OU Medicine

OU Medical Center | The Children's Hospital | OU Medical Center Edmond | Breast Health Network

Credentialing Online – Provider Authorization for Delegate

Step 1: Contact Information

The contact information listed below has been pre-populated based on your information in our credentialing system. If changes are needed, please indicate below:

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 Date (MM/DD/YYYY)

PLEASE COMPLETE, SIGN, DATE THE FORM AND RETURN TO:
OU Medicine, Medical Staff Support Services Department
Email: OUMSCredentialing@oumedicine.com
Phone: 405-271-3741 Fax: 405-271-3602