Dear Kareo Customer,

The Kareo Provider Enrollment/ Credentialing Intake Form *must be completed in its entirety* to ensure accurate enrollment for your selected insurance plans, or payers.

Please provide the following information and documentation and return the documentation to Kareo.

**The following supporting documentations are required for the practice business:**

- ☐ Copy of letter from the IRS with TIN number
- ☐ Copy of W-9
- ☐ Copy of bank letter stating your name, company name, routing number, account number and bank contact name and phone number. If full routing and account numbers are not included in letter, a copy of non-starter voided check.
- ☐ Copy of State Business License
- ☐ Copy of Local Business License (*If applicable.*)
- ☐ Articles of Incorporation
- ☐ Signed copy of an Office Lease
- ☐ Summary of Services – on your company letterhead and signed by the authorized official, provide a summary of services your professional group is providing.
- ☐ Copy of Commercial General Liability Insurance Policy (*Applicable only if providing DME Services*)
- ☐ Copy of CLIA License (*If applicable.*)

**The following supporting documentations are required for the rendering provider:**

- ☐ Copy of valid Driver's License
- ☐ Copy of valid Passport or Naturalization Certificate
- ☐ Copy of valid Visa/Work Permit (*If applicable.*)
- ☐ Copy of valid state(s) Medical License
- ☐ Copies of CPR, ACLS, BLS, PATLS Certificates (*If applicable.*)
- ☐ Copy of your State(s) Pharmacy Certificate (*If applicable.*)
- ☐ Copy of your DEA certificate. (*If you do not have a DEA certification, please sign the DEA Waiver form on page 17.*)
- ☐ Copy of your Malpractice insurance face sheet. (*Must have FTCA documentation if that is your coverage.*)
- ☐ Copy of your Board Certification Letter or Certificate.
- ☐ Copy of your Medicaid, Medicare, Individual NPI and/or UPIN login and passwords numbers.
- ☐ Copy of your Professional Liability Insurance
- ☐ Copy of your detailed information for any/all malpractice cases—these statements should be the explanation for the provider's role in the case in the provider's own words. You may not only submit the insurance company summary or explanation. Including all supporting court and or attorney documentation
- ☐ Copies of your Medical Diploma and/or other pertinent Diplomas.
- ☐ Copies of Certificates of Completion for all Internships, Residencies and Fellowships
- ☐ Copy of Military Discharge and DD214 (*If applicable.*)

Kareo ID: _____Last Name: _____First Name: _____Date: _____

- ☐ If you are the graduate of a Medical School outside the US, please provide a copy of your ECFMG certificate.
- ☐ Copy of your letter of hospital appointment and privileges and/or any admitting agreement you may have.
- ☐ Copy of your CURRENT Curriculum Vitae (CV) (resume for ancillary providers) in MM/YYYY format.
- ☐ Copies of Continuing Medical Education Documentation (*Hospital Credentialing Only*)
- ☐ Copy of TB Test Results or Chest X-Ray (no older than 1 year) (*Hospital Credentialing Only*)
- ☐ Case Logs listing 50 cases within the past year. (*Hospital Credentialing Only*)

Please feel free to contact your Credentialing Account Manager if you have any questions. We are happy to answer any that you might have.

A few notes:

1. Complete and accurate information received in a timely fashion significantly speeds what can be a very time consuming process.
2. The Kareo Credentialing Provider Enrollment Intake Form follows CAQH and Joint Commission data rules and regulations. All data provided applies for both attending physicians and physician extenders / allied health providers. All data is kept strictly confidential.
3. If you do not have the requested information *please explain why.*
4. If not applicable, note "N/A" next to the item requested.
5. Please complete all fields on the intake form.
6. Please make sure all documents are submitted in pdf format only; legible clear view
7. On your company letterhead and signed by the authorized official, please provide a summary of the services your professional group is providing. It is important to note any services that are specialized as this will stand out to the insurance network.
8. Please complete the payer list which is a list of insurance payer networks you want to join. Please review the form attached and using the links below please let us know what payers you are interested in. The links are a resource for you. Enter your state and a list specific to your area will populate.
   http://www.consumerreports.org/health/insurance/health-insurance-plans.htm
   https://www.aapc.com/provider-manual/

## Kareo Provider Intake Form

This form *must be completed in its entirety* to ensure accurate enrollment for your selected insurance plans, or payers. Fields marked with an asterisk (*) may not apply. If so, please indicate with *N/A*.

### PRACTICE SECTION

**General Practice Demographics:**

Legal Business Name: _____

DBA: _____

Tax ID #: _____ *Group NPI#: _____

Group NPI Username: _____ Password: _____

*Group Medicare#: _____ *Group Medicaid#: _____

**Billing/Correspondence Address:**

Make Payments Payable to: _____

Mailing Address: _____

Primary Billing Contact Name: _____

Tel #: _____ Fax#: _____Email: _____

**Primary Practice Location:**

Address: _____

Tel #: _____ Fax#: _____Email: _____

Office Hours: _____ Office Manager: _____ Start date: _____

Patient Ages: _____ - _____ Handicapped Accessible: ◯ Yes ◯ No

Languages other than English spoken by office staff: _____

***Secondary Practice Location:**

Address: _____

Tel #: _____ Fax#: _____Email: _____

Office Hours: _____ Office Manager: _____ Start date: _____

Patient Ages: _____ - _____ Handicapped Accessible: ◯ Yes ◯ No

Languages other than English spoken by office staff: _____

Kareo ID: _____Last Name: _____First Name: _____Date: _____

**OWNERSHIP OF PRACTICE DISCLOSURE INFORMATION**

(*If additional owners, please provide list with same information. Total ownership must equal 100 %.)*

**Owner #1**

Name: _____ SSN: _____

DOB: _____ City/State/Country of Birth: _____

Home address: _____

% of ownership: 0.00%

***Owner #2**

Name: _____ SSN: _____

DOB: 0.00% City/State/Country of Birth: _____

Home address: _____

% of ownership: _____

***Owner #3**

Name: _____ SSN: _____

DOB: _____ City/State/Country of Birth: _____

Home address: _____

% of ownership: 0.00%

## PROVIDER SECTION

**General Provider Demographics:**

Provider's Legal Name: _____ Degree(s): _____

Any other names used (i.e. maiden):_____ Date used: _____

Date of Birth: _____ Sex: _____ SS#: _____ Place of Birth: _____

Home address: _____

Email address: _____ Cell phone #: _____ Pager #: _____

Languages spoken by provider other than English: _____

Primary Specialty: _____ Secondary /Sub Specialty: _____

Current State License #: _____ Other State License #: _____ State: _____

Individual NPI #: _____

Individual NPI Username: _____ Password: _____

*DEA#: _____ *State CDS/RDS#: _____ *State: _____

Individual Medicare#: _____ Individual Medicaid#: _____

*UPIN: _____

## EDUCATION AND TRAINING

**Undergraduate Education**

Institution Name: _____

Institution Address: _____

Institution Tel #: _____ Fax#: _____

Start Date: _____ Completion Date: _____ Major: _____

**Medical School/Graduate School:**

Institution Name: _____

Institution Address: _____

Institution Tel #: _____ Fax#: _____

Start Date: _____ Completion Date: _____ Major: _____

***Internship**

Institution Name: _____

Institution Address: _____

Institution Tel #: _____ Fax#: _____

Start Date: _____ Completion Date: _____ Specialty: _____

***Primary Residency**

Institution Name: _____

Institution Address: _____

Institution Tel #: _____ Fax#: _____

Start Date: _____ Completion Date: _____ Specialty: _____

***Secondary Residency/ Fellowship** *(Please indicate which, if more than one please use separate sheet.)*

Institution Name: _____

Institution Address: _____

Institution Tel #: _____ Fax#: _____

Start Date: _____ Completion Date: _____ Specialty: _____

**BOARD CERTIFICATIONS**

**Primary Practicing Specialty**

Specialty: _____ Date Originally Certified: _____

Name of Board: _____ Date of Expiration: _____

Certificate #: _____

***Secondary Practicing Specialty**

Specialty: _____ Date Originally Certified: _____

Name of Board: _____ Date of Expiration: _____

Certificate #: _____

***Additional Specialty**

Practicing? ____Yes ____No

Specialty: _____ Date Originally Certified: _____

Name of Board: _____ Date of Expiration: _____

Certificate #: _____

***If you are not Board Certified**

Are you Board qualified/eligible? ____Yes ____No As of what date? _____

Are you scheduled to sit for the Exam? ____Yes ____No Date of Exam: _____

**PROFESSIONAL REFERENCES** *(Please provide three along with letters.)*

1.) Name: _____ Title/Degree: _____ Specialty: _____

Mailing Address: _____

Tel #: _____ Fax#: _____ Email address: _____

2.) Name: _____ Title/Degree: _____ Specialty: _____

Mailing Address: _____

Tel #: _____ Fax#: _____ Email address: _____

3.) Name: _____ Title/Degree: _____ Specialty: _____

Mailing Address: _____

Tel #: _____ Fax#: _____ Email address: _____

**PROFESSIONAL MALPRACTICE LIABILITY HISTORY**

If you do **NOT** have malpractice liability history (judgment, settled, dismissed or pending), please sign here:

_____

If you have judgments, settlements, dismissed or pending cases complete the following. *(If more than two cases please use separate sheet and provide requested information)*

Date of occurrence: _____ Date claim file:_____

Professional liability carrier involved: _____

Patient/Plaintiff Name: _____

Were you the Primary or Co-Defendant? _____

Identify any/all other defendants: _____

Describe the allegations:

_____

Describe the alleged injury to the patient:

Disposition of Case

Settled/Judgment - Date: _____ Amount: _____

Dismissed/Dropped - Date: _____ Pending: _____

Kareo ID: _____Last Name: _____First Name: _____Date: _____

Date of occurrence: _____ Date claim file: _____

Professional liability carrier involved: _____

Patient/Plaintiff Name: _____

Were you the Primary or Co-Defendant? _____

Identify any/all other defendants: _____

Describe the allegations:

Describe the alleged injury to the patient:

Disposition of Case:

Settled/Judgment - Date: _____ Amount: _____

Dismissed/Dropped - Date: _____ Pending: _____

Kareo ID: _____Last Name: _____First Name: _____Date: _____

**FACILITIES**

Please list all hospitals and facilities *you* have privileges with:

| Facility Name | Staff Category | Date of Affiliation |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list your covering physicians, if applicable.

| Physician Name | Affiliated Facility | NPI |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**PROFESSIONAL LIABILITY CARRIERS**

Is your coverage in accordance with the Federal Tort Claims Act? ____Yes ____No

If you answered "no," please complete the following information:

Name of Carrier: _____

Address: _____

Tel #: _____ Fax#: _____ Email: _____

Policy number: _____Effective Date: _____ Retro Date: _____ Expiration Date: _____

**QUESTIONS**

Did you attend Medical School outside of the United States? ____Yes ____No

If you answered Yes: ECFMG Certificate Number: _____ Date Issued: _____

Are you currently enrolled in any Managed Care and /or Health Plans? ____Yes ____No

If you answered yes, please provide the following:

**Plan Name:** **Provider Number:**

_____

_____

_____

_____

_____

_____

**WORK HISTORY**

Please list information requested for the last five years. Please be sure to explain any gaps of more than six months.

From: _____/_____ To: _____/_____

Employer Name: _____

Address: _____

Tel#: _____ Fax: _____ Email: _____

From: _____/_____ To: _____/_____

Employer Name: _____

Address: _____

Tel#: _____ Fax: _____ Email: _____

From: _____/_____ To: _____/_____

Employer Name: _____

Address: _____

Tel#: _____ Fax: _____ Email: _____

Please use this space to explain any gaps of six months or more:

**CREDENTIALING DATA**

1. Has your medical provider license to practice in any jurisdiction ever been limited, suspended, placed on probation, revoked, or voluntarily or involuntarily surrendered for any reason. [ ] Yes [ ] No

2. Have your hospital privileges ever been revoked, suspended, denied, restricted or voluntarily surrendered for any reason? [ ] Yes [ ] No

3. Have you ever been subjected to any sanction or disciplinary action by a hospital, Board of Medical Examiners, organized medical society, or Federal, State, Local or other regulatory or oversight body? [ ] Yes [ ] No

4. Have you ever been denied membership or renewal thereof or been subject to any sanction or disciplinary action by any medical organization, Board of Medical Examiners or other regulatory or oversight body? [ ] Yes [ ] No

5. Have you ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid? [ ] Yes [ ] No

6. Have you ever unsuccessfully defended a malpractice claim, settled out of court, or do you have any malpractice claims pending? [ ] Yes [ ] No

7. Have you had any malpractice claims made against you in the previous ten (10) years? [ ] Yes [ ] No

8. Has your malpractice coverage ever been denied or canceled? [ ] Yes [ ] No

9. Are you currently under indictment for any crime? [ ] Yes [ ] No

10. Have you ever been convicted or pleaded no contender to a criminal offense? [ ] Yes [ ] No

11. Are you currently suffering or have you ever suffered from a disability due to mental, physical or psychological illness that would impair or hinder your ability to perform any of the duties of your employment or licensure? [ ] Yes [ ] No

Kareo ID: _____Last Name: _____First Name: _____Date: _____

12. Do you now or have you ever had any dependency on or abuse of any chemical, illegal drug, prescription or over the counter drug, alcohol or any other substance? [ ] Yes [ ] No

13. Has your license to prescribe or dispense controlled substances ever been denied, suspended, restricted, revoked or voluntarily surrendered for any reason? [ ] Yes [ ] No

14. Do you have any financial interest in any health care facility, institution, or organization other than your own private office? [ ] Yes [ ] No

15. Has your participation with an HMO or PPO ever been voluntarily or in-voluntarily terminated, suspended or denied? [ ] Yes [ ] No

**If you answer yes to any of the above questions, please provide details on a separate sheet of paper.**

I warrant that the information provided herein including the answers to the above questions are true and correct to the best of my knowledge and belief.

I hereby authorize Kareo to credential my qualifications and verify the information provided herein.

Provider Signature: _____

Print Provider Name: _____

Date: _____

Kareo ID: _____Last Name: _____First Name: _____Date: _____

**APPLICANT ACKNOWLEDGMENT AND CONSENT**

I fully understand that any significant mis-statements in, or omissions from this application constitute cause for denial of appointment/enrollment/credentialing or cause for summary dismissal from any entity for which I am appointed/enrolled or credentialed. All information submitted by me and/or on my behalf in this application is true, correct and complete, to my best knowledge and belief. I acknowledge that all files pertaining to my credentialing are considered privileged and confidential and access is limited to Kareo Credentialing("KAREO"), its Staff and its representatives, as well as certain government and regulatory entities, as provided by applicable law, for the purpose of credentialing, enrollment, appointment and re-credentialing, reappointment, enrollment functions.

I acknowledge that I have received (or have had access to) and have read (or been given the opportunity to read) the current, Confidentiality Policies and Procedures of KAREO.

By submitting my applications for enrollment/appointment to the contracted entities, health plans, payers, I:

1. Signify my willingness to fully cooperate in the submission and application process
2. Authorize Kareo Credentialing to conduct provider enrollment services on behalf of myself and/or the institution where I am primarily employed
3. Authorize Kareo Credentialing representatives to consult with others who have been associated with me or who may have information bearing on my competence and qualifications
4. Consent to KAREO representatives inspecting all records and documents that may be material to an evaluation of my professional qualifications and competence to carry out the clinical duties in my applying specialty I request, of my physical and mental health status and of my professional ethical qualifications
5. Release from any liability all KAREO representatives for their acts performed in good faith and without malice in connection with evaluating me and my credentials
6. Release from any liability all individuals and organizations who provide information, including otherwise privileged or confidential information, to KAREO representatives in good faith and without malice concerning my competence, professional ethics, character, physical and mental health, emotional stability, and other qualifications for enrollment, appointment and credentialing.

   Authorize and consent to KAREO representatives providing hospitals, medical associations, licensing boards, and other organizations concerned with provider performance and the quality and efficiency of patient care with any

information relevant to such matters that KAREO may have concerning me, and release KAREO from liability for so doing, provided that such furnishing of information is done in good faith and without malice.

The term "Kareo Credentialing" representative (KAREO) includes all staff members, contracted vendors and which have responsibility for collecting or evaluating the applicant's credentials or acting upon his/her application; and any authorized representative of any of the foregoing. I understand and agree that I, as an applicant for provider enrollment and/or physician credentialing, have the burden of producing adequate and accurate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

Provider Signature: _____

Print Provider Name: _____

Date: _____

**NATIONAL PROVIDER IDENTIFIER (NPI) APPLICATION**

Federal law now requires every Medical Provider to have an NPI number.

**If you have obtained or applied for your NPI number please provide it below and submit the documentation (confirmation page) to Kareo. NPI Number: _____.**

If you have NOT obtained or applied for your NPI number **KAREO** will apply and obtain your NPI number for you. Please complete the form below.

Please sign below indicating your agreement with **KAREO** applying for and obtaining your NPI number.
When the NPI number is obtained it will be forwarded to you along with the written documentation, for your knowledge and records.

I, _____ grant my permission for **KAREO** to apply for and obtain my NPI number. I understand that obtaining this number is mandatory. I further understand that once received the NPI number and any accompanying documentation will be forwarded to me for my knowledge and records.

Provider Signature: _____

Print Provider Name: _____

Date: _____

Kareo ID: _____Last Name: _____First Name: _____Date: _____

**DEA WAIVER/ ATTESTATION**

☐ I, _____, agree that during any time that I do not have a current/valid DEA certificate, I will not write prescriptions for any drugs that require a DEA certificate.

☐ I, _____, attest that I will not write prescriptions for drugs that are not covered under the Schedules on my current/valid DEA certificate.

☐ I, _____, attest that I have applied for my DEA certificate on _____.

☐ I, _____, do not have a current/valid DEA certificate at this time because:

☐ Covering providers with current/valid DEA certificates, will provide prescription writing coverage as required by patient need.

Provider Signature: _____

Print Provider Name: _____

Date: _____

Kareo ID: _____Last Name: _____First Name: _____Date: _____

**COUNCIL FOR AFFORDABLE QUALITY HEALTHCARE (CAQH) APPLICATION**

All Medical Providers must enroll in CAQH as a requirement for inclusion in health plan/payer network panels.

If you have enrolled or applied for your CAQH number please provide it below and submit the user ID and password along with your application:

CAQH Number: _____

CAQH User ID: _____

CAQH Password: _____

If you have **NOT** enrolled or applied for your CAQH number Kareo Credentialing will apply and obtain your CAQH number for you.

Please sign below indicating your agreement with Kareo Credentialing applying for and obtaining your CAQH number. When the CAQH number is obtained it will be forwarded to you for your knowledge and records.

I, _____ grant my permission for Kareo Credentialing to apply for and obtain my CAQH number. I understand that obtaining this number is mandatory. I further understand that once received the CAQH number and any accompanying documentation will be forwarded to me for my knowledge and records.

Provider Signature: _____

Print Provider Name: _____

Date: _____

**PAYER LIST**

Please complete the below payer list to identify which payer networks you would like to join. **Kareo will provide credentialing services for up to 20 payers.** We will do our very best to get you credentialed with your selected payer networks but ultimately the payer decides if they have availability for you to join.

Provided below is a limited selection of the most common payer networks that you can mark if you so choose to. Using the links below, please identify additional payers you are interested in. The links are a resource for you to use. Just enter your state and a list specific to your area will populate.

http://www.consumerreports.org/health/insurance/health-insurance-plans.htm
https://www.aapc.com/provider-manual/

| **Payer Name** | **Yes/No** |
|---|---|
| Medicare | _____ |
| Medicaid | _____ |
| Blue Cross/ Blue Shield | _____ |
| Aetna | _____ |
| AARP | _____ |
| Cigna | _____ |
| Coventry | _____ |
| Humana | _____ |
| United HealthCare | _____ |

_____

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Kareo ID: _____Last Name: _____First Name: _____Date: _____