

**Primary Care Association, L.L.C.
Credentialing Addendum**

Practicing Specialty (-ies):	
*Primary	
Secondary	
Tertiary	

Physician Demographics	
Last Name	
First Name	
Middle Name	
Degree	
Date of Birth	
NPI (Individual)	
Physician E-Mail Address	
Office Manager	
Office Manager E-Mail Address	

Current Physician Organization Affiliations		
Organization	Type (PHO, IPA, etc.)	Member since (date)

Primary Physical Office Location		
Practice Name		
Tax Identification Number		
NPI (Organizational)		
Street Address		
City, State ZIP		
County		
Medicaid Number for Location		
Phone #		
Fax #		
Office Hours:	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Practice limited to...		
Other physicians in practice at this location:	1	6
	2	7
	3	8
	4	9
	5	10
Handicap Access? (Yes/No)		
List this location in the directory? (Yes/No)		
Billing Information For Primary Physical Office Location		
Address		
City, State ZIP		
County		
Phone #		
Fax #		
Call Coverage for this Location Provided By		
Physician Name		
State Medical License Number		
Street Address, City, State Zip		
Phone #		

Additional Office Location		
Practice Name		
Tax Identification Number		
NPI (Organizational)		
Street Address		
City, State ZIP		
County		
Medicaid Number for Location		
Phone #		
Fax #		
Office Hours:	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Practice limited to...		
Other physicians in practice at this location:	1	6
	2	7
	3	8
	4	9
	5	10
Handicap Access? (Yes/No)		
List this location in the directory? (Yes/No)		
Billing Information For Additional Office Location		
Address		
City, State ZIP		
County		
Phone #		
Fax #		
Call Coverage for this Location Provided By		
Physician Name		
State Medical License Number		
Street Address, City, State Zip		
Phone #		

Additional Office Location		
Practice Name		
Tax Identification Number		
NPI (Organizational)		
Street Address		
City, State ZIP		
County		
Medicaid Number for Location		
Phone #		
Fax #		
Office Hours:	From	To
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	2	7
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	4	9
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Handicap Access? (Yes/No)		
List this location in the directory? (Yes/No)		
Billing Information For Additional Office Location		
Address		
City, State ZIP		
County		
Phone #		
Fax #		
Call Coverage for this Location Provided By		
Physician Name		
State Medical License Number		
Street Address, City, State Zip		
Phone #		

Additional Office Location		
Practice Name		
Tax Identification Number		
NPI (Organizational)		
Street Address		
City, State ZIP		
County		
Medicaid Number for Location		
Phone #		
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Office Hours:	From	To
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Handicap Access? (Yes/No)		
List this location in the directory? (Yes/No)		
Billing Information For Additional Office Location		
Address		
City, State ZIP		
County		
Phone #		
Fax #		
Call Coverage for this Location Provided By		
Physician Name		
State Medical License Number		
Street Address, City, State Zip		
Phone #		

ATTESTATION

I the undersigned, do hereby attest that the statements and responses that I have provided in this addendum, are to the best of my knowledge and recollection, complete and correct and that I have not deliberately omitted, misrepresented or misstated any material fact(s). I agree to indemnify and hold harmless Primary Care Association, L.L.C., its respective officers, directors, agents and employees against any and all claims, demands, damages, liabilities, losses, costs and expenses including attorneys fees incurred as a result of any false, incomplete or outdated information contained in this application. I understand that falsification of any of these statements or responses, or omissions of any material fact may result in my inability to participate in, or continue to participate in Primary Care Association, L.L.C.

Signature of Provider

Date

Printed Name

Social Security Number

AUTHORIZATION TO RELEASE INFORMATION

I understand that submission of this application does not imply or guarantee acceptance or membership in Primary Care Association, L.L.C.

I acknowledge and understand that Primary Care Association, L.L.C. ("PCA") has a legitimate right to obtain and verify any information regarding my professional competency.

Therefore, I the undersigned Provider do hereby authorize PCA and their authorized representatives to consult with any third party who may have information including otherwise privileged or confidential information, relating to my professional qualifications, credentials, professional competence, physical, mental or emotional condition, moral or ethical character, or any other matter relating to this application or affiliation with PCA. I also authorize any third party, including but not limited to medical associations/societies of which I am a member, all hospitals or other healthcare facilities in which I have held or now hold privileges, any state licensing board to which I ever applied or been granted a professional license, other physicians or healthcare providers, government agencies, peer review or professional standards review organizations, managed care organizations, state public health department and professional liability insurers, to release to PCA and their authorized representatives upon their request, any information any such third party may have which, in the judgment of any such third party, has a bearing upon my acceptability to PCA. I also agree to indemnify and hold harmless PCA, its respective officers, directors, agents and employees and any third party releasing information pursuant to this authorization from any and all claims, damages, liabilities, costs and expenses including attorneys fees incurred by these persons, organizations or entities for releasing such information.

Signature of Provider

Date

Printed Name

Social Security Number