question has been addressed. We request that you **print** your answers in **ink**.

If you have any **questions** about completing the form, please contact our office for assistance or further information. The following credentialing materials must be forwarded with your application:

- Current copy of **Resume/Curriculum Vitae**
- Copy of **Professional Liability Policy and cover sheet**
- Copy of **License, if applicable**
- Signed **Provider Service Agreement**

Mail the completed application and credentialing materials to the address listed above. The application fee must be paid with the application. The application fee is based on your annual revenue. If you are not accepted into the network, you will receive a full refund.

Provider Fees

Over \$500 Thousand in Annual Revenue	Call for Pricing	
\$100 - 499 Thousand in Annual Revenue	\$	1,000
\$0 - 99 Thousand in Annual Revenue	\$	500

**Payments should be made to American Health Fairs.
Thank you for your interest in Pathways to *SmartCare*.**

GENERAL INFORMATION

Name _____

Practice/Group Name _____

Business Address: _____ Tax ID # _____

City _____ State _____ Zip Code _____
County _____ Phone _____ Fax _____

E-Mail and Practice Web Site Address _____

Practice Administrator/Office Manager's Name _____

Office Hours _____

(list additional addresses and office hours on a separate sheet)

PRACTICE INFORMATION

Accepting Patients? **Y N** Owned by/Affiliated with _____

Specialty _____

List the specialties you would like to be categorized under in the provider directory:

What foreign languages are fluently spoken in your office? Self _____ Staff _____

RISK MANAGEMENT INFORMATION

- 1. Has your professional liability insurance ever been cancelled denied? ___Yes ___ No
- 2. Has your professional license ever been denied, restricted, limited, suspended or revoked; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license, in Pennsylvania or any other state? _____ Yes _____ No If Yes, in what state? _____
Date _____

Primary License State & License Number _____

- 3. Do you now have or have you ever had a chemical dependency problem (legal or illegal drugs)? ___ Yes
No
- 4. Are you currently taking any medications that may affect either you clinical judgment or motor skills?
___Yes ___No
- 5. Other than traffic offenses, have you been convicted of a crime or do you have any felony or misdemeanor charges pending? ___ Yes ___ No
- 6. Do you have any condition that affects the performance of your duties, with or without accommodation?
___Yes ___No
- 7. Have you voluntarily relinquished hospital privileges, academic appointments or any other professional status while an investigation was conducted? _____ Yes _____ No
- 8. Have you voluntarily relinquished any licensure or registration? _____

CREDENTIALING/EDUCATION/TRAINING INFORMATION

School & Address _____

Date started _____ Date completed _____

Internship _____ **Other Training** _____

Location _____ Location _____

Date started _____ Date started _____
Date completed _____ Date completed _____

REFERENCES

List three professional references (*Include name, address & phone number*)

- 1. _____
- 2. _____
- 3. _____

ACTIVE PROFESSIONAL AFFILIATIONS

I hereby certify and attest that all information provided herein is complete and accurate. By my signature hereon, I hereby authorize American HealthCare Group and its employees or representatives, to contact, for purposes of verification of any information contained on my American HealthCare Group Application, any institution or individual. I authorize such institution or individual to release either written or oral information accordingly as requested by American HealthCare Group. I release American HealthCare Group and all verification entities from any liability concerning the processing of this application. I authorize any and all payors to release all requested information concerning my standing, records, performance report, and practice review system report to American HealthCare Group.

Signature

Date

Print Name