REQUEST FOR APPLICATION

****Must be completed in entirety****

Practitioner Name: _____ _____ _____
(First) (Middle) (Last)

Cell Phone: _____ **Email Address:** _____

Degree Type (*MD/DO, APRN, RN, PA, PhD, etc.*): _____

Date of Birth: _____ **Social Security #:** _____ **NPI Number:** _____

Specialty: _____ **Subspecialty:** _____

Anticipated Start Date: _ _____

Employment: (Select One)

- ☐ OU Health/OU Health Partners
- ☐ OUHSC
- ☐ Dual-OU Health or OU Health Partners and OUHSC
- ☐ Other (Contract/Locum Tenens/Private) please specify: _____

Practice Location:

Primary OU Health Hospital Location: _____

Primary OU Health Clinic Location (physical address): _____

Secondary OU Health Clinic Location (physical address): _____

Is the Provider in a current training program? No ☐ **Yes** ☐

If yes, completion date: _____

Requested Medical Staff Category: (Select one)

- ☐ **Active: Regularly & routinely practice in Hospital – Can vote**
- ☐ **Courtesy: Not actively involved in Medical Staff affairs and unable to vote or hold office**
- ☐ **Ambulatory: Refer & Follow – No privileges**
- ☐ **Privileges without Membership:** (Also select all applicable boxes below)
  - ☐ ***PA-C, APRN, PhD, PsyD*** ☐ ***Locum Tenens-Intermittent or Substitute Pract (Complete Page 2)*** ☐ ***Telemedicine***
- ☐ **Dependent Health Practitioner (DHP): (RN, Research Coordinator, Dental Assistant, Audiologist, etc.)**

NP/PA or DHP Sponsoring Phys. on Staff: _____ **NP Certification:** _____

Locum/Telemedicine Company Name: _____

Oklahoma Medicaid Provider #: _____

Credentialing Contact and/or Delegate Name: _____

Phone: _____ **Fax:** _____ **Email:** _____

*****PLEASE SUBMIT REQUEST FOR APPLICATION FORM, DELEGATE FORM, AND A COPY OF PROVIDER'S RESUME TO THE MEDICAL STAFF SUPPORT SERVICES DEPARTMENT*****

Office: (405) 271-3741 / Fax (405) 271-3602 / credentialing@ouhealth.com

LOCUM PROVIDERS MUST COMPLETE AND SUBMIT INFORMATION BELOW

Name: _____

NPI #: _____

Cell: _____

E-mail: _____

Specialty: _____

Locums Company: _____

OK Medicaid Provider ID: _____

Please submit only this page to:

Patricia.Bradley@ouhealth.com
Lucille.Jones@ouhealth.com
Fax: (405) 271-5006
Phone: (405) 271-8132

Credentialing Online – Provider Authorization for Delegate

Step 1: Contact Information

Provider Name: _____

Provider Phone: _____

Provider Email *(Required)*: _____

(Email **must be unique** to the provider; it cannot be the same address as the delegate)

Step 2: Delegate Designation

_____ I do not want to select a delegate at this time. I will personally provide credentialing information. (*Initial and Skip to Step 3*)

I hereby authorize _____ (hereinafter, individually referred to as "Delegate") to access the online web portal to enter data and submit documents for Initial/Reappointment requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before my delegate or myself submit them via the Credentialing Online web portal.

Delegate Name: _____

Delegate Phone: _____

Delegate Email: _____

Step 3: Acknowledgement and Signature

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 (Print)

_____ _____

Social Security Number or NPI Today's date (MM/DD/YYYY)

PLEASE RETURN TO:

OU Health
Medical Staff Support Services Department
Email: Credentialing@ouhealth.com
Phone: 405-271-3741 Fax: 405-271-3602