

Health and Insurance Services

A Medical Protective Company

Provider Database Form

GUIDELINES

Welcome to Garnet Health and Insurance Services. The document you are about to complete will be the source of the data that we will use to print your credentialing applications. It is very important to us that we provide you with applications that are as complete and accurate as possible.

When completing your Provider Database Form (PDF), please remember to:

- 1. Please print legibly.
- 2. Fill in all fields. Anything you leave blank will be blank on the Credentialing Applications we print for you.
- 3. Enter dates in the following format: MM/DD/YYYY.
- 4. Place "N/A" in any field that is not applicable to you.
- 5. Send copies of any documents listed on page 13 that you want attached to Credentialing Applications we print for you.
- 6. Sign the Authorization on page 14.

Personal Information

Demograp	hic Data			
Last Name	First	Middle	Suffix (e.g. Jr	., Sr., III)
Maiden Name, Alias or Other	Surname	Title (e a	MD, PhD, ARNP)	Gender
MM / DD / YYYY		Title (e.g.	Are you a US Citiz	en2 ☐ Yes
Date of Birth	Place of Birth		The you a do chiz	□ No
If not a US citizen, pleas	e complete the following:	Are you eligible to work	in the US? $=$ $\frac{\text{Yes}}{\text{No}}$	
			_ 110	
Visa Number	Visa Status	Country	of Citizenship	
Home Ad	dress			
	u. 655			
				,,
Address			Suite / Apartment	#
City	County	State	Zip	
Homo Tolonhono	Mobile Telephone	E-Mail Addres		
Home Telephone	Mobile Telephone	E-Mail Address	5	
Identifying I	Numbers			
Social Security Number		Individual Medicare Nu	umber	
Federal UPIN (e.g. Z12345)		Individual Medicaid Nu	ımber Med	dicaid State
CAQH ID		National Provider Iden	tifier	
Miscellaneo	us Data			
Foreign Languages Spoken B	y You			

Specialty and Board Certification

	Primary Specialty	** List Specialties in the order they should appear on applications.**
1.	Specialty Name	Name of Certifying Specialty Board
	Board Certification Status: Certified	Qualified Eligible Not Eligible Not Pursuing
	If Certified MM / DD / YYYY MM / DD / YYYY Initial Cert Last Recert	Expiration Cert # If Pursuing MM / DD / YYYY Exam Date
	Additional Specialty(ies)	
2.		
	Specialty Name	Name of Certifying Specialty Board
	Board Certification Status: Certified	Qualified
	If Certified MM / DD / YYYY MM / DD / YYYY Initial Cert Last Recert	MM / DD / YYYY If Pursuing MM / DD / YYYY Expiration Cert # Exam Date
3.		
3.	Specialty Name	Name of Certifying Specialty Board
	Board Certification Status: Certified	Qualified Eligible Not Eligible Not Pursuing
	If Certified MM / DD / YYYY MM / DD / YYYY Initial Cert Last Recert	MM / DD / YYYY If Pursuing MM / DD / YYYY Expiration Exam Date
	Initial cere Last Receiv	Expiration Cere ii
4.		
	Specialty Name	Name of Certifying Specialty Board
	Board Certification Status: Certified	Qualified Eligible Not Eligible Not Pursuing
	If Certified MM / DD / YYYY MM / DD / YYYY Initial Cert Last Recert	MM / DD / YYYY If Pursuing MM / DD / YYYY Expiration Cert # Exam Date

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Educational Background

Medical or Professional E	Education	
Medical or Professional School Name)	
City	State/Foreign Equivalent	Country
MM / DD / YYYY	MM / DD / YYYY	
Date Enrolled	Date Graduated	Degree Awarded
Foreig	gn Medical School Graduates Please Con	ıplete
ECFMG Number		ay (Please provide 5th Pathway on page 4 with Post Graduate
Other Graduate Educ	ation	
Other Graduate Luic	auon	
Other Graduate Edde	auon	
	ation	
Jniversity or College Name	State/Foreign Equivalent	Country
Jniversity or College Name		Country
Jniversity or College Name City	State/Foreign Equivalent	Country Degree Awarded
University or College Name City MM / DD / YYYY Date Enrolled	State/Foreign Equivalent M M / D D / YYYY Date Graduated	
University or College Name City	State/Foreign Equivalent M M / D D / YYYY Date Graduated	
University or College Name City MM / DD / YYYY Date Enrolled	State/Foreign Equivalent M M / D D / YYYY Date Graduated	
Undergraduate Education	State/Foreign Equivalent M M / D D / YYYY Date Graduated	
Undergraduate Educa	State/Foreign Equivalent MM / DD / YYYY Date Graduated	Degree Awarded

Post Graduate Training

** List training in chronological order.**						
Internship, Residency and Fellowship ** Make additional copies of this page as necessary.**						
Type: Internship	Residency	☐ Chief Res	sidency	Fellowship		
Institution or Facility Name						
Institution of Facility Name			MM / DD / YYYY	MM / DD / YYYY		
City		State	Start Date	Complete Date		
Specialty	Pr	ogram Director	Affiliate	d University		
Type:	Residency	☐ Chief Res	sidency	Fellowship		
Institution or Facility Name			MM / DD / YYYY	MM / DD / YYYY		
City		State	Start Date	Complete Date		
Specialty	Pr	ogram Director	Affiliate	d University		
Type: Internship	Residency	☐ Chief Res	sidency	Fellowship		
Institution or Facility Name			MM / DD / YYYY	MM / DD / YYYY		
City		State	Start Date	Complete Date		
Specialty	Pr	ogram Director	Affiliate	d University		
Other Training						
Other Training						
Туре						
Institution or Facility Name						
			MM / DD / YYYY	MM / DD / YYYY		
City		State	Start Date	Complete Date		
Specialty	Prog	gram Director	Affiliated U	niversity		

Patient Care Locations

Primary Location			
Address			
	n Nicora la con		
Department, Suite, Office or Floo	r Number		
City	County		State Zip
Provider Type: PCP	☐ Specialist	☐ PCP/Specialist	☐ Allied Health
Are you currently accepting new p	patients?		
Oo you wish to receive mail at thi	is location? Yes No		
Are there any restrictions on your	practice? Yes No	If yes, list restrictions:	
Address			
Address			
	r Number		
Department, Suite, Office or Floo	r Number		
	r Number County		State Zip
Department, Suite, Office or Floo		☐ PCP/Specialist	State Zip
Department, Suite, Office or Floo City	County Specialist	☐ PCP/Specialist	·
Department, Suite, Office or Floo City Provider Type: PCP	County Specialist patients? Yes No		·
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new p	County Specialist patients? Yes No is location? Yes No	☐ PCP/Specialist If yes, list restrictions:	•
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at this	County Specialist patients? Yes No is location? Yes No	If yes,	•
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at the large there any restrictions on your	County Specialist patients? Yes No is location? Yes No	If yes,	•
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at this	County Specialist patients? Yes No is location? Yes No	If yes,	•
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at the large there any restrictions on your	County Specialist patients? Yes No is location? Yes No r practice? Yes No	If yes,	•
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at this are there any restrictions on your Address	County Specialist patients? Yes No is location? Yes No r practice? Yes No	If yes,	•
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at this are there any restrictions on your Address	County Specialist patients? Yes No is location? Yes No r practice? Yes No	If yes,	·
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at this are there any restrictions on your Address Department, Suite, Office or Floo	County Specialist patients? Yes No is location? Yes No r practice? Yes No	If yes,	Allied Health
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor you wish to receive mail at this are there any restrictions on your enderse. Address Department, Suite, Office or Floo	County Specialist patients? Yes No is location? Yes No r practice? Yes No r No r Number County Specialist	If yes, list restrictions:	Allied Health State Zip
Department, Suite, Office or Floo City Provider Type: PCP Are you currently accepting new poor your wish to receive mail at this are there any restrictions on your poor some poor som	County Specialist patients?	If yes, list restrictions:	Allied Health State Zip

Covering Providers

Covering Provider List

**

Covering Provider's Full Name	Specialty	Phone Number

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Printed: 01-Jun-07

Hospital/Other Facility Affiliations

	Primary Hospital/Other Facility Affiliation	n ** List Hospital Affiliations in the order they should appear on applications.**
1.		
	Hospital/Facility Name	Voc
	City. Cha	Do you have admitting privileges? ☐ No tate Zip
	City Sta	tate Zip MM / DD / YYYY
	Staff Category/Privilege Type Departme	nent or Service Start Date
	Additional Hospital/Facility Affiliation(s))
2.	Hospital/Facility Name	
	Trospicary runic	Do you have admitting privileges?
	City Sta	tate Zip No
	Cheff Cohange (Divisible on Time	Affiliation Status: Current Previous
	Staff Category/Privilege Type Departme	nent or Service Start Date
	If previous:	December 6 and assistant
	End Date	Reason for Leaving
3.		
	Hospital/Facility Name	Do you have admitting privileges?
	City Sta	Do you have admitting privileges? No late Zip
		MM / DD / YYYY Affiliation Status:
	Staff Category/Privilege Type Departme	nent or Service Start Date Previous
	If previous:	
	End Date	Reason for Leaving
4.		
	Hospital/Facility Name	Vec
	City.	Do you have admitting privileges? No
		tate Zip MM / DD / YYYYY Affiliation Status: Current Previous Start Date
	If previous: MM / DD / YYYYY End Date	Reason for Leaving

Professional Affiliations

Academic/Teaching App			in the order they should tions.**
Organization Name			
			Affiliation Status: Current Previous
		Zip	_
		Annointn	nent Type/Academic Rank
Start Date	Life Date	прропи	Terre Type//teaderine realix
Organization Name			Acciliation Chatana Current
City	State	7in	Affiliation Status: Previous
MM / DD / YYYY	MM / DD / YYYY		
Start Date	End Date	Appointn	nent Type/Academic Rank
Organization Name			
			Affiliation Status: Current
City	State	Zip	Previous
MM / DD / YYYY	MM / DD / YYYY		
Start Date	End Date	Appointn	nent Type/Academic Rank
Professional Societies/A	ssociations		
Society/Association Name			
Society/Association Name			
Cariata/Aasariatian Nama			
Society/Association Name			
Society/Association Name			
Society/Association Name			
Society/Association Name			
	Organization Name City Start Date Organization Name City MM / DD / YYYY Start Date Organization Name City MM / DD / YYYY Start Date Professional Societies/A Society/Association Name Society/Association Name Society/Association Name Society/Association Name	Organization Name City State MM / DD / YYYY Start Date End Date Organization Name City State MM / DD / YYYY Start Date End Date Organization Name City State MM / DD / YYYY Start Date End Date Organization Name City State MM / DD / YYYY Start Date End Date Professional Societies/Associations Society/Association Name Society/Association Name Society/Association Name Society/Association Name	Organization Name City State Zip MM / DD / YYYY Appointm Start Date End Date Appointm Organization Name City State Zip MM / DD / YYYY Appointm Organization Name City State Zip MM / DD / YYYY Appointm Organization Name City State Zip MM / DD / YYYY Appointm Organization Name City State Zip MM / DD / YYYY Appointm Frofessional Societies/Associations Society/Association Name Society/Association Name Society/Association Name Society/Association Name

Liability Insurance

Current Liability Carrier	
Insurance Carrier (not broker/producer) Policy Effective	Policy Number Limits: Per Claim/Occurrence Annual Aggregate Retroactive Date (Claims Made only): MM / DD / YYYY
Excess Liability Insurance	
Insurance Carrier (not broker/producer) Policy Effective MM / DD / YYYY MM / DD / YYYYY Dates: From To	Policy Number Limits: Per Claim/Occurrence Annual Aggregate
Previous Insurance Carriers (10 yrs)	
Insurance Carrier (not broker/producer) Policy Effective	Policy Number Limits: Per Claim/Occurrence Annual Aggregate Retroactive Date (Claims Made only): MM / DD / YYYY
Insurance Carrier (not broker/producer) Policy Effective MM / DD / YYYY MM / DD / YYYY Dates: From To Policy Type: Occurrence Claims Made	Policy Number Limits: Per Claim/Occurrence Annual Aggregate Retroactive Date (Claims Made only): MM / DD / YYYY
Insurance Carrier (not broker/producer) Policy Effective MM / DD / YYYY MM / DD / YYYY Dates: From To Policy Type: Occurrence Claims Made	Policy Number Limits: Per Claim/Occurrence Annual Aggregate Retroactive Date (Claims Made only): MM / DD / YYYY

Work History

	Work History	** List work history for last 1 chronological order (curre	.0 years in reverse nt first).**
1.	Current Organization Name		
	Address	Suite, Offic	ce, Floor Number, etc.
	City	State	Zip
	Position Held MM / DD / YYYY Start Date	Contact Name	Contact Telephone
2.	Organization Name		
	Address	Suite, Offic	ce, Floor Number, etc.
	City Position Held	State Contact Name	Zip Contact Telephone
	MM / DD / YYYY MM / DD / YYYY Start Date End Date	Contact Hame	contact relephone
3.	Organization Name		
	Address	Suite, Offic	ce, Floor Number, etc.
	City	State	Zip
	Position Held MM / DD / YYYY Start Date End Date	Contact Name	Contact Telephone

Professional References

	Professional References	** Do	not list cu	rrent Associat	es in Practice.**
1.					
	Reference Name				Title (e.g. MD)
	Specialty			Relationship:	☐ Peer ☐ Department Head
	Address				
	City	State	Zip		Telephone
2.					
	Reference Name				Title (e.g. MD)
	Specialty			Relationship:	☐ Peer ☐ Department Head
	Address				
	City	State	Zip		Telephone
	,		·		
3.	Reference Name				Title (a.c. MD)
	Reference name			Relationship:	Title (e.g. MD) ☐ Peer
	Specialty			reacionship.	☐ Department Head
	Address				
	City	State	Zip		Telephone
	,		·		
4.	Reference Name				Title (e.g. MD)
	Reference maine			Relationship:	Peer
	Specialty			- Tolucionompi	☐ Department Head
	Address				
	City	State	Zip		Telephone

Licensure and Registration

State Profe	ssional License(s)		to 3 licens on applica	es in the order t itions.**	hey should
1. License T	uno Licos	nse Number	State 0	MM/DD/YYYY Driginal Issue Date	MM/DD/YYYY Expiration Date
License 1	Are you currently pract		Yes	□ No	Expiration Date
2. License T	ype Lice	nse Number	State 0	MM/DD/YYYY Driginal Issue Date	MM/DD/YYYY Expiration Date
	Are you currently pract	icing in this state?	☐ Yes	□ No	
3. License T	, ,	nse Number		MM/DD/YYYY Original Issue Date	MM/DD/YYYY Expiration Date
	Are you currently prac	ticing in this state?	☐ Yes	□ No	
Federal DE	A Registration(s)				
1.		M	1/DD/ YY	YY	M/DD/YYYY
DEA N	umber S	tate I	ssue Date	E :	xpiration Date
2.			1/DD/ YY		M/DD/YYYY
DEA N	umber S	tate I	ssue Date	E:	xpiration Date
State Controlled	Substance License(s)			
1.		M	1/DD/ YY	Y Y M	M/DD/ YYYY
License	Number S	tate I	ssue Date	E:	xpiration Date
2.			1/DD/ YY		M/DD/YYYY
License	Number S	tate I	ssue Date	E	xpiration Date

Documents Checklist

Primary Credentialing Documents	Are You Certified?	On File?	Check if Attached
Medical or Other Professional Licenses			
Federal DEA Certificate			
State Narcotics License			
Liability Insurance Face Sheet			
Curriculum Vitae			
ECFMG Certificate (if applicable)			
Specialty Board Certificate(s)			
NPI Letter			
tate Specific Credentialing Documents			
MA - Most Recent License Application			
NY - Certificate of Registration			
NY - Infection Control Certificate			
NY - Injection Control Certificate			
NY - Abuse Control Certificate			
NY - Abuse Control Certificate Additional Credentialing Documents			
NY - Abuse Control Certificate Additional Credentialing Documents CLIA Laboratory Certificate (if applicable)			
NY - Abuse Control Certificate Additional Credentialing Documents			
NY - Abuse Control Certificate Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s)			
NY - Abuse Control Certificate Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate Post Graduate Certificate(s)			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate Post Graduate Certificate(s) Workers' Compensation			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate Post Graduate Certificate(s) Workers' Compensation Advanced Cardiac Life Support (ACLS)			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate Post Graduate Certificate(s) Workers' Compensation Advanced Cardiac Life Support (ACLS) Advanced Trauma Life Support (ATLS)			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate Post Graduate Certificate(s) Workers' Compensation Advanced Cardiac Life Support (ACLS) Advanced Trauma Life Support (ATLS) Basic Life Support (BLS)			
Additional Credentialing Documents CLIA Laboratory Certificate (if applicable) CME Certificate(s) Excess Insurance Face Sheet Hospital Privilege Letter(s) Letter(s) of Reference Medical or Professional School Certificate Post Graduate Certificate(s) Workers' Compensation Advanced Cardiac Life Support (ACLS) Advanced Trauma Life Support (ATLS) Basic Life Support (BLS) Cardiopulmonary Resuscitation (CPR)			

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Authorization and Signature

I hereby acknowledge that I have reviewed the information presented herein and agree that, to the best of my knowledge and
belief, it is true and accurate and free of any material misstatement or omission. I further authorize Garnet Health and Insurance
Services to use said information in the completion of credentialing
applications and to act on my behalf when necessary in matters relating to my credentialing and enrollment with health plans and
third party payors, or for any other contracted purpose.
Signature Date
Upon completion, please forward the Provider Database Form and all Attachments to:
Garnet Health and Insurance Services
4 Merrill Industrial Drive
Hampton, NH 03843-0476