INTEGRIS HEALTH Partners

Participation Request Form

- Please complete the form in its entirety. This form will be used to determine your eligibility to join INTEGRIS Health Partners (IHP).
- If you have or will be applying for privileges at an INTEGRIS Health facility, you will not need to complete the IHP Credentialing. application. Please visit https://integrisok.com/ihp/prospective-providers for additional forms to complete this process.
- Please return this form to INTEGRIS Credentialing Office at IHPCredentialing@integrishealth.org. You will receive an e-mail with further instructions.

Last Name	First Name
Birth Date	Primary Degree (APRN, MD, etc.)
NPI Number	
Provider E-mail (must be unique to this provider)	

If you have an admin completing this application, please complete the Credentialing Contact section below.

Credentialing Contact Name	Credentialing Contact Phone Number
Credentialing Contact E-Mail (cannot be the same as the provider)	

Primary Office Location	
Practice Name	**City and State of Practice**

For Advance Practice Providers:				
Is your supervising physician in network with INTEGRIS Health Partners?	**Yes**		**No**	
Please list your supervising physician(s):				

Specialty Information				
Are you board certified?	**Yes**		**No**	
If not certified, are you board eligible?	**Yes**		**No**	
If not board certified or eligible, please explain your board status or lack of certification.				
Board Certified Specialty				
Practicing Specialty				

Admitting Privileges				
Do you possess admitting privileges at an in-network facility?	**Yes**		**No**	
Do you have admitting privileges outside of the IHP Network?	**Yes**		**No**	
Please list **ALL** facilities in which you hold privileges.				

Please reach out to IHPCredentialing@integrishealth.com to obtain a list of in-network facilities.

Medicare Opt-Out				
Are you currently opted-out of Medicare through CMS.gov?	**Yes**		**No**	
DEA/OBNDD				
Do you possess and plan to maintain a DEA and OBNDD?	**Yes**		**No**	

Reason for request
What is the reason you would like to join INTEGRIS Health Partners?

I expressly agree that, in consideration for the Network's willingness to review and consider the information provided herein, I waive and release any claims, including but not limited to any claim of entitlement to a hearing or appellate review, against the Network, its participants, officers, directors and agents, arising from a decision to not provide me an application for membership in the Network. I expressly agree that such a decision is an administrative and business decision which may be made by the Network independent of any professional review and that such a decision will not result in any report to the National Practitioner Data Bank or any other agency. I also agree that if I am offered an application, granted participation, and fail to fulfill the conditions to which I have agreed, my network eligibility may be administratively terminated without giving rise to any claim of any nature against INTEGRIS Health Partners, its participants, officers, directors, and agents. I hereby attest that the information provided above is true and correct. I fully understand that any significant misstatements in or omissions from this document constitute cause for denial of my request for an application, denial of appointment to the network, or termination from the network. I will immediately notify INTEGRIS Health Partners if any information provided in this document changes or is no longer true and correct.

Provider Name: _____

Signature: _____ Date: _____

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Initial Application Requirements

The following items will be needed for the IHP (INTEGRIS Health Partners) online application. Please prepare these documents prior to receiving the application. This will ensure the application is completed promptly and will prevent any delays in credentialing.

Please do not send these documents with the Participation Request Form, they will be discarded.

	Claims Information All claims information must be entered into the online application under **Malpractice Claims**.
	ECFMG Certificate Required if the practitioner is a foreign graduate.
	Disclosure Questions An explanation must be provided for any questions in which the practitioner answered 'yes'.
	Education/Training: APPs must provide the highest level of education in the medical field. Physicians must provide Medical School, Residency, and Fellowship (when appicable)..
	Board Certification or Board Eligibility Proof of board certification/board eligibility or an IHP Lack of Board Certification approved waiver (must request waiver from IHP Credentialing).
	State License Must have an Oklahoma License that is unlimited and within the applicant's scope of practice.
	Other State License Must provide information on any active and inactive state license
	Photo The photo must be current and in a .jpg or. tif file. All other formats will be rejected.
	DEA/CDS Practitioner must maintain a DEA/CDD. If the practitioner does not maintain a DEA/CDS they must provide the DEA/CDS Prescribing Agreement.
	Current Malpractice Please provide all current insurance certificates. Coverage for IHP must be at least $1Mil/$3Mil.
	Previous Malpractice Certificates Certificates for the last five (5) years or from the highest level of education. If the Practitioner has/had Tort Coverage, we require you upload the letter for certification.
	Peers Two (2) peer references. One (1) peer is required, second is a back-up. Must meet guidelines. Provide accurate e-mails that are unique to the reference, so confidentiality is maintained.
	Sponsoring Physician (APPs only) Must be in-network or go through credentialing simultaneously.
	Hospital Privileges: Specialists who perform hospital procedures must hold membership and clinical privileges at an IHP in-network facility. Any provider without admitting privileges must provide the Hospital Coverage Letter.
	Work History A complete list of work history as a medical professional including any gaps greater than 30 days. If you graduated less than 5 years ago, you would need to provide any experience as a healthcare professional (such as a moonlighting physician, RN, lab tech, etc.)
	Curriculum Vitae (CV) Please provide an up-to-date CV.
	Signed Document The Practitioner must sign any documents attached to the application.

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Peer Reference Requirements

Please do not send these documents with the Participation Request Form, they will be discarded.

Please list two (2) references that meet the following guidelines:

- Current professional reference who is familiar with your work and the same discipline (physicians for physicians, podiatrists for podiatrists, etc.)
- The reference must be familiar with your work in the past six (6) months to twenty-four (24) months.
- Reference cannot be someone of relation (previous, current, or future) to the applicant.
- If you are applying directly from a training program (residency, fellowship, preceptorship, etc.), and have not practiced at your current location for at least six (6) months, please list your program director and/or preceptor.

For Advanced Practice Professionals:

- You must meet the above criteria.
- **And** list your current supervising physician, if you have worked with them for at least 6 months. Otherwise, please list your previous supervising physician.

Other criteria can be deemed acceptable by the Network Strategy and Credentials Committe upon further review.

Note: Although only one (1) peer is required for committee, please list at least a 2nd peer as a back-up.