



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 / oumscredentialing@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: OUMSCredentialing@ouhealth.com
Phone: 405-271-3741 Fax: 405-271-3602