GARNET

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

Demographic Data

Last Name | First | Middle | Suffix (e.g. Jr., Sr., III)

Maiden Name, Alias or Other Surname | Title (e.g. MD, PhD, ARNP) | Gender

MM / DD / YYYY

Date of Birth | Place of Birth | Are you a US Citizen? ☐ Yes ☐ No

If not a US citizen, please complete the following: Are you eligible to work in the US? ☐ Yes ☐ No

Visa Number | Visa Status | Country of Citizenship

Home Address

Address | Suite / Apartment #

City | County | State | Zip

Home Telephone | Mobile Telephone | E-Mail Address

Identifying Numbers

Social Security Number | Individual Medicare Number

Federal UPIN (e.g. Z12345) | Individual Medicaid Number | Medicaid State

CAQH ID | National Provider Identifier

Miscellaneous Data

Foreign Languages Spoken By 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 Initial Cert | MM / DD / YYYY Last Recert | MM / DD / YYYY 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 ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: MM / DD / YYYY Initial Cert | MM / DD / YYYY Last Recert | MM / DD / YYYY Expiration | Cert #

If Pursuing: MM / DD / YYYY Exam Date

3.

Specialty Name

Name of Certifying Specialty Board

Board Certification Status: ☐ Certified ☐ Qualified ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: MM / DD / YYYY Initial Cert | MM / DD / YYYY Last Recert | MM / DD / YYYY Expiration | Cert #

If Pursuing: MM / DD / YYYY Exam Date

4.

Specialty Name

Name of Certifying Specialty Board

Board Certification Status: ☐ Certified ☐ Qualified ☐ Eligible ☐ Not Eligible ☐ Not Pursuing

If Certified: MM / DD / YYYY Initial Cert | MM / DD / YYYY Last Recert | MM / DD / YYYY Expiration | Cert #

If Pursuing: MM / DD / YYYY Exam Date

Educational Background

Medical or Professional Education

Medical or Professional School Name

City | State/Foreign Equivalent | Country

MM / DD / YYYY Date Enrolled | MM / DD / YYYY Date Graduated | Degree Awarded

Foreign Medical School Graduates Please Complete

ECFMG Number | MM / DD / YYYY ECFMG Date | OR | ☐ 5th Pathway (Please provide 5th Pathway internship on page 4 with Post Graduate Training)

Other Graduate Education

University or College Name

City | State/Foreign Equivalent | Country

MM / DD / YYYY Date Enrolled | MM / DD / YYYY Date Graduated | Degree Awarded

Undergraduate Education

University or College Name

City | State/Foreign Equivalent | Country

MM / DD / YYYY Date Enrolled | MM / DD / YYYY Date Graduated | Degree Awarded

Post Graduate Training

**** List training in chronological order.****

**** Make additional copies of this page as necessary.****

Internship, Residency and Fellowship

Type: ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship

Institution or Facility Name

City | State | Start Date (MM / DD / YYYY) | Complete Date (MM / DD / YYYY)

Specialty | Program Director | Affiliated University

Type: ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship

Institution or Facility Name

City | State | Start Date (MM / DD / YYYY) | Complete Date (MM / DD / YYYY)

Specialty | Program Director | Affiliated University

Type: ☐ Internship ☐ Residency ☐ Chief Residency ☐ Fellowship

Institution or Facility Name

City | State | Start Date (MM / DD / YYYY) | Complete Date (MM / DD / YYYY)

Specialty | Program Director | Affiliated University

Other Training

Type

Institution or Facility Name

City | State | Start Date (MM / DD / YYYY) | Complete Date (MM / DD / YYYY)

Specialty | Program Director | Affiliated University

Patient Care Locations

**** List Locations where YOU provide patient care for in the order they should appear on applications.****

Primary Location

1.

Address

Department, Suite, Office or Floor Number

City County State Zip

Provider Type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Allied Health

Are you currently accepting new patients? ☐ Yes ☐ No

Do you wish to receive mail at this location? ☐ Yes ☐ No

Are there any restrictions on your practice? ☐ Yes ☐ No If yes, list restrictions:

2.

Address

Department, Suite, Office or Floor Number

City County State Zip

Provider Type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Allied Health

Are you currently accepting new patients? ☐ Yes ☐ No

Do you wish to receive mail at this location? ☐ Yes ☐ No

Are there any restrictions on your practice? ☐ Yes ☐ No If yes, list restrictions:

3.

Address

Department, Suite, Office or Floor Number

City County State Zip

Provider Type: ☐ PCP ☐ Specialist ☐ PCP/Specialist ☐ Allied Health

Are you currently accepting new patients? ☐ Yes ☐ No

Do you wish to receive mail at this location? ☐ Yes ☐ No

Are there any restrictions on your practice? ☐ Yes ☐ No If yes, list restrictions:

Covering Providers

Covering Provider List **

Covering Provider's Full Name	Specialty	Phone Number

Hospital/Other Facility Affiliations

Primary Hospital/Other Facility Affiliation

** **List Hospital Affiliations in the order they should appear on applications.****

1\.

Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type

Department or Service

MM / DD / YYYY
Start Date

Additional Hospital/Facility Affiliation(s)

2\.

Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type

Department or Service

MM / DD / YYYY
Start Date

Affiliation Status: ☐ Current ☐ Previous

If previous: MM / DD / YYYY
End Date

Reason for Leaving

3\.

Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type

Department or Service

MM / DD / YYYY
Start Date

Affiliation Status: ☐ Current ☐ Previous

If previous: MM / DD / YYYY
End Date

Reason for Leaving

4\.

Hospital/Facility Name

City State Zip

Do you have admitting privileges? ☐ Yes ☐ No

Staff Category/Privilege Type

Department or Service

MM / DD / YYYY
Start Date

Affiliation Status: ☐ Current ☐ Previous

If previous: MM / DD / YYYY
End Date

Reason for Leaving

Professional Affiliations

Academic/Teaching Appointments

**** List Appointments in the order they should appear on applications.****

1. Organization Name
City / State / Zip — Affiliation Status: ☐ Current ☐ Previous
MM / DD / YYYY Start Date — MM / DD / YYYY End Date — Appointment Type/Academic Rank

2. Organization Name
City / State / Zip — Affiliation Status: ☐ Current ☐ Previous
MM / DD / YYYY Start Date — MM / DD / YYYY End Date — Appointment Type/Academic Rank

3. Organization Name
City / State / Zip — Affiliation Status: ☐ Current ☐ Previous
MM / DD / YYYY Start Date — MM / DD / YYYY End Date — Appointment Type/Academic Rank

Professional Societies/Associations

1. Society/Association Name
2. Society/Association Name
3. Society/Association Name
4. Society/Association Name
5. Society/Association Name

Liability Insurance

Current Liability Carrier

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: MM / DD / YYYY From | MM / DD / YYYY To

Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made

Retroactive Date (Claims Made only): MM / DD / YYYY

Excess Liability Insurance

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: MM / DD / YYYY From | MM / DD / YYYY To

Limits: Per Claim/Occurrence | Annual Aggregate

Previous Insurance Carriers (10 yrs)

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: MM / DD / YYYY From | MM / DD / YYYY To

Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made

Retroactive Date (Claims Made only): MM / DD / YYYY

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: MM / DD / YYYY From | MM / DD / YYYY To

Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made

Retroactive Date (Claims Made only): MM / DD / YYYY

Insurance Carrier (not broker/producer) | Policy Number

Policy Effective Dates: MM / DD / YYYY From | MM / DD / YYYY To

Limits: Per Claim/Occurrence | Annual Aggregate

Policy Type: ☐ Occurrence ☐ Claims Made

Retroactive Date (Claims Made only): MM / DD / YYYY

Work History

Work History

** **List work history for last 10 years in reverse chronological order (current first).****

1\.

Current Organization Name

Address | Suite, Office, Floor Number, etc.

City | State | Zip

Position Held | Contact Name | Contact Telephone

MM / DD / YYYY
Start Date

2\.

Organization Name

Address | Suite, Office, Floor Number, etc.

City | State | Zip

Position Held | Contact Name | Contact Telephone

MM / DD / YYYY | MM / DD / YYYY
Start Date | End Date

3\.

Organization Name

Address | Suite, Office, Floor Number, etc.

City | State | Zip

Position Held | Contact Name | Contact Telephone

MM / DD / YYYY | MM / DD / YYYY
Start Date | End Date

Professional References

Professional References

**** Do not list current Associates 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 (e.g. MD)

Specialty — Relationship: ☐ Peer ☐ Department Head

Address

City — State — Zip — Telephone

4.

Reference Name — Title (e.g. MD)

Specialty — Relationship: ☐ Peer ☐ Department Head

Address

City — State — Zip — Telephone

Licensure and Registration

State Professional License(s)

**** List up to 3 licenses in the order they should appear on applications.****

1. License Type | License Number | State | Original Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)
   Are you currently practicing in this state? ☐ Yes ☐ No

2. License Type | License Number | State | Original Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)
   Are you currently practicing in this state? ☐ Yes ☐ No

3. License Type | License Number | State | Original Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)
   Are you currently practicing in this state? ☐ Yes ☐ No

Federal DEA Registration(s)

1. DEA Number | State | Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)

2. DEA Number | State | Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)

State Controlled Substance License(s)

1. License Number | State | Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)

2. License Number | State | Issue Date (MM/DD/YYYY) | Expiration Date (MM/DD/YYYY)

Documents Checklist

Please attach current copies of the following documents as they apply:

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			

State Specific Credentialing Documents	Are You Certified?	On File ?	Check if Attached
MA - Most Recent License Application			
NY - Certificate of Registration			
NY - Infection Control Certificate			
NY - Abuse Control Certificate			

Additional Credentialing Documents	Are You Certified?	On File ?	Check if Attached
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)			
Health Care Provider (Core 'C')			
Neonatal Advanced Life Support (NALS)			
Pediatric Advanced Life Support (PALS)			

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