Dear Provider,

Thank you for your interest in applying for membership and/or privileges at one or more of our HCA Healthcare Capital Division Hospitals. Please complete the enclosed Provider Interest Form in its entirety and return it with copies of all required documents to Capital Division Medical Staff Services. Upon receipt of your information, each hospital will review your request. Provided you meet general eligibility requirements, you will receive a link via email and be provided with a Request for Consideration (RFC) via our online system, Parallon HCA Credentialing Online (HCO).

Enclosed you will also find a Delegate Authorization Form that will need to be completed if you would like to designate someone to submit the credentialing materials on your behalf. You and/or your designee will complete your RFC in HCO. Once the RFC is completed and you have attested in HCO, the credentialing process takes an average of 35-40 days. Should there be an important patient care need that may require expedited processing, please contact the specific hospital's Medical Staff Office.

Online RFCs are expected to be completed and submitted within 7-14 business days from the date the link is emailed to you. To become familiar with the HCA credentialing process please visit www.HCAcredentialingonline.com. The following documentation will be required when submitting your online RFC:

- Case Logs/Clinical Activity for the most recent 24 months from your primary facility or training program
- CME certificates or CME course completion list for most recent 24 months

Additionally, please look for an email with a link and login information to complete any online education requirements through the Physician Learning Center/Healthstream that may be necessary to satisfy credentialing criteria. The online training will provide education on our electronic health record system, and as well as applicable policies, procedures and safety protocols in place at our Hospitals. Note that, prior to providing any patient care, you will be required to complete all assigned online courses and have your identity verified by Medical Staff Services. You must receive hospital specific approvals prior to exercising privileges at any facility.

Completed Provider Interest Forms and supporting documentation may be sent via email to: CAPDMedicalStaffServices@HCAHealthcare.com

To submit via mail, please send to:
HCA Healthcare Capital Division Medical Staff Services
Attn: Sarah Toler
901 E Cary Street
Suite 2100
Richmond, VA 23219

You may submit questions or concerns regarding the prescreening process via email at CAPDMedicalStaffServices@HCAHealthcare.com or by phone at (804) 806-8550.
Please submit application fees directly to the facilities as listed on the provider interest form and direct any Hospital facility specific questions to the Hospital's Medical Staff Office.

Thank you again for your interest in our Hospitals, we look forward to working with you.

Sincerely,

Sarah Toler, CPMSM
Assistant Vice President
HCA Capital Division Medical Staff Services

HCA Healthcare℠ | Capital Division

MEDICAL & ADVANCED PRACTICE PROFESSIONAL PROVIDER INTEREST FORM

Select Hospital(s) where you are requesting to initiate a Request for Consideration of Membership and/or Clinical Privileges.	Richmond VA Market	Northern VA Market	Southwest VA Market	NH Market
	☐ Chippenham & Johnston-Willis Hospitals	☐ Reston Hospital Center	☐ LewisGale Medical Center	☐ Portsmouth Regional Hospital
	☐ Henrico Doctors' Hospital-Forest, Parham, Retreat	☐ StoneSprings Hospital Center	☐ LewisGale Hospital Alleghany	☐ Parkland Medical Center
	☐ TriCities Hospital	☐ Dominion Hospital	☐ LewisGale Hospital Montgomery	☐ Frisbie Memorial Hospital
	☐ Spotsylvania Regional Medical Center		☐ LewisGale Hospital Pulaski	☐ Catholic Medical Center

If selecting more than one Hospital, please state which will be your primary hospital: _____

PROVIDER DEMOGRAPHIC INFORMATION

FIRST NAME	MIDDLE NAME	LAST NAME	DEGREE

DATE OF BIRTH	GENDER	SOCIAL SECURITY NUMBER	NPI
	☐M ☐F		

PRACTICE AREA/SPECIALTY	PROVIDER CELL PHONE	PROVIDER EMAIL

HOME ADDRESS INFORMATION

STREET	UNIT/APT

CITY	STATE	ZIP CODE

PRIMARY OFFICE INFORMATION

GROUP NAME

STREET	SUITE

CITY	STATE	ZIP CODE

PHONE	FAX

OFFICE MANAGER NAME	OFFICE MANAGER EMAIL

CREDENTIALING ADDRESS INFORMATION

STREET	SUITE

CITY	STATE	ZIP CODE

PHONE	FAX

CREDENTIALING CONTACT NAME	CREDENTIALING CONTACT EMAIL

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PRACTICE INFORMATION

EXPECTED START DATE:	ARE YOU A LOCUMS PROVIDER? ☐ YES ☐ NO
ARE YOU AN HCA EMPLOYED PROVIDER? ☐ YES ☐ NO	ARE YOU COVERED UNDER HCI MALPRACTICE INSURANCE? ☐ YES ☐ NO
ARE YOU A TELEMEDICINE PROVIDER? ☐ YES ☐ NO	ARE YOU A HOSPITALIST PROVIDER? ☐ YES ☐ NO

ARE YOU LAWFULLY AUTHORIZED TO WORK IN THE UNITED STATES OF AMERICA, WHETHER THROUGH CITIZENSHIP, PERMANENT RESIDENT STATUS, OR POSSESSION OF A VALID VISA? ☐ YES ☐ NO

NAME OF BACK UP PHYSICIAN(S)

NAME OF PHYSICIANS WHO SHARE CALL IF OUTSIDE YOUR GROUP

APPS-LIST SPONSORING PHYSICIAN(S)

IF CURRENTLY IN RESIDENCY OR FELLOWSHIP, LIST EXPECTED DATE OF COMPLETION

LICENSURE & CERTIFICATION INFORMATION

**PLEASE NOTE APPLICATION REQUESTS WILL NOT BE SUBMITTED UNTIL PROVIDER HAS ACTIVE STATE LICENSE and DEA WITH ADDRESS IN STATE WHICH PRIVILEGES ARE BEING REQUESTED

BOARD CERTIFICATION

IF YOU HAVE TAKEN AND FAILED TO PASS A SPECIALTY BOARD EXAMINATION, PLEASE LIST THE BOARD'S NAME AND DATE OF EXAMINATION(S):

IF STATUS IS ONE OF ELIGIBILITY, INDICATE DATE ELIGIBILITY STATUS WILL TERMINATE UNDER RULES OF THAT SPECIFIC BOARD:

LICENSE STATE	LICENSE NUMBER	EXPIRATION DATE
LICENSE STATE	LICENSE NUMBER	EXPIRATION DATE
LICENSE STATE	LICENSE NUMBER	EXPIRATION DATE
DEA CERTIFICATION STATE	DEA NUMBER	EXPIRATION DATE
DEA CERTIFICATION STATE	DEA NUMBER	EXPIRATION DATE
DEA CERTIFICATION STATE	DEA NUMBER	EXPIRATION DATE

DISCLOSURE QUESTIONS – ANY YES RESPONSES REQUIRE A DETAILED EXPLANATION

	YES	NO
1. HAS YOUR LICENSE TO PRACTICE IN ANY STATE EVER BEEN DENIED, LIMITED, SUSPENDED, REVOKED, PLACED ON PROBATION, OR VOLUNTARILY/INVOLUNTARILY RELINQUISHED?	☐	☐
2. ARE THERE CURRENTLY ANY RESTRICTIONS ON YOUR DEA AND/OR STATE CONTROLLED SUBSTANCE LICENSE(S)?	☐	☐
3. HAVE YOU EVER BEEN CONVICTED OF MEDICARE, MEDICAID, OR OTHER GOVERNMENTAL OR THIRD-PARTY PAYOR FRAUD OR PROGRAM ABUSE, BEEN REQUIRED TO PAY CIVIL MONEY PENALTIES FOR THE SAME, OR EXCLUDED, OR PRECLUDED FROM PARTICIPATION IN MEDICARE OR MEDICAID?	☐	☐
4. HAVE YOU EVER BEEN CONVICTED OF ANY FELONY OR MISDEMEANOR?	☐	☐
5. HAVE YOU EVER HAD YOUR MEDICAL STAFF APPOINTMENT OR ANY CLINICAL PRIVILEGES DENIED, REVOKED, SUSPENDED OR TERMINATED BY ANY HOSPITAL FOR REASONS RELATED TO CLINICAL COMPETENCE OR PROFESSIONAL CONDUCT?	☐	☐
6. WERE YOU EVER PLACED ON PROBATION, DISCIPLINED, FORMALLY REPRIMANDED, SUSPENDED OR ASKED TO RESIGN DURING AN INTERNSHIP, RESIDENCY, FELLOWSHIP, PRECEPTORSHIP OR OTHER CLINICAL EDUCATION PROGRAM?	☐	☐
7. ARE YOU PRESENTLY UNDER INVESTIGATION BY ANY HOSPITAL, STATE OR FEDERAL AGENCY/AUTHORITY, OR HAVE YOU RESIGNED WHILE UNDER INVESTIGATION?	☐	☐
8. HAVE ANY PROFESSIONAL LIABILITY CLAIMS, SUITS OR JUDGMENTS EVER BEEN FILED AGAINST YOU? IF YES, INCLUDE CURRENT STATUS OF ALL CLAIMS WITH DETAILED EXPLANTION	☐	☐

TUBERCULOSIS SCREENING		
1a. Please provide the date of your most recent tuberculosis skin test (TST) or an Interferon Gamma Release Assay (IGRA) blood test	Date:	N/A; not tested* Unknown*
1b. Please state whether your most recent TST or IGRA was positive or negative for tuberculosis.	Negative Test	Positive Test* Unknown*
1c. Please state whether you have a history of a TST, an IGRA or a chest x-ray that was positive for tuberculosis.	Negative history	Positive history* Unknown*
1d. Please state whether any of the following statements are true for you: • You are currently immunosuppressed (e.g., organ transplant recipient, or receiving treatment with immunosuppression drugs, including prednisone). • You have had close contact with someone who has had infectious TB disease since your last TB test.	No to all statements in 1d	Yes to one or more statements*
1e. Please state whether you currently have any of the following symptoms: • Persistent cough lasts 3 weeks or longer • Pain in the chest • Coughing up blood or bloody sputum • Weakness or fatigue • Unexplained weight loss • No appetite • Chills • Fever, or low grade persistent fevers • Sweating at night • Shortness of breath	Negative for symptoms in 1e	Positive for listed symptoms*

NOTE: Answers annotated with an asterisk (*) must be referred by Medical Staff Services to the facility's representative assigned to provide follow-up, i.e., Infection Prevention Specialist (IPS), Workforce Health & Safety, or others.

TO INITIATE PROCESSING, THIS FORM MUST BE RETURNED WITH COPIES OF THE FOLLOWING DOCUMENTS:
(SEND AS PDF FILES)

1. Certificate of coverage from professional liability insurance carrier with required limits
2. Current Curriculum Vitae (CV) listing all education, training and employment dates in mm/yyyy format
3. APPs - copies of executed practice Agreement, Collaborative Agreements and/or Written Protocols

I understand that the information requested on this pre-screening form is sought to enable the hospital(s) to make an administrative determination as to whether or not I am eligible to receive a request for consideration. The provider interest form does NOT constitute an application.
I hereby release from any and all liability, and agree to not take any legal action against, the hospital(s) or its representatives for their actions in connection with evaluating the information provided on this form and determining whether or not I am eligible to receive a request for consideration. I understand a determination that I am ineligible to receive a request for consideration does not give rise to any hearing rights under the Medical Staff Bylaws and/or Credentials Policy, and does not require a report to the National Practitioner Data Bank.

_____

Provider Signature and Date

RETURN COMPLETED FORMS TO THE CAPITAL DIVISION CREDENTIALS OFFICE via email to CAPDMedicalStaffServices@HCAHealthcare.com

* If you will be using a credentials delegate to assist with submission of your credentialing information, the HCA Delegate Form must accompany these forms.

HCA Healthcare | Capital Division

HCA HEALTHCARE CAPITAL DIVISION FACILITY REQUIRED PROVIDER APPLICATION FEES	
RESTON HOSPITAL CENTER Application fee: $200 Made payable to: Reston Hospital Center Mail to: Reston Hospital Center Attn: Medical Staff Office 1850 Town Center Pkwy Reston, VA 20190 (Application fee must be paid prior to application being advanced to Hospital committee for approval.)	**STONESPRINGS HOSPTIAL CENTER** Application fee: $150 Made payable to: StoneSprings Hospital Center Mail to: StoneSprings Hospital Center Attn: Medical Staff Office 24440 StoneSprings Blvd. Dulles, VA 20166
PORTSMOUTH REGIONAL HOSPITAL Initial Application Fee: $500 Reappointment Application Fee: $200 Invoice will be issued by Cents and Balance Bookkeeping once applicant is approved.	**FRISBIE MEMORIAL HOSPITAL** Initial Application Fee: $300 Reappointment Application Fee: $150 Invoice will be issued by Cents and Balance Bookkeeping once applicant is approved.
PARKLAND MEDICAL CENTER Application fee: $400 Reappointment Application fee: $200 Made payable to: Parkland Medical Center Mail to: Parkland Medical Center Attn: Medical Staff Office 1 Parkland Drive Derry, NH 03038	**CATHOLIC MEDICAL CENTER** Application fee: $150 Made payable to: Catholic Medical Center Reappointment Dues: $200 Made payable to: CMC Medical Staff Mail to: Catholic Medical Center Attn: Medical Staff Office 100 McGregor Street Manchester, NH 03102

Delegate Authorization Form

Practitioner Name: _____

Group Name of Practitioner: _____

Street Address: _____

City: _____

State: _____

We are excited to partner with you through our credentialing services!

The Parallon credentialing process includes a convenient online tool, the Credentialing Portal. This tool serves as a single point of access and is a secure website allowing you to view and manage your portion of the credentialing process, monitor progress at each step, and upload documents to update expiring or missing items at any time.

How to Use the Portal

You will receive an email notification when it is time for you or your delegate to complete your initial appointment or re-appointment packet. This email will provide you with a link to job aids, instructions and training material. If you would like to see this information before it is time for you to complete the forms, you can do so by visiting www.hcacredentialingonline.com.

Credentialing Portal Benefits and Features

- Enables you to complete the credentialing packet online for multiple entities
- Provides you with electronic access to create, modify and submit your credentialing documents
- Ensures accuracy and completeness of your submitted data
- Provides the ability to establish a delegate to prepare the required forms and documentation for your approval
- Allows access to all practitioners who are associated with or seeking association to our entity
- Enables online attestation form completion

Action Needed from You to Get Started!

To ensure you have the capability to receive and submit information online through the Portal, please complete and return the attached form indicating whether you will provide credentialing information personally or through a delegate. Please note that should a delegate be assigned, the individual will also be considered as your Credentialing Contact and will receive all communication related to the credentialing process.

Please complete the attached authorization form and return via email or mailing address indicated at the bottom of this communication. If you have any questions, please contact our customer service at the telephone number listed below.

HCA Healthcare Capital Division Medical Staff Services
901 E. Cary Street | Richmond, VA 23219
804-806-8550 phone
CAPDMedicalStaffServices@HCAHealthcare.com
(12.06.23 version)

PARALLON

HCA Credentialing Portal – Practitioner's Authorization for Delegate

Step 1:

Please enter your contact information to ensure the information we may already have is accurate in our credentialing system.

Practitioner Name: _____

Practitioner Phone: _____

Practitioner Email* (required): _____

NOTE: Practitioner email must be unique to the practitioner; it cannot be the same address as a delegate.

Step 2:

☐ I do not want to select any delegates at this time. I will personally provide credentialing information. _____ (Please initial and skip to Step 3)

☐ The individual **OR** group listed below will act as my delegate. I hereby authorize (hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Portal to enter data and submit documents for the Request for Considerations (RFC) and Recredentialing Requests for Consideration (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to the entity via the HCA Credentialing Portal.

Please provide the following information for the delegate if the delegate is an individual

Delegate Name	**First***	**Last***
Contact Information	**Email***	**Phone***

Please provide the following information for if the delegate is a group

Group Name	**Name***	
Contact Information	**Email***	**Phone***

NOTE: Please complete either an individual delegate **or** a group delegate **(*do not complete both, as only one can be added*). Fields with an asterisk are required.**

Step 3:

Please complete, sign and date. Your signature may be a wet ink signature, digitally created signature (made on electronic device using finger or mouse) or an authenticated electronic signature using technology authentication and data encryption. The form may be returned via email or U.S. mail using the contact information provided at the bottom of this communication.

Where applicable, I acknowledge that my group may leverage a shared or generic delegate account to access the HCA Credentialing Portal, update data, and submit documents on my behalf. I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

_____ _____

PRACTITIONER SIGNATURE **NAME (printed)**

_____ _____

LAST 4 of SSN or FULL NPI **DATE (MM/DD/YYYY)**

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PARALLON