



HCA MIDWEST DIVISION PRE-REQUEST FOR CONSIDERATION FORM

We have received information that you would like to apply for Request for Consideration (RFC) at an HCA Midwest Division facility. Please complete this form and send as indicated below. **Fields marked with an asterisk must be completed.**

HCAPS?(Employed with HCA Physician Services) Yes No Employed or Contracted _____ Start Date _____

*Name _____ *Degree (e.g. MD, DO, DPM, CRNA) _____

*Group Practice Name _____ *Provider E-mail Addr. _____

*DOB: _____ *SS#: _____ *NPI: _____

*Home Address: _____ Phone: () _____
Street Address Apt # City, State Zip

*Credentialing Address: _____ Phone: () _____ Fax: () _____
Street Address Ste # City, State Zip

*Primary Address: _____ Phone: () _____ Fax: () _____
Street Address Ste # City, State Zip

* If the same as credentialing address check here ** Please note "primary address" type is used for our website directory.*

*Board Certification: Are you board certified? Yes No If yes, what specialty(ies) _____
If no, are you eligible to take the exam? Yes No
Date of scheduled exam _____

*If you are currently in Residency or Fellowship -Date of Completion _____ Specialty _____

I hereby make a Request for Consideration for membership on the Medical Staff to practice at the following HCA Midwest Division facility(s) as noted on the attached document. Furthermore, I also make Request for Consideration for the privileges checked as indicated on the attached document.

Physician / Advanced Practice Professional Signature (Or Delegate) _____ Date _____

(If using a delegate please print, complete and fax back with the pre-app the Provider's Authorization for Delegate form)

Upon receipt of this information, the Nashville Credentialing Processing Center (CPC) will send a RFC Packet to the address you indicated above. This form will also be faxed to the Facility(ies) that you indicated and they will send to you their Facility-Specific Document Packet.

Please mail or fax **all five pages** of this completed form to: HCA Midwest Division
Phone: (816)246-2054

*** FAX ALL 5 PAGES TO THE DIVISION OFFICE or EMAIL TO MWDO.PRERFC@HCAHEALTHCARE.COM ***

*** Primary fax (816) 359-3520 Alternate fax (816)246-5013 ***

For Internal Use Only: HMCC – Associate Provider Approved By: _____

Kansas Hospital Requests

*1. Do you hold an active Kansas state license? Yes No

*2. Do you hold a current DEA for the State of Kansas? Yes No

If yes, what is the number? _____

If yes, what is the number? _____

If no, have you applied for one? Yes- Date _____ No

If no, have you applied for one? Yes- Date _____ No

Kansas Privilege Lists Physicians

CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)

<input type="checkbox"/> ALLEN COUNTY HOSPITAL		<input type="checkbox"/> MENORAH MEDICAL CENTER		<input type="checkbox"/> OVERLAND PARK REGIONAL MEDICAL CENTER	
<input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Radiology	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Physician Asst. <input type="checkbox"/> APP-Nurse Practitioner	<input type="checkbox"/> Anesthesiology <input type="checkbox"/> Pain. Mgt. <input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Hospitalist –IM <input type="checkbox"/> Hospitalist –FM <input type="checkbox"/> Hospitalist-Other _____ <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Nurse Clinician/Clinical Nurse <input type="checkbox"/> APP-Neonatal Nurse Practitioner <input type="checkbox"/> APP-Physician Asst. <input type="checkbox"/> APP-Psychology <input type="checkbox"/> APP-CNM	<input type="checkbox"/> Anesthesiology <input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Hospitalist –IM <input type="checkbox"/> Hospitalist –FM <input type="checkbox"/> Hospitalist - Other _____ <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Radiology <input type="checkbox"/> Radiology/Onc. <input type="checkbox"/> Teleradiology <input type="checkbox"/> Trauma	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-CNM <input type="checkbox"/> APP-Neonatal Nurse Practitioner <input type="checkbox"/> APP-Nurse Practitioner <input type="checkbox"/> APP-Physician Asst. – Medical <input type="checkbox"/> APP-Physician Asst. - Surgical <input type="checkbox"/> Psychologist
Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys. Med./Rehab <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology	Surgery <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Colon-Rectal <input type="checkbox"/> Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology	Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Phys. Med./Rehab <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology Surgery <input type="checkbox"/> Cardiovasc. Surgery <input type="checkbox"/> General Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Surgery	<input type="checkbox"/> Otolaryngology <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Thoracic Surgery <input type="checkbox"/> Urology <input type="checkbox"/> Vascular <input type="checkbox"/> Wound Care Orthopaedic Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Podiatry Neurology/Neurosurgery <input type="checkbox"/> Neurology <input type="checkbox"/> Neurosurgery Radiology/Radiation Therapy <input type="checkbox"/> Radiology <input type="checkbox"/> Radiation Oncology	Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys. Med./Rehab <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology <input type="checkbox"/> Physiatry OB/GYN <input type="checkbox"/> OB/GYN <input type="checkbox"/> Perinatology <input type="checkbox"/> Gyn Oncology	Surgery <input type="checkbox"/> Cardio/Thoracic <input type="checkbox"/> Colon-Rectal <input type="checkbox"/> Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Peripheral Vascular <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology

Kansas Privilege Lists Physicians

CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)

<input type="checkbox"/> MID AMERICA SURGERY INSTITUTE	<input type="checkbox"/> OVERLAND PARK SURGERY CENTER	<input type="checkbox"/> SURGICENTER OF JOHNSON COUNTY
<p>5525 W 119th St Overland Park, KS 66209</p> <p>Advanced Practice Professionals (APP)</p> <p><input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Physician Asst. <input type="checkbox"/> APP- Nurse Practitioner</p>	<p>10601 Quivira Rd Ste 100 Overland Park, KS 66215</p> <p>Advanced Practice Professionals (APP)</p> <p><input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Physician Asst <input type="checkbox"/> APP-Nurse Practitioner</p>	<p>8800 Ballentine Overland Park, KS 66214</p> <p>Advanced Practice Professionals (APP)</p> <p><input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Physician Asst <input type="checkbox"/> APP-Nurse Practitioner</p>
<p><input type="checkbox"/> Anesthesiology <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Dentistry/Oral Surgery <input type="checkbox"/> Gastroenterology</p> <p style="text-align: center;">Surgery</p> <p><input type="checkbox"/> General Surgery <input type="checkbox"/> Gynecology <input type="checkbox"/> Laser <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedic <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Urology <input type="checkbox"/> Pain Management <input type="checkbox"/> Pathology <input type="checkbox"/> Podiatry</p>	<p style="text-align: center;">Surgery</p> <p><input type="checkbox"/> Anesthesiology <input type="checkbox"/> Dentistry and Oral Surgery <input type="checkbox"/> Gastroenterology <input type="checkbox"/> General Surgery <input type="checkbox"/> Gynecology <input type="checkbox"/> Laser <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedic <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology</p>	<p style="text-align: center;">Surgery</p> <p><input type="checkbox"/> Anesthesiology <input type="checkbox"/> General & Pediatric Dentistry <input type="checkbox"/> General <input type="checkbox"/> OB/GYN <input type="checkbox"/> Oral & Maxillary <input type="checkbox"/> Orthopedic <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Plastic & Reconstructive <input type="checkbox"/> Podiatric</p>

Please note all fields marked with an asterisk must be completed and all five pages returned.

Also if using a delegate you must submit the Provider Authorization for Delegate form.

Missouri Hospital Requests

*1. Do you hold an active Missouri state license? Yes No

If yes, what is the number? _____

If no, have you applied for one? Yes- Date _____ No

*2. Do you hold a current DEA for the State of Missouri? Yes No

If yes, what is the number? _____

If no, have you applied for one? Yes -Date _____ No

*3. Do you hold a current Missouri BNDD? Yes No

If yes, what is the number? _____

If no, have you applied for one? Yes- Date _____ No

Missouri Privilege Lists

CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)

<input type="checkbox"/> CASS REGIONAL MEDICAL CENTER		<input type="checkbox"/> CENTERPOINT AMBULATORY SURGERY CENTER		<input type="checkbox"/> CENTERPOINT MEDICAL CENTER		<input type="checkbox"/> LAFAYETTE REGIONAL HEALTH CENTER	
<input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Radiology	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Nurse Practitioner <input type="checkbox"/> APP-Psychologist		Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Physician Asst.	<input type="checkbox"/> Anesthesia <input type="checkbox"/> ER Medicine <input type="checkbox"/> Hospitalist -IM <input type="checkbox"/> Hospitalist -FM <input type="checkbox"/> Hospitalist - Other _____ <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics-Newborn <input type="checkbox"/> Neonatology <input type="checkbox"/> Perinatology <input type="checkbox"/> Radiology <input type="checkbox"/> Teleradiology	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-APRN/PA <input type="checkbox"/> APP-APRN/PA-ED <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Neonatal Nurse Practitioner <input type="checkbox"/> APP-Nurse Midwife <input type="checkbox"/> APP-Pediatric Nurse Practitioner <input type="checkbox"/> APP-Psychologist	<input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Pathology <input type="checkbox"/> Radiology <input type="checkbox"/> OB/GYN	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-NP
Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Metabolic & Endocrine <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys. Med./Rehab <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology	Surgery <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardio/Thoracic <input type="checkbox"/> Colon-Rectal <input type="checkbox"/> Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Peripheral Vascular <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Urology <input type="checkbox"/> Podiatry		Surgery <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Dentistry <input type="checkbox"/> Gastroenterology <input type="checkbox"/> General Surgery <input type="checkbox"/> Gynecology <input type="checkbox"/> Laser <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedic <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Pediatric Dent. <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology	Medicine <input type="checkbox"/> Allergy/Immun. <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Family Practice <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys Med/Rehab <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology	Surgery <input type="checkbox"/> Colon & Rectal Surgery <input type="checkbox"/> Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Maxillo Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Pediatric Surgery (Consultation Only) <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology	Medicine <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys. Med./Rehab <input type="checkbox"/> Pulmonology <input type="checkbox"/> Rheumatology	Surgery <input type="checkbox"/> Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology

Missouri Privilege Lists

CHECK ONLY THE FACILITIES TO WHICH YOU ARE APPLYING (Do not include facilities at which you are already on staff)

<input type="checkbox"/> LEE'S SUMMIT MEDICAL CENTER		<input type="checkbox"/> BELTON REGIONAL MEDICAL CENTER		<input type="checkbox"/> RESEARCH MEDICAL CENTER		<input type="checkbox"/> RESEARCH PSYCHIATRIC CENTER	
<input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Hospitalist –IM <input type="checkbox"/> Hospitalist-FM <input type="checkbox"/> Hospitalist – Other _____ <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Radiology <input type="checkbox"/> Tele-radiology	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-ANP <input type="checkbox"/> APP-ANP-ER <input type="checkbox"/> APP-PA <input type="checkbox"/> APP-PA-ER	<input type="checkbox"/> Hospitalist-IM <input type="checkbox"/> Hospitalist-FM <input type="checkbox"/> Hospitalist-Other _____	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-Physician Asst. <input type="checkbox"/> APP-Nurse Practitioner <input type="checkbox"/> APP-Nurse Practitioner-Hospitalist	<input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Medicine <input type="checkbox"/> Hospitalist –IM <input type="checkbox"/> Hospitalist –FM <input type="checkbox"/> Hospitalist – Other _____ <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pathology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Radiology Anesthesiology <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Pain Management	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-CRNA <input type="checkbox"/> APP-NP <input type="checkbox"/> APP-NP ED <input type="checkbox"/> APP-Nurse Midwife <input type="checkbox"/> APP-PA <input type="checkbox"/> APP- PA ED <input type="checkbox"/> APP-Psychologist	<input type="checkbox"/> Anesthesiology <input type="checkbox"/> Family Practice <input type="checkbox"/> Hospitalist –IM <input type="checkbox"/> Hospitalist –FM <input type="checkbox"/> Hospitalist – Other _____ <input type="checkbox"/> OB/GYN <input type="checkbox"/> Pediatrics <input type="checkbox"/> Radiology	Advanced Practice Professionals (APP) <input type="checkbox"/> APP-Nurse Practitioner <input type="checkbox"/> APP -Psychologist
Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys. Med./Rehab <input type="checkbox"/> Psychiatry <input type="checkbox"/> Pulmonary Disease <input type="checkbox"/> Radiation/Onc. <input type="checkbox"/> Rheumatology <input type="checkbox"/> Tele-neurology <input type="checkbox"/> Wound Care	Surgery <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardio/Thoracic <input type="checkbox"/> Colon-Rectal <input type="checkbox"/> General Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral/Max. Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Pediatric Dentistry <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology <input type="checkbox"/> Vascular/Thor. Wound Care	Medicine <input type="checkbox"/> Allergy <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> ER Medicine <input type="checkbox"/> Family Practice <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hematology/Onc <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Pediatrics <input type="checkbox"/> Phys Med/Rehab <input type="checkbox"/> Pulmonology <input type="checkbox"/> Radiology <input type="checkbox"/> Rheumatology <input type="checkbox"/> Psychiatry	Surgery <input type="checkbox"/> Anesthesiology <input type="checkbox"/> Cardio/Thor Surgery <input type="checkbox"/> Colon-Rectal <input type="checkbox"/> Dent/Gen <input type="checkbox"/> General Surgery <input type="checkbox"/> Gynecology <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Pain Management <input type="checkbox"/> Oral Maxillo Facial <input type="checkbox"/> Pathology <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology	Medicine <input type="checkbox"/> Allergy/Immun. <input type="checkbox"/> Cardiology <input type="checkbox"/> Dermatology <input type="checkbox"/> Endocrinology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Disease <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Neurology <input type="checkbox"/> Phys Med/Rehab <input type="checkbox"/> Pulmonology <input type="checkbox"/> Radiation Oncology <input type="checkbox"/> Rheumatology <input type="checkbox"/> Psychiatry	Surgery <input type="checkbox"/> Dentistry <input type="checkbox"/> General Surgery <input type="checkbox"/> Neurosurgery <input type="checkbox"/> Ophthalmology <input type="checkbox"/> Oral Maxillo Surgery <input type="checkbox"/> Orthopedics <input type="checkbox"/> Otolaryngology <input type="checkbox"/> Plastic Surgery <input type="checkbox"/> Podiatry <input type="checkbox"/> Urology	Neurology/Psychiatry <input type="checkbox"/> Psychiatry <input type="checkbox"/> Neurology Medicine <input type="checkbox"/> Cardiology <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Hemat/Oncology <input type="checkbox"/> Infectious Dis <input type="checkbox"/> Internal Med. <input type="checkbox"/> Nephrology <input type="checkbox"/> Pulmonology	Surgery <input type="checkbox"/> General Surgery <input type="checkbox"/> Urology

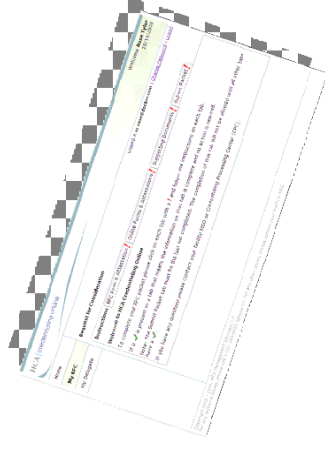
Please note all fields marked with an asterisk must be completed and all five pages returned.

Also if using a delegate you must submit the Provider Authorization for Delegate form.

Announcing Online Credentialing!!!

We are pleased to announce a new credentialing process!! The new process will provide you the capability to submit your credentialing requests electronically for all HCA hospitals with the HCA Credentialing Online (HCO) tool.

The HCO tool will take the manual paperwork and data entry credentialing processes and transform them into an easy to use electronic process.



HCO Benefits

- Allow you to submit 1 credentialing request for all HCA hospitals
- Provide you with electronic access to create, modify, and submit your credentialing documents
- Electronic credentialing processes will ensure accuracy and completeness of your data being considered

HCO Features

- Ability to establish a delegate to prepare the required forms and documentation for your approval
- Accessible to all providers having association to or seeking association to our facility
- Online attestation form completion

Learning about HCO and how to use it

- You will receive an email notification when it is time for you or your delegate to complete your initial appointment or re-appointment packet which will provide you a link to job aids, instructions and training materials. If you would like to see this information before it is time for you to complete the forms you can do so by logging onto www.hcacredentialingonline.com

Action Needed!

To ensure you have capability to receive and submit information online through the HCA Credentialing Online system, please complete and return the attached form notifying us that you will provide credentialing information personally or through a delegate.

Please complete the attached authorization form and return in **14 days** to the fax number or mailing address indicated in Step 3. If you have any questions please contact our call center at

Shared Services Center - Nashville
 552 Metroplex Dr. Nashville, TN 37211
 Phone: 615-886-4318 Toll-Free: 866-376-1045 Fax: 877-405-6604
 Email: NSSC.CPCRRequests@HCAhealthcare.com

HCA Credentialing Online - Provider's Authorization for Delegate

Step 1

The contact information listed below has been pre-populated based on your information in our credentialing system. If changes are needed, please indicate below.

Provider Name: _____
Provider Phone: _____
Provider Email (required): _____

NOTE: Provider email must be unique to the provider; it cannot be the same address as a

Step 2

- I do not want to select any delegates at this time. I will personally provide re-credentialing information. _____
initial and skip to Step 3
- I understand that one delegate for all entities is preferred; however, I have different people handle my credentialing at different entities. The delegate listed below is my primary delegate for HCA access.
- The delegate listed below is my delegate for all entities.
- I hereby authorize:

name:
email:
phone: () - ext.

Delegate

(hereinafter, individually referred to as "Delegate") to access the HCA Credentialing Online web portal to enter data and submit documents for the HCA Requests for Considerations (RFC) and HCA Reappointment Requests for Information (RRFCs) requests on my behalf. I understand that I will need to review the data and documents and attest to their accuracy before I submit them to HCA via the HCA Credentialing Online web I acknowledge that I have voluntarily provided the above information, and I have carefully read and understand this Authorization. I understand and agree that a facsimile or photocopy of this Authorization shall be as effective as the original.

PROVIDER SIGNATURE _____ NAME _____

SOCIAL SECURITY NUMBER or NPI _____ DATE (MM/DD/YYYY) _____

Step 3

Please complete, sign and date. The form may be returned via:

1. Scanned and e-mailed to email below
2. Faxed to the attention of the Intake Team at the fax below or
3. U.S. mail to the address below

Shared Services Center - Nashville
552 Metroplex Dr. Nashville, TN 37211
Phone: 615-886-4318 Toll-Free: 866-376-1045 Fax: 877-405-6604
Email: NSSC.CPCRequests@HCAhealthcare.com