



Hearing Care Provider Application

- Credentialing
- Re-credentialing

PRACTICE INFORMATION		
Is Practice (Check One): <input type="checkbox"/> Solo <input type="checkbox"/> Partnership <input type="checkbox"/> Professional Corporation <input type="checkbox"/> Other		
Are you part of a retail chain or affiliation? If so, please provide name and address of corporate office: <input type="checkbox"/> National <input type="checkbox"/> Regional		
Provider's Name:		
Corporation's Name (if applicable):		
TIN:	NPI-2 (if applicable):	
Practice Name:		
Mailing Address:		
Billing Address: addresses		<input type="checkbox"/> Check here if multiple billing (Please list on separate page)
Please indicate address where to send signed Provider Agreement and Welcome packet: <input type="checkbox"/> Mailing Address <input type="checkbox"/> Billing Address <input type="checkbox"/> Other:		
Business Contact:	Phone:	Email:
Practice Manager:	Phone:	Email:

OFFICE LOCATIONS PLEASE PROVIDE INFORMATION FOR ONLY THOSE LOCATIONS TO PARTICIPATE WITH EPIC						
Primary Office Location						
Address:						
City:	State:	ZIP:				
Office Manager:						
Phone:	Fax:	E-mail:				
HOURS OF OPERATION						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
PATIENT RELATION SERVICES						
Languages Spoken by Provider:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other:			
Languages Spoken by Staff:	<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Other:			
Accepts Patients with Developmental Disabilities: <input type="checkbox"/> Yes <input type="checkbox"/> No		TTY Available: <input type="checkbox"/> Yes <input type="checkbox"/> No		Signing Available: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Handicap Accessible Office (ADA Compliant): <input type="checkbox"/> Yes <input type="checkbox"/> No		Handicap Parking Available: <input type="checkbox"/> Yes <input type="checkbox"/> No				
Age of Patients: <input type="checkbox"/> Pediatrics <input type="checkbox"/> Adults						

ADDITIONAL OFFICE LOCATION						
Address:						
City:			State:		Zip:	
Office Manager:						
Phone:			Fax:		E-mail:	
HOURS OF OPERATION						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
PLEASE COMPLETE IF DIFFERENT FROM ABOVE PRACTICE INFORMATION						
Billing Address for this Location:						
TIN for this Location (if different, please submit additional W-9):						

ADDITIONAL OFFICE LOCATION						
Address:						
City:			State:		ZIP:	
Office Manager:						
Phone:			Fax:		E-mail:	
HOURS OF OPERATION						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
PLEASE COMPLETE IF DIFFERENT FROM ABOVE PRACTICE INFORMATION						
Billing Address for this Location:						
TIN for this Location (if different, please submit additional W-9):						

ADDITIONAL OFFICE LOCATION						
Address:						
City:			State:		ZIP:	
Office Manager:						
Phone:			Fax:		E-mail:	
HOURS OF OPERATION						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
PLEASE COMPLETE IF DIFFERENT FROM ABOVE PRACTICE INFORMATION						
Billing Address for this Location:						
TIN for this Location (if different, please submit additional W-9):						

(Duplicate this page as necessary for more office locations)

PROVIDER INFORMATION				
Provider's Name			Suffix (Jr., Sr., etc.)	
Maiden/Other Name(s) (if applicable)		<input type="checkbox"/> Owner	<input type="checkbox"/> Associate	<input type="checkbox"/> Employee
SSN:	TIN (if different):	DOB (MM/DD/YY): / /		<input type="checkbox"/> Male
Medicaid Number (if applicable):	NPI-1:			<input type="checkbox"/> Female
Do you submit claims under your TIN or the Practice? <input type="checkbox"/> TIN <input type="checkbox"/> Practice <input type="checkbox"/> NA			E-MAIL:	
PROFESSIONAL TRAINING				
Professional School:				
Degree:		Year Graduated:	Years in Practice:	
LICENSING INFORMATION				
State Licenses: Please attach copies of current license(s) and certificate(s)	Medicare:	License Number:	Effective Date:	Expiration Date:
	Medicaid:	License Number:	Effective Date:	Expiration Date:
	Audiology/Dispensing:	License Number:	Effective Date:	Expiration Date:
PROFESSIONAL LIABILITY INSURANCE INFORMATION				
Professional Liability Insurance Carrier:				
Limits of Coverage: Individual:		Aggregate:		
Effective Date (MM/DD/YY):			Expiration Date (MM/DD/YY)	
PROFESSIONAL QUESTIONS AND ATTESTATION				
1. In the last five (5) Years have you had any gaps of six (6) months or greater, where you did not work as a practitioner in this current discipline? If "YES." Please explain the reason(s) for any gap(s) on a separate page.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
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 actions?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
3. Has your professional liability insurance ever been denied, suspended, revoked, canceled or not renewed?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
4. Has your status as a provider, or membership with any professional organization, ever been denied, suspended, disciplined, canceled, sanctioned; or are you currently under investigation by any municipal, state, federal, or any other governmental agency, HMO, PPO, or other prepaid health plan? (E.g. Medicare, Medicaid).			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
5. Do you currently, or did you in the last two years, engage in the unlawful use of drugs, including the improper use of prescription drugs?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
6. Do you have any felony or misdemeanor charges pending against you, other than traffic violations, or have you ever been convicted or pleaded "nolo contendere" to a felony?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
7. Have you been involved, within the last ten (10) years, or are you currently involved in ANY claims/lawsuits, settlements, or judgments (other than divorce or custody)? If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, the names of the plaintiff(s) and defendant(s) and date(s) of the incident(s), your involvement, current disposition, and the amount of settlement, if any.			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
8. Are you currently practicing WITHOUT, or with an EXPIRED, Professional Liability/Malpractice Insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA	
If you answered "yes" to any of the above questions, please explain, in detail, on an additional page.				
I understand that acceptance of my application for participation in the EPIC Hearing Care Network may require EPIC or its designee to review information as listed above. I hereby authorize the release of such information to EPIC and its authorized designee. I further understand that all information provided in this document will be held in confidence by EPIC, to the extent permitted by law. I agree that EPIC and its agents shall not be liable for any action or omission related to the evaluation or verification of information provided in this document. I further agree to notify EPIC within thirty (30) days of any change to the information requested herein. I understand that submission of this application does not constitute approval or acceptance as an EPIC participating provider.				
I hereby acknowledge that I have read, and understood each of the questions contained herein and that I certify that the responses I have provided herein are accurate, complete and the truth, to the best of my knowledge and belief.				
Provider's Name (Print):				
Signature:			Date:	



Credential Verification Release

Provider Name

I, the undersigned provider, acknowledge and agree that EPIC and its subsidiaries have a valid interest in obtaining and verifying information concerning my professional competence for the sole purpose of evaluating my credentials and qualifications as a provider. EPIC agrees to keep this information confidential and may use such confidential information only in the furtherance of the purposes and obligations of the Provider Agreement. Accordingly,

1. I represent and warrant to EPIC that the information contained herein is true and complete, to the best of my knowledge and belief.
2. I authorize EPIC or its authorized agents to consult with previous employers, members of medical or other professional staffs, malpractice carriers, hospital administrators and other persons to obtain and verify my credentials and qualifications as a provider. I release EPIC and its employees and agents from any and all liability for their acts performed in good faith without malice in obtaining and verifying such information and evaluating my application.
3. I consent to release by any person to EPIC or its authorized agents all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical stature. This information is tot include any information relating to any disciplinary action; suspension or curtailment of surgical/medical privileges; and/ or any malpractice actions. I hereby release any such person providing such information in good faith from any and all liability for doing so.
4. I agree to immediately notify EPIC upon any investigation, revocation, reduction, termination, denial, limitation or suspension of my professional license, professional liability insurance, participation in Medicare or Medicaid Programs or other certification programs, other credentialing programs authorizing me to practice audiology, otolaryngology or hearing aid dispensing. I understand that the NPDB will be reviewed.
5. I agree to inform EPIC promptly of any material change in the information submitted herein occurs whether before or after entering into an agreement with EPIC for the provision of professional services.

Signature:	Date:
Printed Name:	
Address:	
Phone:	

A photocopy of this consent shall be as effective as the original when so presented.