NEW THERAPIST APPLICATION INSTRUCTIONS

Who Must be Credentialed?

All licensed Physical, Occupational and Speech Language Pathologists practicing in your clinic(s) must be credentialed through *PREFERRED Therapy Providers, Inc.*

Return completed applications and requested documents to *PREFERRED Therapy Providers, Inc.*

The verification process for applications will not begin until all required documentation is complete and *PREFERRED* has received the credentialing fee for that therapist.

Please be advised that due to our credentialing policy, new therapist(s) cannot be added to our network as active until credentialing has been completed and the therapist is approved through *PREFERRED's* Credentialing Committee.
Note: Credentialing typically takes 30-45 days. After these requirements have been met, we will submit the new therapist(s) to the contracted health plans accordingly. Plan recognition may take 30-90 days. See MCO contract listing details. Network Benefits, including Contracts and PSV credentialing fees are non-transferable.

REQUIRED DOCUMENTS CHECKLIST

- ☐ ADD NEW THERAPIST APPLICATION
- ☐ CREDENTIALING FEE $55.00
- ☐ RESUME with 5 YEAR Work History (include month/year)
  (Former Military please include DD214 if within 5 years)
- ☐ THERAPIST CERTIFICATIONS, CHT, NBCOT
- ☐ PROFESSIONAL LIABILITY INSURANCE
- ☐ NPI/MEDICARE ACCEPTANCE LETTER
- ☐ COPY OF SCHOOL DEGREE or TRANSCRIPTS
- ☐ COPY OF CLINIC W 9
- ☐ STATE APPLICATION or printout of CAQH *(if applicable)*
  CO, IL, KY,LA, ME, MS, MO, NC, NJ, OH, OK, TX, and WV
- ☐ FINANCIAL DISCLOSURE - (*Texas Only*)

PREFERRED Therapy Providers, Inc. **would like you to be aware that all information obtained through the credentialing process is confidential. At any time during the credentialing process you have the right to:**

1. Review information submitted to support your credentialing application.

2. Correct erroneous information.

3. Receive the status of your credentialing or recredentialing application, upon request.

4. Be notified if information collected during the credentialing/recredentialing process varies substantially from the information that was collected by the practitioner (e.g., actions on a license, malpractice claims history, sanctions, board certification). If this situation arises, Preferred Therapy Providers will send a notification letter to the provider indicating such.

Should you wish to exercise these rights please contact the Credentialing Division at *PREFERRED , contact information is listed below.*

Questions:	If you have questions about this process, please contact *PREFERRED Therapy Providers, Inc.* immediately at 800.664.5240, as NCQA imposes time limits/constraints on information returned for verification.
Contact Us:	23460 N. 19th Ave Suite 250 Phoenix, AZ 85027 (Phone) 800-664-5240 /(Fax) 623-869-9102 Email: credentialing@preferredtherapy.com Website: www.preferredtherapy.com

Revised 03/28/2018

PREFERRED THERAPY PROVIDERS

ADD NEW THERAPIST APPLICATION

CLINIC / PRACTICE NAME

CLINIC / PRACTICE NAME	MEMBER NUMBER
PRACTICE NAME:	
STREET ADDRESS:	
STREET ADDRESS:	
STREET ADDRESS:	
STREET ADDRESS:	

THERAPIST INFORMATION

LEGAL FIRST NAME:	☐ **MALE**	☐ **FEMALE**
PREFERRED TO BE CALLED BY:	DATE OF BIRTH:	
MIDDLE:	STATE OF BIRTH:	
LAST NAME:	COUNTRY OF BIRTH:	
SUFFIX: JR SR II III IV V	MAIDEN NAME:	
ADDITIONAL LANGUAGES SPOKEN:		

THERAPIST NPI NUMBER:	SOCIAL SECURITY NUMBER:
TAXONOMY NUMBER:	WORKMANS COMP CERTIFICATION #: *if applicable*
MEDICARE #: MEDCAID #:	STATE MEDICAL PLAN: #

LICENSE INFORMATION

LICENSE TYPE	ISSUE DATE	NUMBER	STATE	EXPIRATION DATE
PT **OT** **SLP** **CHT**				
PT **OT** **SLP** **CHT**				

BOARD CERTIFICATION

						NUMBER	EXPIRATION DATE
TYPE	☐ ABPTS	☐ NBCOT	☐ ASHA	☐ HTCC	☐ *ABA*		
TYPE	☐ ABPTS	☐ NBCOT	☐ ASHA	☐ HTCC	☐ *AUTISM*		

COLLEGE INFORMATION - HIGHEST DEGREE ONLY

SCHOOL:		
CITY:	STATE/COUNTRY:	ZIP:
NAME USED WHILE ATTENDING SCHOOL:		
DEGREE: BS MS PHD OF:	GRADUATION DATE (MMDDYYYY):	

TRAINING INFORMATION: ☐ INTERNSHIP ☐ RESIDENCY ☐ FELLOWSHIP

FACILITY:		YEAR OF COMPLETION:	
ADDRESS:	CITY:	STATE:	ZIP:

APPLICANT NAME ______________________________

PREFERRED THERAPY PROVIDERS

ADD NEW THERAPIST APPLICATION

5 YEAR LICENSE HISTORY

HAVE YOU BEEN LICENSED OR PRACTICED IN ANY OTHER STATE IN THE PAST 5 YEARS: YES ☐ NO ☐

STATE	LICENSE #	EXPIRATION DATE	STATE	LICENSE #	EXPIRATION DATE

5 YEAR THERAPIST WORK HISTORY- please include month/year

RESUME ATTACHED ☐ NEW GRADUATE ☐

CURRENT COMPANY NAME:	PHONE:
ADDRESS:	START DATE (MONTH/YEAR):
CITY, STATE, ZIP:	CONTACT:
COMPANY NAME:	PHONE:
ADDRESS:	DATES FROM/TO (MONTH/YEAR):
CITY, STATE, ZIP:	CONTACT:
COMPANY NAME:	PHONE:
ADDRESS:	DATES FROM/TO (MONTH/YEAR):
CITY, STATE, ZIP:	CONTACT:
COMPANY NAME:	PHONE:
ADDRESS:	DATES FROM/TO (MONTH/YEAR):
CITY, STATE, ZIP:	CONTACT:

WORK GAP EXPLANATIONS required, if gap is 6 months or more :

PEER REFERENCES-3 REFERENCES REQUIRED

NAME:	PROF. TITLE:
EMAIL ADDRESS:	PHONE:
NAME:	PROF. TITLE:
EMAIL ADDRESS:	PHONE:
NAME:	PROF. TITLE:
EMAIL ADDRESS:	PHONE:

CONTINUING EDUCATION UNITS-LAST 24 MONTHS ONLY

RESUME ATTACHED ☐ NEW GRADUATE ☐

DATE	COURSE NAME	CEU'S EARNED
	Use additional page if needed	

APPLICANT NAME ______________________

PREFERRED THERAPY PROVIDERS

PROFESSIONAL QUESTIONS AND ATTESTATION FORM

FOR EACH “YES” RESPONSE, PLEASE INCLUDE A DETAILED EXPLANATION WITH THIS FORM.

1	IN THE LAST FIVE (5) YEARS, HAVE YOU HAD ANY GAPS OF SIX (6) MONTHS OR LONGER WHERE YOU DID NOT WORK AS A LICENSED PRACTITIONER IN THIS CURRENT DISCIPLINE AFTER GRADUATION?	YES	NO
2	HAS YOUR LICENSE(S) TO PRACTICE IN ANY JURISDICTION(S), WHETHER COMPLETED OR STILL PENDING EVER BEEN DENIED, LIMITED, SUSPENDED, REVOKED, NOT RENEWED, OR HAVE YOU EVER BEEN PLACED UNDER PROBATION, SUBJECTED TO DISCIPLINARY ACTION OR HAVE YOU VOLUNTARILY RELINQUISHED ANY LICENSE IN ANTICIPATION OF ANY OF THESE ACTIONS?	YES	NO
3	HAS YOUR PROFESSIONAL LIABILITY INSURANCE EVER BEEN DENIED, SUSPENDED, REVOKED, CANCELED, OR NOT RENEWED?	YES	NO
4	HAS YOUR STATUS AS A PROVIDER, OR MEMEBERSHIP WITH ANY PROFESSIONAL ORGANIZATION EVER BEEN DENIED, SUSPENDED, DISCIPLINED, CANCELED, SANCTIONED, OR ARE YOU CURERNTLY UNDER INVESTIGATION BY ANY MUNICIPAL STATE, FEDERAL OR ANY OTHER GOVERNMENTAL AGENCY, HMO, PPO, OR OTHER PREPAID HEALTH PLAN? (E.G. MEDICARE, MEDI-CAL, MEDICAID)	YES	NO
5	DO YOU HAVE ANY CONDITIONS THAT PREVENT YOU FROM PROVIDING SERVICES IN A REASONABLY SAFE MANNER, WITH OR WITHOUT ACCOMMODATIONS OR THAT WOULD POSE A SIGNIFICANT HEALTH OR SAFETY RISK TO YOUR PATIENTS?	YES	NO
6	DO YOU HAVE ANY PAST OR PRESENT ISSUES REGARDING LOSS OR LIMITATION OF CLINICAL PRIVILEGES AT ANY FACILITY OR ORGANIZATION WITH WHICH YOU HAVE HAD PRIVILEGES	YES	NO
7	DO YOU CURRENTLY OR DID YOU IN THE LAST THREE YEARS ENGAGE IN THE UNLAWFUL USE OF DRUGS, INCLUDING IMPROPER USE OF PRESCRIPTION DRUGS?	YES	NO
8	DO YOU HAVE ANY FELONY OR MISDEMEANOR CHARGES PENDING AGAINST YOU OTHER THAN A TRAFFIC VIOLATION, OR HAVE YOU EVER BEEN CONVICTED OR PLEADED “NOLO CONTENDERE” (NO CONTEST) TO A FELONY?	YES	NO
9	HAVE YOU EVER BEEN INVOLVED WITHIN THE LAST TEN (10) YEARS, OR ARE YOU CURRENTLY INVOLVED IN ANY CLAIMS/LAWSUITS, SETTLEMENTS, OR JUDGEMENTS (OTHER THAN DIVORCE OR CUSTODY)? IF YES, PLEASE PROVIDE DETAILED INFORMATION ON A SEPARATE SHEET OF PAPER INCLUDING DOCKET # OF THE CASE & COURT LOCATION, THE NAMES OF THE PARTY PLAINTIFF(S) AND DEFENDANT(S) OF THE INCIDENT(S), YOUR INVOLVEMENT, CURRENT DISPOSITION, AND THE AMOUNT OF THE SETTLEMENT.	YES	NO
10	ARE YOU CURRENTLY PRACTICING WITHOUT, OR WITH EXPIRED PROFESSIONAL LIABILITY / MALPRACTICE INSURANCE?	YES	NO
11	ARE YOU CURRENTLY PRACTICING WITHOUT, OR WITH AN EXPIRED STATE LICENSE?	YES	NO

IF YES TO ANY OF THE ABOVE PLEASE PROVIDE A WRITTEN EXPLANATION: USE SEPARATE SHEET IF NECESSARY

RELEASE OF INFORMATION: I authorize Preferred Therapy Providers, Inc and/or its delegated agents to consult with and obtain from any and all individuals and organizations who can provide information concerning my professional liability coverage and claims, information bearing on my professional competence, ability to perform appropriate services and procedures, character, ethical qualifications and ability to work cooperatively with others. I release from liability and hold harmless both those individuals and organizations who have provided this information and Preferred Therapy Providers, Inc and its delegated agents in using this information. I understand I have the burden of producing adequate information for a proper evaluation or reevaluation of my professional, ethical and other qualifications. I acknowledge that any significant misstatement in, or omission of, information provided may result in the termination of my relationship with Preferred Therapy Providers, Inc.

I, THE UNDERSIGNED, HEREBY CERTIFY THAT THE INFORMATION PROVIDED IN THIS APPLICATION AND ATTACHED DOCUMENTS ARE TRUTHFUL, CORRECT AND COMPLETE IN ALL RESPECTS.

APPLICANT SIGNATURE:	SIGN DATE:

SIGNATURE REQUIRED

APPLICANT NAME: ______________________

PRIMARY SOURCE VERIFICATION INVOICE

EXPLANATION OF INVOICE:

- Professionals will be presented for Board approval by PREFERRED Therapy Providers, Inc., only after completing credentials verification.
- The per-practitioner credentialing fee of $55.00 should be made payable to PREFERRED Therapy Provid-ers, Inc.
- Should you have any questions, please call us at 800-664-5240.

DUE DATE: **UPON RECEIPT**
CLINIC NAME:
MEMBER NUMBER:

Please provide PREFERRED Therapy Providers, Inc. with the name and license number of the therapist(s) for whom you are paying in the spaces provided below:

THERAPIST NAME	LICENSE NUMBER

# OF NEW THERAPISTS	X	$55.00 CREDENTIALING FEE PER THERAPIST	=	TOTAL AMOUNT TO BE PAID

PLEASE INCLUDE THIS INVOICE WITH YOUR PAYMENT TO PREFERRED THERAPY PROVIDERS, INC.
MUST MARK PAYMENT SELECTION BELOW :

CHECK NUMBER:	☐ USE CARD ON FILE ENDING IN	
CIRCLE ONE: AMERICAN EXPRESS	MASTERCARD	VISA
CARD NUMBER:		SECURITY CODE:
EXPIRATION DATE:		
PRINT CARD HOLDER NAME:		

CONTACT PREFERRED:
23460 N 19th Ave Suite 250
Phoenix, AZ 85027
Phone 800-664-5240 / Fax 623.869.9102
www.preferredtherapy.com

UPDATED: 1/2018