Credentialing by Proxy Intake



# Instructions

Form Approved OMB XXXX-XXXX

Expires XX/XX/XXXX

*The Federal Health Program for American Indians/Alaska Natives*

The overall mission of the Indian Health Service is to raise the physical, mental, and social and spiritual health of American Indians and Alaska Natives (AI/AN) to the highest level.

To ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indians & Alaska Native people.

Enter all pertinent information, as applicable. Fill out all required sections and ﬁelds that are marked in ; these are mandatory and must be completed to submit the application. At any point, the electronic intake form may be saved by clicking and completed at a later time. The blue toolbar at the top right provides additional help.

included on the previous home screen are . These must be viewed and/or ﬁlled out and uploaded into the section on this application. Please note that any documents that require electronic signature are found at the end of the application.

at the top right allows the applicant to change or reset the password and authorize account

access to a delegate.

provides support if technical diﬃculties are encountered.

after submitting the application, where the completed intake form and supporting documents may be viewed, downloaded, or printed.

Completed documents and forms must be uploaded in the section of this

application. Please contact the Medical Staﬀ Credentialing Coordinator for other delivery methods if technical diﬃculties are encountered.



Misrepresentations, inaccuracies, or falsiﬁcation of any information may be grounds for denial or termination of medical staﬀ appointment and/or associated clinical privileges, and may be subject to the reporting requirements of the National Practitioner Data Bank (NPDB), and state and federal licensing boards.

Intake forms with incomplete information or missing documents will be returned to the applicant and may delay the credentialing by proxy process.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is [####-####]. This information collection is to be used in verifying an applicant’s credentials to meet agency policy, Centers for Medicare Conditions of Participation requirements, and accrediting body standards. The time required to complete this information collection is estimated to average less than 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is required to determine an applicant’s credentials to provide healthcare (IHS IHM 3-1.4 C. (1-2), CMS CoP §482.12(a)(6) and §482.22(c)(4) and [the nature and extent of conﬁdentiality to be provided, if any (the Privacy Act, 5 U.S.C. § 552a, 25 U.S.C. 1675; the Privacy Rule promulgated under the

Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Part 160 and Subparts A and E of Part 164; the Indian Health Care Improvement Act, 25 U.S.C. § 1675; and the Confidentiality of Substance Use Disorder Patient Records regulations, 42 C.F.R. Part 2)]]. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Indian Health Service, 5600 Fishers Lane, mailstop: 09E07, Rockville, MD 20857, Attention: Information Collections Clearance Oﬃcer.



to save the information entered.

to modify this section and

Personal Information



List all institutions and colleges where education and training was received.

Undergraduate

Medical Education



Enter the information for A LL i n a ct i v e a n d active state m ed i c al licenses.

State License

Issue Date



List all board certiﬁcations currently held, if applicable.

Dental

Initial Certiﬁcation



Files 0 of 1 Required

Upload the following required document. Forms that require signature are either housed on the login screen, at the end

Signed IHS Conditions of Application & Release Form

Click on to browse for the ﬁle

If unable to perform a document upload, please contact MD-App Support at 1-800-736-7276 or the Medical Staﬀ Oﬃce. File Type

File Description Expiration Date

# Privileges

Privileges are specific to the facility

Review and request any privileges by clicking on the checkbox. If applicable, please review the core privileges and uncheck

Privileges are specific to the facility

Submit Application - Instructions