HealthChoice

IDRS Oklahoma Department of Rehabilitation Services

DOC Oklahoma Department Of Corrections

Network Provider Application Requirements

Please complete the Oklahoma Uniform Credentialing Application (OUCA), attached Supplement, and submit with the required attachments listed below.

Type or print your responses and complete all sections of this Application. If an area of inquiry is not applicable to you or your practice, please indicate. If you need additional space to provide COMPLETE answers, attach additional sheets of paper and clearly indicate the item to which each sheet applies.

Retain the Contract for your records.

REQUIRED ATTACHMENTS

Please attach a copy of each of the following documents to your completed Application:

- ☐ **Current state(s) board issued license(s)**
- ☐ **Current DEA registrations (narcotics license), if applicable**
- ☐ **Current state narcotics registration, if applicable**
- ☐ **Face sheet of current professional liability insurance policy**
  Insurance Certificate/Face Sheet must have the name of the applicant listed as the insured and must indicate that it is professional liability coverage. The insurance limits must be at the levels required in the Contract.
- ☐ **W-9 form for each Federal Tax ID Number**
  W-9 forms must be signed and list only the Federal Tax ID Number or Social Security Number for each location listed on the Application which will be used on claim forms submitted for reimbursement.
- ☐ **Contract Signature Page**
- ☐ **Uniform Credentialing Application (UCA)**
- ☐ **UCA Supplement Form**

Incomplete Applications will be returned

Supplement Information

- **Mid-Level Practitioners must disclose their supervising physician:**

  Name: _____
  (Last) (First) (Middle)

- **Liability Insurance-Minimum requirements:**

  $1,000,000 per occurrence and $1,000,000 aggregate for Oklahoma providers

  Minimums established by other states will be accepted for providers practicing in other states

  Name of Carrier: _____
  (Attach a copy of the insurance certificate/face sheet)

  Coverage Amounts: Per Occurrence: _____ Aggregate: _____

  Expiration Date: _____

The contact below will be used for fee schedules, and contractual notices as defined in section 12.2 of the provider contract. The email address of the designated mail contact is one of the required fields for accessing the on-line fee schedules for HealthChoice and the Department of Corrections.

Office Name: _____

Mailing Address: _____

_____
(City) (State) (Zip)

Phone: _____ Fax: _____

Contact Person: _____ Email: _____

Provider Addresses from UCA, Application, or Provider Profile (if applicable):

ONLY the following Address fields will be used by the Employees Group Insurance Division in the following manner**:**
Office Street Address will be utilized for provider directories**
Credentialing Correspondence Mailing Address will be utilized for all credentialing notices/documents**
Claims Payment Address will be utilized for all payment related notices/documents**

*****If Mailing or Claims Payment Addresses are not listed, related contractual notices and documents will go to the Office Street Address.***

Provider Printed Name _____

Provider Signature _____ Date_____

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