Important Notice

Dear Provider or Delegate,

Please note: It is very important you complete all of the preRFC. Failure to do so will result in the form being sent back for completion. This will cause a delay in processing your request. If you have any questions regarding facility specific information like category, or privileges please contact the facility. For questions regarding filling out the form please email to ***MWDO.PRERFC@HCAHEALTHCARE.COM.***

Thank you for interest in our facilities.
Crystal Singer
Division Credentialing Data & Support Manager
crystal.singer@hcamidwest.com

HCA MIDWEST HEALTH SYSTEM
DIVISION PROVIDER INFORMATION FORM

We have received information that you would like to apply for Request for Consideration (RFC) at an HCA Midwest Division facility. Please complete this form and send as indicated below. *Fields marked with an asterisk (*) must be completed.*

***PSG?**(**Employed** with HCA Physician Services) **Yes** ☐ **No** ☐ ***If Yes PSG Employed or Contracted** ________________ **PSG Start Date** _______________

*Are you **Locum** provider? Yes ☐ No ☐ ***Hospitalist**? Yes ☐ No ☐ If Yes - Contracted ☐ Employed ☐ Independent ☐ Other ☐ ***Telemedicine**? Yes ☐ No ☐

***Name** ________________________________ ***Degree (e.g. MD, DO, DPM, CRNA)**________________________

Group Practice Name** ______________________________ ******Provider **E-mail Addr.**______________________________

***DOB:**____________________ ***SS#:**__________________________ ***NPI:** __________________________ ***Gender** __________

***Home Address:** ____ **Phone: (   )** _____________
Street Address Apt # City, State Zip

***Credentialing Address:** ____ **Phone: (   )** _____________ **Fax: (   )** _______________
Street Address Ste # City, State Zip

***Primary Address:** ____ **Phone: (   )** _____________ **Fax: (   )** _______________
Street Address Ste # City, State Zip

***Board Certification**: Are you board certified? Yes ☐ No ☐ If yes, what specialty (ies) ______________________________
If no, do you meet the requirements for Board Eligibility as set by your specialty board? Yes ☐ No ☐
Date of scheduled exam ___________ or, Date of Completion of Formal training _____________

***If you are currently in Residency or Fellowship –Date of Completion** ______________________ **Specialty** ______________________________
***If you are currently in Residency/Fellowship is completion required for privileges you are requesting?** Yes ☐ No ☐

I hereby make a Request for Consideration for membership on the Medical Staff to practice at the following HCA Midwest Division facility(s) as noted on the attached document. Furthermore, I also make Request for Consideration for the privileges checked as indicated on the attached document.

***Physician / Advanced Practice Professional Signature (Or Delegate)** ______________________________________ **Date** _______________
(If using a delegate please print, complete and fax back with the pre-app the Provider's Authorization for Delegate form)
Upon receipt of this information, the Nashville Credentialing Processing Center (CPC) will send a RFC Packet to the address you indicated above. This form will also be faxed to the Facility (ies) that you indicated and they will send to you their Facility-Specific Document Packet.
Please email or fax all pages of this completed form to:

**** FAX ALL PAGES TO THE DIVISION OFFICE or EMAIL TO MWDO.PRERFC@HCAHEALTHCARE.COM ****

Fax (816) 359-3520

*All pages must be completed and returned

Facility Category/Alternate Coverage/Sponsoring Physician

(Please complete for each facility you are applying for –For questions or clarification please call facility)

Belton Regional Medical Center

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Ambulatory ☐ Associate/Affiliate ☐ Courtesy ☐ Consulting ☐ Privileges without Membership ☐

Cass Regional Medical Center - 816-887-0310

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Ambulatory ☐ Associate/Affiliate ☐ Courtesy ☐ Consulting ☐ Privileges without Membership ☐

Centerpoint Medical Center - 816-698-8152

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Ambulatory ☐ Associate/Affiliate ☐ Courtesy ☐ Consulting ☐ Privileges without Membership ☐

Lafayette Regional Health Center

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Ambulatory ☐ Associate/Affiliate ☐ Courtesy ☐ Consulting ☐ Privileges without Membership ☐

Lee's Summit Medical Center - 816-282-5750

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Ambulatory ☐ Consulting ☐ Courtesy ☐ Privileges without Membership ☐

Menorah Medical Center - 913-498-6625

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Ambulatory ☐ Associate/Affiliate ☐ Courtesy ☐ Consulting ☐ Privileges without Membership ☐

Overland Park Regional Medical Center - 913-541-5353

Physician – Alternate Physician: ___________________________

Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ______________________________

Staff Category Requesting: Active ☐ Associate/Affiliate ☐ Courtesy ☐ Privileges without Membership ☐

Facility Category/Alternate Coverage/Sponsoring Physician Con't

Please complete for each facility you are applying for)

Research Medical Center - 816-276-4256
Physician – Alternate Physician: ________________________
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Active ☐ Ambulatory ☐ Associate/Affiliate ☐ Privileges without Membership ☐

Centerpoint Ambulatory Surgery Center - 913-227-0835, extension 2 or 3
Physician – Alternate Physician: N/A
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Physician - Active ☐ Advanced Practice Professional - Privileges without Membership ☐

Heart of America Surgery Center -913-227-0835, extension 2 or 3
Physician – Alternate Physician: N/A
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Physician - Active ☐ Advanced Practice Professional - Privileges without Membership ☐

Mid America Surgery Institute - 913-227-0835, extension 2 or 3
Physician – Alternate Physician: N/A
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Physician - Active ☐ Advanced Practice Professional - Privileges without Membership ☐

Overland Park Surgery Center - 913-227-0835, extension 2 or 3
Physician – Alternate Physician: N/A
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Physician - Active ☐ Advanced Practice Professional - Privileges without Membership ☐

Surgery Center of Johnson County - 913-227-0835, extension 2 or 3
Physician – Alternate Physician: N/A
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Physician - Active ☐ Advanced Practice Professional - Privileges without Membership ☐

Surgicenter of Kansas City - 913-227-0835, extension 2 or 3
Physician – Alternate Physician: N/A
Advanced Practice Professional (NP, PA, CRNA, NMW etc) – Sponsoring Physician: ___________________________
Staff Category Requesting: Physician - Active ☐ Advanced Practice Professional - Privileges without Membership ☐

Kansas Hospital DEA Privileges

*1. Do you hold an active Kansas state license? Yes ☐ No ☐

If yes, what is the number? ________________________________

If no, have you applied for one? ☐ Yes- Date _______________ ☐ No

*2. Do you hold a current DEA for the State of Kansas? Yes ☐ No ☐

If yes, what is the number?__________________________

If no, have you applied for one? ☐ Yes- Date ______________ ☐ No

☐ Not Requesting DEA privileges for Kansas

Missouri Hospital DEA Privileges

*1. Do you hold an active Missouri state license? Yes ☐ No ☐

If yes, what is the number? ________________________________

If no, have you applied for one? ☐ Yes- Date & PIN# _______________________ ☐ No

*2. Do you hold a current DEA for the State of Missouri? Yes ☐ No ☐

If yes, what is the number?__________________________

If no, have you applied for one? ☐ Yes- Date ______________ ☐ No

☐ Not Requesting DEA privileges for Missouri – If not requesting DEA privileges no need to complete BNDD information.

*3. Do you hold a current Missouri BNDD? Yes ☐ No ☐

If yes, what is the number? ___________________________

If no, have you applied for one? ☐ Yes- Date __________ ☐ No

Kansas Hospital Requests

Kansas Privilege Lists Physicians

***CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)**

❑ ALLEN COUNTY REGIONAL HOSPITAL		❑ MENORAH MEDICAL CENTER		❑ OVERLAND PARK REGIONAL MEDICAL CENTER	
Contact ACRH @ 620-365-1165		❑ Anesthesiology ❑ Pain. Mgt. ❑ ER Medicine ❑ Family Medicine ❑ Hospitalist –IM ❑ Hospitalist –FM ❑ Hospitalist-Other__________ ❑ OB/GYN ❑ Pathology ❑ Pediatrics	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Nurse Clinician/Clinical Nurse Specialist/Nurse Practitioner ❑ APP-Neonatal Nurse Practitioner ❑ APP-Physician Asst. ❑ APP-Psychology ❑ APP-CNM	❑ Anesthesiology ❑ ER Medicine (ER &Trauma Priv.) ❑ Family Practice ❑ Hospitalist –IM ❑ Hospitalist –FM ❑ Hospitalist - Other __________ ❑ Pathology ❑ Pediatrics ❑ Radiology ❑ Radiology/Onc. ❑ Teleradiology ❑ Trauma	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-CNM ❑ APP-Neonatal Nurse Practitioner ❑ APP-Nurse Practitioner ❑ APP-Physician Asst. ❑ Psychologist
		Medicine ❑ Allergy ❑ Cardiology ❑ Dermatology ❑ Endocrinology ❑ Gastroenterology ❑ Hemat/Oncology ❑ Infectious Disease ❑ Internal Med. ❑ Nephrology ❑ Phys. Med./Rehab ❑ Psychiatry ❑ Pulmonology ❑ Rheumatology **Surgery** ❑ Cardiovasc. Surgery ❑ General Dentistry ❑ General Surgery ❑ Ophthalmology Oral Surgery	❑ Otolaryngology ❑ Plastic Surgery ❑ Thoracic Surgery ❑ Urology ❑ Vascular ❑ Wound Care **Orthopaedic Surgery** ❑ Orthopedics ❑ Podiatry **Neurology/ Neurosurgery** ❑ Neurology ❑ Neurosurgery **Radiology/ Radiation Therapy** ❑ Radiology ❑ Radiation Oncology	**Medicine** ❑ Allergy ❑ Cardiology ❑ Dermatology ❑ Endocrinology ❑ Gastroenterology ❑ Hemat/Oncology ❑ Infectious Disease ❑ Internal Med. ❑ Wound Care ❑ Nephrology ❑ Neurology ❑ Phys. Med./Rehab ❑ Psychiatry ❑ Pulmonology ❑ Rheumatology ❑ Physiatry **OB/GYN** ❑ OB/GYN ❑ Perinatology Gyn Oncology	**Surgery** ❑ Cardio/Thoracic ❑ Colon-Rectal ❑ Dentistry ❑ General Surgery ❑ Neurosurgery ❑ Ophthalmology ❑ Oral Surgery ❑ Orthopedics ❑ Otolaryngology ❑ Pain Management ❑ Plastic Surgery ❑ Podiatry ❑ Urology ❑ Vascular

Kansas Privilege Lists Physicians

***CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)**

❑ **MID AMERICA SURGERY INSTITUTE**		❑ **OVERLAND PARK SURGERY CENTER**		❑ **SURGICENTER OF JOHNSON COUNTY**		❑ **HEART OF AMERICA SURGERY CENTER**	
5525 W 119th St Overland Park, KS 66209	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Physician Asst. ❑ APP- Nurse Practitioner	**10601 Quivira Rd Ste 100 Overland Park, KS 66215**	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Physician Asst ❑ APP-Nurse Practitioner	**8800 Ballentine Overland Park, KS 66214**	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Physician Asst ❑ APP-Nurse Practitioner	**8935 State Ave Kansas City, KS 66112 (913) 334-8935**	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Nurse Practitioner
❑ Anesthesiology ❑ Pediatric Dentistry ❑ Dentistry/Oral Surgery ❑ Gastroenterology **Surgery** ❑ General Surgery ❑ Gynecology ❑ Laser ❑ Neurosurgery ❑ Ophthalmology ❑ Orthopedic ❑ Otolaryngology ❑ Plastic Surgery ❑ Urology ❑ Pain Management ❑ Pathology ❑ Podiatry			**Surgery** ❑ Anesthesiology ❑ Dentistry and Oral Surgery ❑ Gastroenterology ❑ General Surgery ❑ Gynecology ❑ Laser ❑ Neurosurgery ❑ Ophthalmology ❑ Orthopedic ❑ Otolaryngology ❑ Pain Management ❑ Pathology ❑ Plastic Surgery ❑ Podiatry ❑ Urology		**Surgery** ❑ Anesthesiology ❑ General & Pediatric Dentistry ❑ General ❑ OB/GYN ❑ Oral & Maxillary ❑ Orthopedic ❑ Otolaryngology ❑ Pain Management ❑ Pathology ❑ Plastic & Reconstructive ❑ Podiatric		**Surgery** ❑ Anesthesiology ❑ ENT ❑ General Surgery ❑ GYN ❑ Neurology ❑ Ophthalmology ❑ Orthopedic ❑ Pain Management ❑ Pathology ❑ Plastic Surgery ❑ Podiatric ❑ Pulmonary

Please note all fields marked with an asterisk must be completed and all pages returned.

Also if using a delegate you must submit the Provider Authorization for Delegate form.

Missouri Hospital Requests

Missouri Privilege Lists

***CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)**

❑ CASS REGIONAL MEDICAL CENTER		❑ CENTERPOINT AMBULATORY SURGERY CENTER		❑ CENTERPOINT MEDICAL CENTER		❑ LAFAYETTE REGIONAL HEALTH CENTER	
❑ Aspiration/Biopsy ❑ ER Medicine ❑ Family Medicine ❑ OB/GYN ❑ Pathology ❑ Pediatrics ❑ Radiology	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Nurse Practitioner ❑ APP –Nurse Practitioner –ED ❑ APP- Physician Assistant –ED ❑ APP-Psychologist		**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Physician Asst. ❑ APP –NP	❑ Medical Staff No Priv ❑ Anesthesia ❑ ER Medicine ❑ Hospitalist –IM ❑ Hospitalist –FM ❑ Hospitalist - Other____________ ❑ OB/GYN ❑ Pathology ❑ Pediatrics-Newborn ❑ Neonatology ❑ Perinatology ❑ Radiology ❑ Teleradiology	**Advanced Practice Professionals (APP)** ❑ APP–APRN/PA ❑ APP-APRN/PA-ED ❑ APP-Clinical Nurse Specialist ❑ APP-Advanced Adult Wound Care ❑ APP-CRNA ❑ APP-Neonatal Nurse Practitioner ❑ APP-Nurse Midwife ❑ APP-Pediatric Nurse Practitioner ❑ APP-Psychologist	❑ Anesthesiology ❑ ER Medicine ❑ Family Medicine ❑ Internal Medicine ❑ OB/GYN ❑ Pathology ❑ Radiology ❑ Teleradiology	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-NP
Medicine ❑ Allergy ❑ Cardiology ❑ Chronic Wound Care & Hyperbaric Medicine ❑ Dermatology ❑ Metabolic & Endocrine ❑ Gastroenterology ❑ Hemat/Oncology ❑ Infectious Disease ❑ Nephrology ❑ Neurology ❑ Psychiatry ❑ Pulmonology ❑ Rheumatology	**Surgery** ❑ Anesthesiology ❑ Dentistry ❑ General Surgery ❑ Ophthalmology ❑ Orthopedics ❑ Pain Management ❑ Urology ❑ Podiatry		**Surgery** ❑ Anesthesiology ❑ Dentistry ❑ Gastroenterology ❑ General Surgery ❑ Gynecology ❑ Laser ❑ Neurosurgery ❑ Ophthalmology ❑ Orthopedic ❑ Otolaryngology ❑ Pain Management ❑ Pathology ❑ Pediatric Dent. ❑ Plastic Surgery ❑ Podiatry ❑ Urology	**Medicine** ❑ Allergy/Immun. ❑ Cardiology ❑ Dermatology ❑ Endocrinology ❑ Family Practice ❑ Gastroenterology ❑ Hemat/Oncology ❑ Infectious Disease ❑ Internal Med. ❑ Nephrology ❑ Neurology ❑ Phys Med/Rehab ❑ Psychiatry ❑ Pulmonology ❑ Rheumatology	**Surgery** ❑ Colon & Rectal Surgery ❑ Dentistry ❑ General Surgery ❑ Neurosurgery ❑ Ophthalmology ❑ Oral Maxillo Surgery ❑ Orthopedics ❑ Otolaryngology ❑ Pain Management ❑ Pediatric Surgery (Consultation Only) ❑ Plastic Surgery ❑ Podiatry ❑ Urology	**Medicine** ❑ Cardiology ❑ Tele-cardiology ❑ Dermatology ❑ Gastroenterology ❑ Hemat/Oncology ❑ Internal Med. ❑ Nephrology ❑ Neurology ❑ Tele-neurology ❑ Phys. Med./Rehab ❑ Psychiatry ❑ Pulmonology ❑ Rheumatology	**Surgery** ❑ Dentistry ❑ General Surgery ❑ Ophthalmology ❑ Orthopedics ❑ Otolaryngology ❑ Pain Management ❑ Plastic Surgery ❑ Podiatry ❑ Urology

Missouri Privilege Lists

***CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)**

❑ **LEE'S SUMMIT MEDICAL CENTER**		❑ **BELTON REGIONAL MEDICAL CENTER**		❑ **RESEARCH MEDICAL CENTER**		❑ **SURGICENTER OF KANSAS CITY**	
❑ ER Medicine ❑ Family Medicine ❑ Hospitalist –IM ❑ Hospitalist-FM ❑ Hospitalist – Other________ ❑ OB/GYN ❑ Pathology ❑ Pediatrics ❑ Radiology ❑ Tele-radiology	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-ANP ❑ APP-ANP-ER ❑ APP CNM ❑ APP NNP ❑ APP –PA ❑ APP-PA-ER	❑ Hospitalist-IM ❑ Hospitalist-FM ❑ Hospitalist-Other________ ❑ ER Medicine ❑ Radiology **Anesthesiology** ❑ Anesthesiology ❑ Pain Management	**Advanced Practice Professionals (APP)** ❑ APP–CRNA ❑ APP-Physician Asst. ❑ APP-Nurse Practitioner ❑ APP-Nurse Practitioner-Hospitalist	❑ ER Medicine ❑ Family Medicine ❑ Hospitalist –IM ❑ Hospitalist –FM ❑ Hospitalist – Other __________ ❑ OB/GYN ❑ Pathology ❑ Pediatrics ❑ Neonatology ❑ Psychiatry ❑ Radiology **Anesthesiology** ❑ Anesthesiology ❑ Pain Management	**Advanced Practice Professionals (APP)** ❑ CRNA ❑ Nurse Midwife ❑ NNP ❑ NP ❑ PA ❑ Psychologist	**Surgicenter of Kansas City 701 E 101st Terr Kansas City, MO 64131 (816) 523-0100**	**Advanced Practice Professionals (APP)** ❑ APP-NP, PA ❑ APP-CRNA
Medicine ❑ Allergy ❑ Cardiology ❑ Dermatology ❑ Endocrinology ❑ Gastroenterology ❑ Hemat/Oncology ❑ Infectious Disease ❑ Internal Med ❑ Neonatology ❑ Nephrology ❑ Neurology ❑ Phys. Med./Rehab ❑ Psychiatry ❑ Pulmonary Disease ❑ Radiation/Onc. ❑ Rheumatology ❑ Wound Care	**Surgery** ❑ Anesthesiology ❑ Bariatric Surgery ❑ Cardio/Thoracic ❑ Colorectal Surgery ❑ General Surgery ❑ Neurosurgery ❑ Ophthalmology ❑ Oral/Max. Surgery ❑ Orthopedics ❑ Otolaryngology ❑ Pain Management ❑ Pediatric Dentistry ❑ Plastic Surgery ❑ Podiatry ❑ Urology ❑ Vascular/Thor. ❑ Wound Care	**Medicine** ❑ Allergy ❑ Cardiology ❑ Dermatology ❑ Endocrinology ❑ Family Practice ❑ Gastroenterology ❑ Hematology/Onc ❑ Infectious Disease ❑ Internal Med. ❑ Nephrology ❑ Neurology ❑ Pediatrics ❑ Phys Med/Rehab ❑ Pulmonology ❑ Rheumatology ❑ Psychiatry	**Surgery** ❑ Dent/Gen ❑ General Surgery ❑ Gynecology ❑ Ophthalmology ❑ Orthopedics ❑ Otolaryngology ❑ Oral Maxillo Facial ❑ Pathology ❑ Plastic Surgery ❑ Podiatry ❑ Urology ❑ Vascular	**Medicine** ❑ Allergy/Immun. ❑ Cardiology ❑ Dermatology ❑ Endocrinology ❑ Gastroenterology ❑ Hemat/Oncology ❑ Infectious Disease ❑ Internal Med. ❑ Nephrology ❑ Neurology ❑ Phys Med/Rehab ❑ Pulmonology ❑ Radiation Oncology ❑ Rheumatology	**Surgery** ❑ Colon & Rectal Surgery ❑ Dentistry ❑ General Surgery ❑ Neurosurgery ❑ Ophthalmology ❑ Oral Maxillo Surgery ❑ Orthopedics ❑ Otolaryngology ❑ Plastic Surgery ❑ Podiatry ❑ Trauma Surgery ❑ Urology		**Surgery** ❑ Anesthesia/Pain Mgmt ❑ General Surgery ❑ Ophthalmology ❑ Oral Surgery ❑ Orthopedics ❑ Pathology ❑ Plastic Surgery ❑ Podiatry ❑ No Privileges

Please note <u>all</u> fields marked with an asterisk <u>must</u> be completed and all pages returned.

Also if using a delegate you <u>must</u> submit the Provider Authorization for Delegate form.

HCA Credentialing Online – Provider's Authorization for Delegate

Step 1
Please enter your contact information to ensure the information we have is accurate in our credentialing system.

Provider Name: ____

Provider Phone: ____

Provider Email (required): _______________________________________
NOTE: Provider email must be unique to the provider; 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 re-credentialing information.
________ *initial and skip to Step 3*

☐ The individual listed below is my delegate. I hereby authorize (hereinafter, individually referred to as "Delegate") to access the HCO web 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 HCO web portal.

Delegate information is for HCO/Online Credentialing ONLY. No other correspondence will be redirected based on the information provided below. The below individual will be listed as your delegate in our credentialing system.

To assign a delegate, please provide the following for the delegate:

Name:
Email:
Phone: ( ) - ext.

Step 3
Please complete, sign and date. The form should be returned with your PreRFC form using the primary fax number.

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.

PROVIDER SIGNATURE ______________________ NAME (printed) ______________________

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