South Georgia Physicians Association, L.L.C.

Provider Credentialing Information Checklist

Please submit the following to the SGPA at P.O. Box 71887, Albany, GA, 31708-1887:

- SGPA Credentialing Addendum
- W-9 Form(s)
- $350.00 application fee made payable to SGPA must accompany your addendum when you submit it.

The SGPA utilizes the CAQH online application system:

- If you already have a CAQH application, please visit the CAQH site to ensure that your attestation is current so your application can be downloaded.

  https://upd.caqh.org/oas/

- If you do not already have a CAQH application, the SGPA will create a request for you to complete it when your Credentialing Addendum is received.

  When you receive your letter from CAQH, please visit the CAQH site with your Provider ID to complete your application.

  https://upd.caqh.org/oas/

The SGPA will then download your application directly from CAQH to start the credentialing process.

South Georgia Physicians 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)	
Social Security Number	
Do you have a CAQH Application?	
If yes, what is your CAQH Provider ID?	
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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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		
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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 South Georgia Physicians 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 South Georgia Physicians 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 South Georgia Physicians Association, L.L.C.

I acknowledge and understand that South Georgia Physicians Association, L.L.C. ("SGPA") has a legitimate right to obtain and verify any information regarding my professional competency.

Therefore, I the undersigned Provider do hereby authorize SGPA 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 SGPA. 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 SGPA 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 SGPA. I also agree to indemnify and hold harmless SGPA, 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