



## **Please submit your Credentialing Application through the HealthPartners Provider Portal**

[Provider Credentialing Form \(healthpartners.com\)](#)

<https://www.healthpartners.com/provider-public/credentialing-form>

We will not accept applications that are emailed, faxed, or sent by U.S Mail.

*HealthPartners*  
*Medication Therapy Management Pharmacist*  
*Initial Credentialing Application*

**Applicant Name:** \_\_\_\_\_  
Last First Middle Suffix Title

<b>CREDENTIALING CONTACT INFORMATION</b>	
<b>Name</b> _____	<b>Phone Number</b> _____
<b>Address</b> _____ _____ _____	<b>Fax Number</b> _____  <b>E-mail</b> _____

**Instructions**

The initial credentialing application and attachments should be typed, legibly printed in black ink, or electronically generated. If more space is needed than provided on the application, please attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Please mark all non-applicable sections with N/A.

**Checklist** (please complete)

Current copies of the following documents must be submitted with this application. If your application for malpractice insurance is pending, please forward application and send that document as soon as possible.

- If you graduated before 1996, you must provide documentation of completion of a structured and comprehensive education program approved by the Board of Pharmacy and the ACPE for the provision and documentation of pharmaceutical care management services that has both clinical and didactic elements.**
- Provide complete street addresses wherever indicated, including education/training and past employment
- Designate dates by month and year time frames
- Explain all gaps of greater than three months in chronology (Page 5)
- Malpractice liability insurance
- Answer all of the Disclosure Questions on Pages 6 and 7 and provide explanations for affirmative answers
- Sign and date the Attestation Signature and Date section (Page 7)
- Sign and dated the Authorization and Release (Page 9)
- Keep a copy of your completed application for your records

**All Information Must Be Printed in Black Ink, Typed or Electronically Generated**

Practitioner Name: \_\_\_\_\_  
Last First Middle Suffix Title

Practitioner NPI: \_\_\_\_\_

## ***Practitioner Race and Ethnicity***

### ***Supplemental Information Form***

**Race and ethnicity (for health plan use only):**

*The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.*

<p><b>What is your race and/or ethnicity?</b></p> <p><u>Select all that apply and enter additional details in the spaces below:</u></p> <p><input type="checkbox"/> American Indian or Alaskan Native</p> <p><input type="checkbox"/> Asian</p> <p><input type="checkbox"/> Black or African American</p> <p><input type="checkbox"/> Hispanic or Latino</p> <p><input type="checkbox"/> Middle Eastern or North African</p> <p><input type="checkbox"/> Native Hawaiian or Other Pacific Islander</p> <p><input type="checkbox"/> White</p> <p><input type="checkbox"/> Other (please specify): _____</p> <p><input type="checkbox"/> Prefer Not to Say</p>
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*Providing race, ethnicity and/or language information on the credentialing application is entirely optional and refusal to provide this information will **not** subject you to adverse treatment. We do not discriminate or base credentialing decisions on an applicant's race, ethnicity, or language.*

*If provided on the credentialing application, the health plan may utilize race, ethnicity and/or language information in provider directories or in internal resources to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.*

**Check here if you do not wish for your race and ethnicity to be displayed in provider directories:**

**Personal Data**

Applicant Name (as shown on your state license):

\_\_\_\_\_  
Last First Middle Suffix Title

All Former Aliases: \_\_\_\_\_ Spouse Name (optional): \_\_\_\_\_

Gender:  M - Male  F - Female  X - Unspecified or Another Gender Identity  U - Undisclosed

U.S. Citizen:  Yes  No Birthplace City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ NPI: \_\_\_\_\_ CAQH ID: \_\_\_\_\_

Current Home Address: \_\_\_\_\_  
Street

\_\_\_\_\_  
City/State/Country Zip Code

Local Home Address (if different from above): \_\_\_\_\_  
Street

\_\_\_\_\_  
City/State/Country Zip Code

Preferred Mailing Address:  Office  Home Practitioner's Preferred E-mail address: \_\_\_\_\_

Cell Phone Number: \_\_\_\_\_ Home Phone Number: \_\_\_\_\_

Do you speak a language other than English with sufficient fluency to treat patients who speak only that language?  Yes  No

If yes, specify languages: \_\_\_\_\_

Military - Are you currently on active military duty?  Yes  No

**Primary or Pending Practice Location**

Primary Practice Location/Clinic Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_ Type II NPI: \_\_\_\_\_ Start Date (at this location): \_\_\_\_\_

Practicing as (select all applicable):  Primary Care  Specialist  Urgent Care  Locum Tenens  Hospitalist/Hospital-Based  
 Moonlighting Resident  Other: \_\_\_\_\_ Services provided via (select all applicable):  Telehealth  In-Person

Accepting New Patients:  Yes  No Directory Suppress:  Yes  No

Regularly sees patients here at least once per week:  Yes  No

Primary Specialty in which care will be provided: \_\_\_\_\_

Subspecialty(ies) in which care will be provided: \_\_\_\_\_

Provide a narrative description of your clinical practice including special interests (if additional space is required, attach a separate sheet):

**Billing Information**

Billing Name: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_

3. **Other Practice Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Currently practicing at this location?  Yes  No Start Date: \_\_\_\_\_

4. **Other Practice Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Currently practicing at this location?  Yes  No Start Date: \_\_\_\_\_

5. **Other Practice Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Currently practicing at this location?  Yes  No Start Date: \_\_\_\_\_

6. **Other Practice Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Currently practicing at this location?  Yes  No Start Date: \_\_\_\_\_

7. **Other Practice Name:** \_\_\_\_\_ Phone Number: (\_\_\_\_) - \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Office Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Currently practicing at this location?  Yes  No Start Date: \_\_\_\_\_

**Professional Education**

(Month and year required)

From \_\_\_/\_\_\_/\_\_\_ Institution Name: \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Degree Received:  PharmD Other: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Post-Graduate/Professional Training** (If applicable)

(Month, day and year required)

From \_\_\_/\_\_\_/\_\_\_ Institution Name: \_\_\_\_\_

To \_\_\_/\_\_\_/\_\_\_ Type of Program/Specialty: \_\_\_\_\_

Completed Training:  Yes  No If no, expected completion date: \_\_\_\_\_

Program Director: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City/State/Country Zip Code

Phone Number: ( ) - \_\_\_\_\_ Fax Number: ( ) - \_\_\_\_\_

**Licensure** - List all past, current and pending professional licenses.

State	License Number	Date Issued	Expiration Date	License Status
_____	_____	___/___/___	___/___/___	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
_____	_____	___/___/___	___/___/___	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending
_____	_____	___/___/___	___/___/___	<input type="checkbox"/> Active <input type="checkbox"/> Inactive <input type="checkbox"/> Pending

**Liability Insurance** - Insurance Carrier for Primary and Pending Practice Location

Enclose a copy of professional liability insurance coverage (e.g., face sheet/verification of self-insurance) for **primary practice location** to include effective dates, insurance carrier, expiration date, coverage limits, and name of each provider covered. If additional space is required, attach a separate sheet.

**Coverage dates:**

Start \_\_\_/\_\_\_/\_\_\_ Insurance Carrier Name: \_\_\_\_\_

Expire \_\_\_/\_\_\_/\_\_\_ Address \_\_\_\_\_

Certificate Pending Name in which policy issued: \_\_\_\_\_  
Street City/State/Country Zip Code

Policy number: \_\_\_\_\_

Amount of coverage (per occurrence/aggregate): \_\_\_\_\_



Please complete and sign this form, attesting to its accuracy. If any of the following questions are answered in the affirmative, provide an explanation by completing the **Disclosure Explanation Form** on the following page.

1.  Yes  No Has your **professional license or registration** ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished or not renewed by any licensing board or any health-related agency organization, or is there a review pending?
2.  Yes  No Has your **professional license or registration** ever been investigated or is it currently being investigated? *If so, provide details to include the reason for the investigation and the results on the following page.*
3.  Yes  No Has your **DEA registration** ever been revoked, suspended, limited, or conditioned in any way, or have you voluntarily relinquished your DEA registration, or is there a review pending?
4.  Yes  No Has your **membership, participation, clinical privileges, or employment** ever been denied, terminated, stipulated, restricted, refused, limited, suspended, revoked, or not renewed by any peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization, or is there a review pending?
5.  Yes  No Have you ever voluntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license, or registration in lieu of disciplinary action, or prior to or during an investigation into your professional conduct or competency?
6.  Yes  No Have you ever involuntarily relinquished your **membership, participation, clinical privileges** or request for privileges, employment, professional license or registration?
7.  Yes  No Has your **membership or fellowship** in any professional organization or your specialty **board certification** ever been voluntarily or involuntarily denied, terminated, restricted, limited, suspended or revoked?
8.  Yes  No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**
9.  Yes  No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?
10.  Yes  No Are there any **charges pending or are you currently charged with**, or have you ever pled guilty or no contest, been indicted or found guilty of a felony, gross misdemeanor, misdemeanor, or other offense?
11.  Yes  No Have you ever been charged with, pled guilty or no contest to, or otherwise been subject to allegations of having engaged in **sexual harassment, sexual misconduct, stalking, or any other similar behavior or crime**, or are you aware of any current allegations or charges pending of the same? *Allegations include, but are not limited to, any made by a third party, such as through a lawsuit, restraining order, or other civil proceeding, or allegations made by a colleague to a previous or current employer.*
12.  Yes  No Have you ever had any **professional liability claims or lawsuits** brought against you, including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments?
13.  Yes  No Has your **professional liability carrier** ever refused or canceled your coverage or excluded you from performing any specific privileges within your specialty?
14.  Yes  No Have you ever practiced within your profession without **professional liability insurance?**
15.  Yes  No Do you currently have any condition that adversely affects your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent, ethical, and professional manner? *You are not required to disclose a health condition if it is being appropriately treated or otherwise does not affect your ability to provide appropriate care to patients or perform the essential functions of your practice in a competent and professional manner.*
16.  Yes  No Do you use any legal/illegal drugs or substances which adversely affect your ability to perform your duties as a member of the healthcare team?

***Attestation Signature and Date***

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed. I understand that the race, ethnicity, and/or language information I have provided (or withheld) on this application is optional and will not be used as basis for credentialing decisions or lead to discrimination.

**All signatures and dates must be clearly legible or signed with a unique electronic identifier.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name \_\_\_\_\_

**CONFIDENTIAL INFORMATION**

If you answered **yes** to any of the Disclosure Questions on the previous page, provide an explanation for each by completing the following form. Please attach external documentation of your response as applicable (e.g., statement from an attorney, court records, etc.). Make additional copies of this form if needed.

Applicable Disclosure Question(s): \_\_\_\_\_ Date of Occurrence: \_\_\_\_\_

Location of Occurrence: Facility (if applicable) \_\_\_\_\_ State: \_\_\_\_\_

**Provide a complete explanation regarding the reason you answered the applicable disclosure question(s) in the affirmative. Do not include name of patient or any other information that may identify a patient.**

**Describe outcome, as applicable. Note: If responding to disclosure question #12, skip this section and complete next section.**

**If you answered yes to Disclosure Question #12, complete the following section.**

<b>Describe Outcome of Claim or Lawsuit</b>	
Date Filed: _____	
<u>CONCLUDED WITH NO PAYMENTS:</u> (month/year) <input type="checkbox"/> Dropped/Closed Date: _____ <input type="checkbox"/> Verdict for you Date: _____ <input type="checkbox"/> Dismissed with prejudice* Date: _____ <input type="checkbox"/> Dismissed without prejudice** Date: _____	<u>CONCLUDED WITH PAYMENTS:</u> (month/year) <input type="checkbox"/> Verdict for Plaintiff Date: _____ Amount \$ _____ <input type="checkbox"/> Settled Date: _____ Amount \$ _____ <u>PENDING</u> <input type="checkbox"/> Filed, pending Date: _____
<p><i>*Dismissed with prejudice – set aside the lawsuit and deny the right to file another suit on the same claim</i></p> <p><i>**Dismissed without prejudice – set aside the lawsuit but leave open the possibility of another suit on the same claim</i></p>	
<b>Represented by Legal Counsel for this lawsuit:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No - <b>If yes, provide name and address of counsel.</b>	
Counsel Name _____ Phone _____	
Address _____	
<b>Insurance company or employer that provided coverage for this claim.</b>	
Name _____ Policy# _____	
Address _____ Phone _____	

**I hereby certify that all the information on this form is complete, true and accurate.**

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Print Name \_\_\_\_\_ Phone \_\_\_\_\_

# *Application Attestation Update*

**The signature blocks below are to be signed ONLY if a previous completed application is being reviewed and updated.**

## **Application Attestation Update**

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The application was designed so that a practitioner need complete it in its entirety only once. If application is then made to another organization which accepts this Initial Credentialing Application and it has been more than 60 days since the practitioner completed or updated the application, the practitioner may do the following:

- Review the application
- Make any needed modification
- Sign one of the attestation blocks below, reconfirming that the application is complete, true and accurate.

Please note: It is particularly important that the Disclosure Questions be reviewed and any changes made with appropriate documentation included.

## **Update Attestation Signature and Date**

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I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature \_\_\_\_\_ Date    /    /   

## **Update Attestation Signature and Date**

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I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature \_\_\_\_\_ Date    /    /   

## **Update Attestation Signature and Date**

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I have reviewed and updated all of the information on this application, including the Disclosure Questions, and I certify it is complete, true and accurate.

Signature \_\_\_\_\_ Date    /    /

**Authorization and Release**  
**(Please read carefully before signing)**

I understand and acknowledge that, as an applicant for appointment to the medical staff, participation and/or clinical privileges (hereinafter, referred to as "Participation") at **HealthPartners Health Plan, Amery Hospital and Clinic, Hudson Hospital and Clinic, Lakeview Hospital, Park Nicollet Health Services, TRIA Orthopaedic Center, Osceola Medical Center, Regions Hospital, St Croix Regional Medical Center, Westfields Hospital** (hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agents and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.
2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.
3. **Release from Liability.** I hereby further release from liability the Entity and its Agents, state licensing boards, health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carriers, and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand that communication regarding my application may occur via email.

**For employees of HealthPartners/GHI or any of its related organizations and those practitioners whose services are billed by HealthPartners/GHI or any of its related organizations:**

I understand that HealthPartners has entered into delegated credentialing agreements with certain health plans for purposes of streamlining and expediting my participation and credentialing with those health plans. As part of the credentialing process, HealthPartners will provide those health plans with a credentialing profile and additional information as requested in order to facilitate my credentialing with those health plans. I hereby understand and agree that the terms of this authorization and release shall be interpreted to authorize the release of my credentialing information to such health plans, to include such health plans as entities entitled to release from liability, and to otherwise generally apply the terms of this authorization and release to such delegated credentialing activity.

I agree that the information collected through the credentialing processes for HealthPartners, Inc, or any of its related organizations may be shared with any of HealthPartners related organizations for the purposes of credentialing at those organizations.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Name (please print or type) \_\_\_\_\_

# Chronological Employment/Practice History Addendum

(Please make as many extra copies as necessary)

(Month, day and year required)

From:  / /  Organization Name/Activity: \_\_\_\_\_  
To:  / /  Reason for Leaving: \_\_\_\_\_  
Employment Contact Name: \_\_\_\_\_ Clinic Still Open?  Yes  No If no, attach sheet listing address and phone number of someone who can verify your time there.  
Address: \_\_\_\_\_  
Street City/State/Country Zip Code  
Phone Number: ( ) - Fax Number: ( ) -

From:  / /  Organization Name/Activity: \_\_\_\_\_  
To:  / /  Reason for Leaving: \_\_\_\_\_  
Employment Contact Name: \_\_\_\_\_ Clinic Still Open?  Yes  No If no, attach sheet listing address and phone number of someone who can verify your time there.  
Address: \_\_\_\_\_  
Street City/State/Country Zip Code  
Phone Number: ( ) - Fax Number: ( ) -

From:  / /  Organization Name/Activity: \_\_\_\_\_  
To:  / /  Reason for Leaving: \_\_\_\_\_  
Employment Contact Name: \_\_\_\_\_ Clinic Still Open?  Yes  No If no, attach sheet listing address and phone number of someone who can verify your time there.  
Address: \_\_\_\_\_  
Street City/State/Country Zip Code  
Phone Number: ( ) - Fax Number: ( ) -

From:  / /  Organization Name/Activity: \_\_\_\_\_  
To:  / /  Reason for Leaving: \_\_\_\_\_  
Employment Contact Name: \_\_\_\_\_ Clinic Still Open?  Yes  No If no, attach sheet listing address and phone number of someone who can verify your time there.  
Address: \_\_\_\_\_  
Street City/State/Country Zip Code  
Phone Number: ( ) - Fax Number: ( ) -

## Explain time gaps/interruptions of greater than three (3) months in medical/professional practice

From  / /  Explain: \_\_\_\_\_  
To  / /  \_\_\_\_\_  
From  / /  Explain: \_\_\_\_\_  
To  / /  \_\_\_\_\_