Please fill out this application and fax or mail it along with a copy of your State License, DEA Certificate and Insurance Coverage to:

Transparent Health Network
630 Fairview Rd. Ste. 201
Swarthmore, PA 19081-2335
phone: (877) 297-8864
fax: (888) 965-8864
www.TransparentHealthGroup.com/Provider
Providers@TransparentHG.com

PLEASE TYPE OR PRINT NEATLY

I. General Information NPI#

NAME (LAST, First, MIDDLE)

DATE OF BIRTH	GENDER F ☐ M ☐

HOME ADDRESS /STREET

CITY	STATE	ZIP CODE

PRIMARY SPECIALTY	SECONDARY SPECIALTY	OTHER SPECIALTY

PRIMARY LOCATION Please attach additional sheets for other locations.	OTHER LOCATION(S) Please attach additionall sheets for other location&
GROUP PRACTICE NAME (IF APPLICABLE)	GROUP PRACTICE NAME (IF APPLICABLE)
STREET	STREET
CITY	CITY
STATE / ZIP CODE	STATE / ZIP CODE
COUNTY	COUNTY
TELEPHONE	TELEPHONE
FAX	FAX
AFTER HOURS TELEPHONE	AFTER HOURS TELEPHONE
OFFICE MANAGER	OFFICE MANAGER
BILLING ADDRESS / STREET	BILLING ADDRESS/STREET
CITY	CITY
STATE / ZIP CODE	STATE / ZIP CODE
TELEPHONE	TELEPHONE
LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY PHYSICIAN	LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY PHYSICIAN
LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY OFFICE STAFF	LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY OFFICE STAFF

II. License Information

LICENSE

STATE	LICENSE NUMBER	EXPIRATION DATE	ORIGINAL DATE

Do you have a license in any other states or countries yes, please list. Yes ☐ No ☐

STATE/COUNTRY	LICENSE NUMBER	EXPIRATION DATE
STATE / COUNTRY	LICENSE NUMBER	EXPIRATION DATE

DEA NUMBER	EXP.DATE

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III. Practice Information

Type of Practice	Solo ☐	Group ☐	Other ☐	Multi-specialty Group ☐

Names and Specialties of other members in your group. If you need additional space, please attach sheets.

NAME	SPECIALTY
NAME	SPECIALTY
NAME	SPECIALTY
NAME	SPECIALTY

Covering physicians should be participating providers or be in the process of becoming providers in the plan you are applying to.
Please list covering physician(s). If additional names and information, please attach.

NAME	NAME	NAME
STREET ADDRESS	STREET ADDRESS	STREET ADDRESS
CITY	CITY	CITY
STATE / ZIP	STATE / ZIP	STATE / ZIP
TELEPHONE	TELEPHONE	TELEPHONE

IV. Board Certification

PRIMARY SPECIALTY	SECONDARY SPECIALTIES

Are you board certified in this primary specialty ?	Yes ☐	No ☐

BOARD	DATE CERTIFIED	EXP DATE	CERTIFICATE #
BOARD	DATE CERTIFIED	EXP DATE	CERTIFICATE #

Are you board certified in these secondary specialties ?	Yes ☐	No ☐

BOARD	DATE CERTIFIED	EXP DATE	CERTIFICATE #
BOARD	DATE CERTIFIED	EXP DATE	CERTIFICATE #

V. Professional Liability Insurance Carriers

Please provide names, addresses, policy numbers, coverage limits and dates for current malpractice insurance carriers.
(Please give the name of your insurance carrier, not your employer.)

PRESENT PRIMARY INSURANCE CARRIER	NAME

STREET	CITY	STATE	ZIP

POLICY NO.	COVERAGE LIMITS	PHONE	DATE FROM	DATE TO

VI. Hospital Privileges

Please list all hospitals where you currently have active or admitting privileges.
Please list your primary hospital first. Also indicate the average admissions per facility per year.
Please indicate status of privileges using the following key:

1 Active
2 Associate
3 Courtesy
4 Provisional
5 Consulting
6 Temporary
7 Visiting
8 Admitting
9 Suspended
1 0 Pending
11 Active Provisional Staff
12 Courtesy Provisional Staff
13 Senior Staff
14 Other (specify)

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You may only use one number for each hospital. You should use the number which matches the hospital designation.
Attach additional pages as necessary.

Primary Hospital Name	Status of Priv.	Admits/Years	Describe Any Restrictions	
Address		City	State	Zip
Hospital Name	Status of Priv.	Admits/Years	Describe Any Restrictions	
Address		City	State	Zip
Hospital Name	Status of Priv.	Admits/Years	Describe Any Restrictions	
Address		City	State	Zip

Please list all hospitals where you have previously held privileges other than during your intemship/residency/fellowship.
Attach additional pages as necessary.

Hospital Name	Status of Priv.	Admits/Years	Describe Any Restrictions	
Address		City	State	Zip
Hospital Name	Status of Priv.	Admits/Years	Describe Any Restrictions	
Address		City	State	Zip

VII. Affirmation and Release

I hereby authorize and consent to the release of information by any hospital or hospital's medical staff, medical associations, National Practitioner Data Bank, New York State Department of Social Services, New York State Department of Health, other government agencies, malpractice insurance carriers and previous and present and other interested parties regarding information concerning me. I hereby release Transparent Health Group, LLC, well as the institution(s) or organizations providing such information and their staff, from any and all liability for the obtaining and release of such information. I also understand that I have a continuing obligation to amend and update my answers.

By my signature, I hereby attest that the information in this application is complete and accurate and I agree to provide information as required to support this application. The undersigned hereby certifies that the above information requested is truthful, correct and complete in all respects. The undersigned further understands that the submission of false and/or significantly misleading information or the withholding of relevant information is grounds for termination of THG's Provider Agreement.

APPLICANT SIGNATURE

PRINT NAME	GENDER ☐ Male ☐ Female	DATE SIGNED