HSC/LA Credentials
PO Box 92200
Albuquerque, NM 87199-2200
1-866-908-0070 x2006 (Toll-free)
credentialing@nmhsc.com

Credentialing Itemized Request Form

Customer Name: _____

Requested By: _____ Request Date: _____

_____ I agree to pay the itemized fee per the current contract, plus additional verification fees incurred. *Verification fees will be passed though at cost.*

Please place a check mark next to the verification service(s) you are requesting:

NPDB/HIPDB Query	_____	License Verification	_____
Board Certification Verification	_____	AMA Query *(MDs and DOs)*	_____
ECFMG	_____	AMA Query (PAs)	_____
OIG/EPLS	_____	FSMB *(MDs and DOs)*	_____

Other Verification (please specify) _____

In the section below, please provide as much information on the practitioner this request relates to. For NPDB/HIPDB queries, this will ensure a more accurate and detailed report on the practitioner:

Practitioner's Name: _____
Last *First* *MI* *Title, e.g. M.D.*

Gender: _____ Social Security Number: _____

Date of Birth: _____ DEA Number: _____

Office Address: _____
Street Address

_____
City *State* *Zip Code*

License Number: _____ Licensing State: _____

License Number: _____ Licensing State: _____

License Number: _____ Licensing State: _____

Board Specialty: _____

Medical School: _____ Graduation Date _____

Please e-mail the completed form to credentialing@nmhsc.com including a signed release from the practitioner giving us permission to perform these verifications.

Itemized verifications are typically completed within 1 business day of receipt of the completed form and signed release.

HOSPITAL SERVICES CORPORATION
CREDENTIALS VERIFICATION SERVICE
STANDARD AUTHORIZATION, ATTESTATION AND RELEASE

Authority to Release: I consent to complete disclosure by the recipient of this release to Hospital Services Corporation's Credentials Verification Service ("HSC") of all relevant information pertaining to my professional qualifications, moral character, physical and mental health (hereinafter "qualifications") on behalf of those organizations and their authorized representatives (hereafter "Health Care Entity") to which I have applied as a health care provider and which have designated HSC as their agent. I authorize the recipient to make available and/or disclose to HSC all such information in its files from any university, professional school, licensing authority, accreditation board, hospital, physician, dentist, professional society, insurance carrier, law enforcement agency, military service, or any other person or entity deemed necessary or appropriate in the investigation and processing of my application.

I request and authorize the recipient to release the requested information and I expressly waive any claim of privilege or privacy with respect to the released information bearing on my admission to, retention or termination of medical staff appointment or clinical privileges. I release and discharge HSC, the Health Care Entity and the medical, dental, podiatry and ancillary staffs or panels, credentials committees, administrators, review and approval boards or committees, governing boards, whether or not designated by these titles, and their agents, servants or employees authorized by representatives and all other persons or entities supplying information to them from liability or claims of any kind or character in any way arising out of inquiries concerning me or disclosures made in good faith in connection with my application for appointment to the Health Care Entity's Medical Staff or Provider Panel.

This authorization is limited to the acquisition and disclosure of information required by state or federal law, and information which is acquired or disclosed pursuant to activities protected by the state's Review Organizational Immunity Act and the Health Care Quality Improvement Act of 1986.

Attestation: I certify that the information I have provided and the statements I have made on this application are correct, true, and complete to the best of my knowledge. I will abide by the applicable bylaws, rules and regulations, and policies and procedures of the designated health care entity. I acknowledge that I have received and reviewed a copy of the bylaws, if applicable, of the designated health care entity. I further agree that, in the event there should arise an adverse ruling with respect to my status and/or clinical privileges, I will exhaust the administrative remedies afforded by the entity's bylaws before resorting to litigation.

Signature stamps and date stamps are not acceptable.

_____
Applicant Signature

_____ _____
Printed Name Date

Please fax, upload or e-mail this completed form to:
Hospital Services Corporation
Credentials Verification Services
Toll Free: (866) 908-0070 x2006
Email: Credentialing@nmhsc.com

For additional information about disclosures and definitions used in this document, please refer to our website at https://ecreds.nmhsc.com in our Practitioner Documents section.