



CREENTIALING APPLICATION REQUEST (CAR FORM)

Select the entity applying to practice at:

| | | |
|-------|------------------------------|--|
| UNMH | Department: | |
| UNMMG | Clinic/Program: | |
| SRMC | Clinical Service Department: | |

Practitioner Information:

Last: _____ First: _____ Middle: _____
 Degree/License: _____ DOB: _____
 Email: _____ Phone: _____
 Specialt(ies): _____

Credentialing Entry Point:

Anticipated Start Date: _____
 (If employed/contracted, indicate start date. *Please allow at least 60 days or longer if not yet licensed)

- EMPLOYED:
 EMPLOYED – UNM EMPLOYED – SRMC EMPLOYED – UNMH EMPLOYED – UNMMG

- NOT EMPLOYED:
 CONTRACT/PSA NAME: _____
 COMMUNITY PROVIDER (SRMC only)

Privilege Forms: (Note: required for Medical Staff and AHPs. If OHP without Privileges check here)

| | | | |
|-------|--|--|--|
| UNMH | | | |
| SRMC | | | |
| UNMMG | | | |

Credentialing Liaison

(Person to be copied on all correspondence):

Name: _____ Position _____
 Email: _____ Phone: _____

Curriculum Vitae MUST BE ATTACHED

Licensing Applicant is licensed in NM Application has been submitted to State Licensing Board

Enrollment:

(1) Will applicant need to complete billing packet? Y N

(2) If yes, name of person assisting with billing packet: _____

(3) If billing packet previously completed, will there be a change in practice location? Y N

(4) PCP or Specialist?

| Tax ID | Facility/Clinic Name | List in Health Plan Directories? |
|--------|----------------------|----------------------------------|
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| | | |
| | | |
| | | |

Additional Comments:

Authorized Requestor Name: _____ Date: _____

Return to: CREDENTIALING Verification Office (CVO),
University of New Mexico Health System
Tel: 505 272-2526 Fax: 505-272-6055
Email: hsc-unmhs_cvo@salud.unm.edu