

Applicant's Name:	Degree:				
Mailing Address: Is this: ___ Work ___ Home					
Phone Number:	Work:				Home:
Fax Number:	Work:				Home:
Cell Phone/Pager:	Cell Phone:				Pager:
E-mail Address:	Up	Connection Type: ___ High Speed ___ Dial			
Contact Person in your office to confirm receipt of faxes and give status reports.	Name:	Phone:	Extension:		
Tax I.D. # or Social Security # (Must be provided to be reimbursed) Name of Corporation if used for reimbursement	Office Title:				
Professional License(s): Please list all states in which you are licensed, the license number and expiration date. Also, please submit a copy of your Medical License Certificate for EACH state.	State	License #	Expiration Date	Active	Inactive
	1. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	2. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	3. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
	4. _____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
Appeal level Reviewers must be Board Certified. (M.D.'s / D.O.'s must be certified by ABMS or ABOS) Please list ALL specialties in which you are Board Certified and submit a copy of your Board Certification for each specialty.	Specialty	Board Certified?	Board Eligible?	Name of Board:	
	1. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
	2. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
	3. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
	4. _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Practice focus within your specialty:					
Some States require Reviewers to be in active practice a minimum number of hours per week.	Are you currently in active practice? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, # of hours per week: _____ Have you had a minimum of 5 years experience providing health care? <input type="checkbox"/> Yes <input type="checkbox"/> No Describe nature of practice or other current activity you think may qualify:				
Organizations for which you currently provide utilization review services:					
List any areas which may pose a conflict of interest for you in the performance of reviews for PRN:					
Are there any past, present or pending actions against your professional license? <u>Include:</u> Malpractice Suits, Investigations of Wrongdoing, Disciplinary Actions such as Reprimands, Probation, License Limitations, Suspensions or Revocations, Fines or Penalties	<input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please provide a full explanation on a separate sheet and attach copies of any legal documents related to the incident(s), including but not limited to the initial complaint or charges, findings and orders.				

