

# Washington Applicants

## Application Checklist

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Please allow a minimum of **60 days** to process applications for credentialing. The provider will be notified upon completion of the credentialing process **and** will be given an effective date for First Choice Health PPO Network (FCH PPO) participation.

If you are practicing in a home base or non-traditional setting, please contact the Credentialing Department at (800) 231-6935 Ext. 2106 for additional requirements.

Practitioner Application	<b>ALL sections on the Practitioner Application must be completed. Necessary explanations must be provided. If a section is not applicable to you, check the “Does Not Apply Box” or write “N/A”. Your specialty and/or subspecialty must be recognized by FCH PPO.</b>	Complete ✓
	Five year work history must be documented <b>(month and year must be included)</b>  • An explanation of any gaps six months or greater must be explained in writing <b>(month and year must be included)</b>	
	Medical education (qualifying degree) and training must be documented <b>(month and year must be included)</b>	
	An Inpatient Coverage Plan for a practitioner without hospital admitting privileges, practicing in the capacity of a Primary Care Provider, must be documented.	
Practitioner Attestation Questions	<b>CLEARLY</b> answer <b>ALL</b> questions by marking “yes” or “no”. If a question does not apply to your specialty, please mark “no” (“N/A” is <i>Not Acceptable</i> ). Sign and Date.  • A detailed explanation of any “yes” answers must be provided.	

<b>Practitioner Application</b>	<b>ALL sections on the Practitioner Application must be completed. Necessary explanations must be provided. If a section is not applicable to you, check the “Does Not Apply Box” or write “N/A”. Your specialty and/or subspecialty must be recognized by FCH PPO.</b>	<b>Complete</b> ✓
Authorization and Release of Information Agreement	Sign & Date	
W-9	Complete the appropriate information, Sign & Date. <ul style="list-style-type: none"> <li>• Attach a <b>separate</b> signed &amp; dated W-9 for <b>each</b> Tax Identification Number (TIN) that you use for billing purposes.</li> </ul>	

## Please submit the following documents along with the application

<b>Documents</b>	<b>Attached</b> ✓
A copy of your state medical license or certificate or registration	
A copy of your current certificate of malpractice insurance <ul style="list-style-type: none"> <li>• All practitioners must obtain and maintain professional liability insurance that covers all services provided by the practitioner. All practitioners are required to carry malpractice coverage with limits of one million (\$1,000,000) per incident, three million (\$3,000,000) per aggregate.</li> <li>• Chiropractors are required to carry malpractice coverage with limits of two hundred thousand (\$200,000) per incident, six hundred thousand (\$600,000) per aggregate.</li> </ul> <p><i>If an applicant’s name is not documented on the malpractice insurance certificate, please provide documentation of coverage under the existing malpractice policy.</i></p>	
A copy of your current DEA Registration or CDS Certificate (if applicable)	
A copy of your board certification certificate (if applicable)	

## Additional Requirements/Documentation for Allied Health Care Providers

<b>Specialty</b>	<b>Documentation</b>	<b>Attached</b> ✓
Advanced Registered Nurse Practitioner	<ul style="list-style-type: none"> <li>• Hospital Admitting Privileges or In Patient Covering Plan (if practicing as a PCP)</li> </ul>	
Midwife/Certified	<ul style="list-style-type: none"> <li>• Certification by the American College of Nurse Midwives.</li> <li>• A written, formal patient coverage arrangement with a FCH PPO contracted obstetrical physician</li> </ul>	

Specialty	Documentation	Attached ✓
Midwife/Licensed Nurse Midwife	<ul style="list-style-type: none"> <li>• A written, formal patient coverage arrangement with a contracted obstetrical physician.</li> <li>• A copy of the current plan (filed with the state) for consultation with a medical doctor (MD or DO) in an obstetrical practice, emergency transfer and transport client. The physician must be contracted with FCH PPO.</li> </ul>	
Physician Assistant	<ul style="list-style-type: none"> <li>• Name(s) of Sponsoring Physician(s) must be documented in application.</li> <li>• At least one sponsoring physician must be a FCH PPO Preferred Provider.</li> <li>• Hospital Admitting Privileges or Inpatient Coverage Plan (if practicing as a PCP)</li> </ul> <p>Additional Requirements Surgical Assistants:</p> <ul style="list-style-type: none"> <li>• National Surgical Assistant Association <b>or</b></li> <li>• National Commission on Certification of Physician Assistants with additional training in surgery.</li> </ul>	
Registered Nurse First Assistant	<ul style="list-style-type: none"> <li>• Certification by the Certification Board of Perioperative Nursing (CNOR).</li> <li>• Documentation of a written formal agreement to practice in collaboration with and under the on-site supervision and direction of <b>at least one</b> FCH PPO contracted physician.</li> </ul>	
Surgical Assistant	<ul style="list-style-type: none"> <li>• National Surgical Assistant Association <b>or</b></li> <li>• National Commission on Certification of Physician Assistants with additional training in surgery</li> </ul>	