Rev 11/15/07

PROVIDER RECREDENTIALING FORM

AGENCY NAME:	

PROFESSIONAL LIABILITY INSURANCE	**Please attach a separate page with any previous Liability Carriers in the past 3 years**

Name of Company: ______________________ **Start Date:** __________

Complete Address: ______________________ **Policy Number:** __________

____

Phone Number ______________________ **Coverage Amounts:** __________

CLINICIAN/PRACTITIONER

Copy and complete this page for each person to be covered

Name: ______________________ Service Codes: ______________________

Degree: ______________________ Discipline: ______________________

ID NUMBERS			
State License: List all current and past state licenses.			
State of Licensure	**Number**	**Type**	**Expiration Date**
Non-Licensed – Master Prepared Practitioners			
Date 3000 Hour Psychotherapy Letter Issued:			***Include a copy***

	Other ID Numbers	
Type of Number	**Number**	**Expiration Date**
DEA Number		
UPIN Number		
ECFMG Number		
MA Provider Number		
National Provider ID Number		

Background checks have been completed on the above clinician/practitioner within the last 4 years and are available upon request at the above agency. Submit Wisconsin State Dept. of Justice and/or Dept. Regulation and Licensing report to Children Come First for review if criminal record, denial, or revocation is noted.

Signature:______________________ Date ______________

Consent to Release Information
Verification of Professional Liability Insurance

Copy and complete this form for each Insurance Carrier used in the last 5 years.

Consent to Release Information

I understand that this Consent to Release Information is made in connection with Physician/Practitioner contracting, credentialing, or recredentialing activity conducted by Community Partnerships on behalf of the Children Come First Program.

I hereby authorize Community Partnerships and it representatives to contact and consult with the Insurance Carrier identified below with which I have affiliated, have used for liability insurance or who may have information relevant to my professional liability insurance and/or malpractice insurance claims history.

I release and hold harmless from liability all persons, entities, and institutions when in good faith and without malice for acts performed in gathering or exchanging information related to this credentialing or recredentialing process. This release and hold harmless provision applies to all person, entities and institutions that provide and/or receive information as part of the Community Partnerships – Children Come First Program credentialing or recredentialing process.

I, the undersigned, authorize

____
Name of Insurance Carrier

____
Street Address

____
City State Zip Code

____
Policy Number

to send verification of my professional liability coverage, to include dates of coverage, amounts of coverage and any limitations in coverage to Community Partnerships – Children Come First Program who will hereinafter be a Certificate Holder and as such is to be notified of the amount of my current and any future coverage and/or changes to my insurance status.

Print Practitioner Name: ______________________________________

Practitioner Signature: ______________________Date: ____________