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Introduction: Registration (Figure 1001.1)
To begin your ProviderSource application, you must go through www.onehealthport.com and follow the steps below.

Select “CREDENTIALING”
Select Getting Started/Log In and then click the **Log In** button under Step 3.

**Getting Started/Login**

**Step 1**
Read the Getting Started step-by-step guide to set up each credentialed provider or practitioner in your organization before logging in to the ProviderSource application.

**Step 2**
Check to see if you have an existing OneHealthPort Subscriber ID before registering for your credentialing record: Check for Subscriber ID.

If you or the provider(s) in your organization already have a OneHealthPort Subscriber ID, please do not create additional ones.

**Step 3**
You are ready to log in to the ProviderSource Application using your OneHealthPort Subscriber ID and password.

Enter your One Health Port Subscriber ID and Password
Once you enter your ID, this will then take you to ProviderSource™.
Introduction ProviderSource™ Overview (Figure 1001.4)

Quick Tips:
- Throughout the electronic application, required fields are specified with a red asterisk (*).
- You can return where you left off with the “Save Changes” button. The “Save Changes” button will only save information on the current page if all fields are complete and without formatting errors.
- If you need additional support, you can select the “Help” button on the top right-hand side of the screen for a list of frequently asked questions.

Welcome Joel Capps,

The homepage displays three phases of the application (Figure 1001.4):

1. Credentialing Application
2. View Summary
3. Re-Attest Application
General Information: Name and Home Address (Figure 1001.5)

<table>
<thead>
<tr>
<th><strong>Name and Home Address</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><em>First Name</em></td>
<td>Middle Name</td>
</tr>
<tr>
<td>Robert</td>
<td></td>
</tr>
<tr>
<td><em>Degree Titles</em></td>
<td></td>
</tr>
<tr>
<td>MD</td>
<td></td>
</tr>
<tr>
<td><em>State(s) Of Practice (Please select from the list)</em></td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td></td>
</tr>
<tr>
<td><em>Primary Practitioner Type</em></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Drug Counselor</td>
<td></td>
</tr>
<tr>
<td><strong>Other Names</strong></td>
<td></td>
</tr>
<tr>
<td><em>Have you ever used another name?</em></td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Primary Residence</strong></td>
<td></td>
</tr>
<tr>
<td><em>Address Line 1</em></td>
<td>Address Line 2</td>
</tr>
<tr>
<td>350 S Grand Ave</td>
<td></td>
</tr>
<tr>
<td><em>City</em></td>
<td>County</td>
</tr>
<tr>
<td>Los Angeles</td>
<td></td>
</tr>
<tr>
<td><em>State</em></td>
<td><em>Zip Code</em></td>
</tr>
<tr>
<td>California</td>
<td>90071</td>
</tr>
<tr>
<td><em>Telephone Number</em></td>
<td>Fax Number</td>
</tr>
<tr>
<td>2136073563</td>
<td></td>
</tr>
<tr>
<td>Unlisted Number</td>
<td></td>
</tr>
<tr>
<td>Mobile Number</td>
<td>Pager Number</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td><em>Email Address</em></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:robert.alexander@medversant.com">robert.alexander@medversant.com</a></td>
<td></td>
</tr>
</tbody>
</table>

Figure 1001.5
Input the following fields of information:

- Name
- Degree Titles
  - Quick Tip: Enter degrees earned in the order you would like them to appear after your last name.
- State of Practice
- Primary Practitioner Type
- Have you ever used another name?
- Address (Home Address)
- Telephone Number
- Fax Number
- Mobile Number
- Pager Number
- Email Address

Select the “Next” button to continue to the “Personal Information” section.
Input the following fields of information:

- Gender
- Date of Birth
- Citizenship
- Country of Birth
- SSN
- Languages
  - Quick Tip: Type the first few letters of the language. Click on the correct language, and then click the “Add to List” button. Repeat to add more languages.
- Ethnicity
- Marital Status
- Emergency Contact Phone Number

Select the “Next” button to continue to the “Professional IDs” section.
Input the following fields of information:

- **NPI - National Provider Identification Number**
  - Quick Tip: This is a provider's Type 1 National Provider Identifier. The 10-digit identification number is issued to health care providers by the Centers for Medicare and Medicaid Services (CMS).

- **DEA - Drug Enforcement Administration Registration**
  - Quick Tip: Drug Enforcement Administration Registration number, is applicable to MD, DO, DDS, DMD, DVM, and DPM only. The DEA Registration Number must be formatted with two letters, six digits and one check digit (i.e., AD0865937).

- **CDS - Controlled Dangerous Substance Registration**
  - Registration Number related to practicing specialty
  - Quick Tip: The registration number may be assigned by a state to regulate a healthcare practitioner in lieu of licensing.

Select the "Next" button to continue to the “Professional IDs: Licensure” section.
**Professional IDs: Licensure (Figure 1001.8)**

Licensure - enter all state licenses you currently hold or have held.

Input the following fields of information:

- License State
- License Type
- License Number
- License Status
- Issue/Expiration Date
- Are you currently practicing in this state?
- Is this your primary license?
- Does this license require supervision?

**Quick Tips:**
- Select the “Save This Record” button in order to save the license record.
- To add additional license records select the “Add New” button.

Select the “Next” button to continue to the “Professional IDs: Other IDs and Certifications” section.
Input the following fields of information:
- Have you ever voluntarily opted out of Medicare?
- Are you a participating Medicare provider?
- Are you a participating Medicaid provider?
- TRICARE Provider Number
- USMLE Number (without hyphens)
- Workers’ Compensation Number
- Do you hold any other non-specialty related certifications? (i.e., ACLS, BLS, ATLS, CPR, PALS, NALS, Fluoroscopy, Radiography, etc.)

Select the “Next” button to continue to the “Health Plans: Authorization and Release” section.
The selected participating organization will have access to your credentialing profile; select the “Next” button to continue to the “Specialties” section.
Input the following fields of information:

- **Specialty**
  - Quick Tip: If you cannot locate your specialty in this list, select the specialty that is most appropriate for your practice.

- **Do you wish to be listed in the HMO Directory under this specialty?**
- **Do you wish to be listed in the PPO Directory under this specialty?**
- **Do you wish to be listed in the POS Directory under this specialty?**
- **Are/were you board certified in this specialty?**
- **Are you eligible to be certified in this specialty?**

- **Certifying Board**
  - Certifying Board Address
  - Fax Number
  - Initial/Expiration/Recertification Date

- **Have you ever failed to pass a specialty board examination?**
- **Other Specialty Interests**
  - Other areas of professional practice interest, activities, procedures, diagnoses, or populations:

Quick Tips:

- Select the “Save This Record” button in order to save the specialty record.
- To add specialty records select the “Add New” button.

Select the “Next” button to continue to the “Education” section.
Education and Training: Education (Figure 1001.12)

Input the following fields of information:

☐ Did you attend an Undergraduate school?
   ☐ Undergraduate School Location
   ☐ Undergraduate School Name
   ○ Quick Tip: Inputting the first letters of the school name will prompt pre-population of name and address information.
   ☐ Address
   ☐ Telephone/Fax Number
   ☐ Undergraduate Major
   ☐ Degree Awarded
   ○ Quick Tip: Inputting the first letters of the Degree Awarded will prompt pre-population.
   ☐ Did you complete your undergraduate education at this school?
   ☐ Start/End Date

☐ Have you ever attended a Graduate/Professional School?
   ☐ Education Type
   ☐ Graduate/Professional School Location
   ☐ Professional School Name
   ○ Quick Tip: Inputting the first letters of the school name will prompt pre-population of name and address information.
   ☐ Address
   ☐ Telephone/Fax Number
Graduate Type
Specialization
Degree Awarded
  Quick Tip: Inputting the first letters of the Degree Awarded will prompt pre-population.
Faculty Director Name
Director Degree
Did you complete your professional education at this school?
Start/End Date
Are you ECFMG certified (non-U.S./Canadian graduates only)?
  Issue Date
  Valid Through Date
Permanent

Quick Tips:
  Select the “Save This Record” button in order to save the record.
  To add more education records select the “Add New” button.

Select the “Next” button to continue to the “Training” section.
Input the following fields of information:
- Did/Do you attend a training program?
- Training Program Location
- Training Program Name
  - Quick Tip: Inputting the first letters of the training program name will prompt pre-population of name and address information.
- Address
- Telephone/Fax Number
- Email address
- Type of Training
- Specialty
- Program Director Name
- Program Director Degree
- Program Director Email Address
- Start/End Date
- Did you complete your training at this institution?
- University Affiliated Program Location
- Address
- Telephone/Fax Number

Select the “Next” button to continue to the “Education and Training: Teaching Appointments” section.
Input the following fields of information:

- Are/Were you an instructor or faculty for a teaching program?
- Teaching Program Location
- Teaching Program Name
  - Quick Tip: Inputting the first letters of the teaching program name will prompt pre-population of name and address information.
- Address
- Telephone/Fax Number
- Email address
- Program Director Name
- Program Director Degree
- Academic Rank or Title
- Start/End Date

Select the “Next” button to continue to the “Healthcare Facility Affiliations: Affiliation Information” section.
Quick Tips:
- List all institutions where you have current affiliations, applications in process, or have had previous affiliations. This includes hospitals, surgery centers, institutions, corporations, military assignments, and government agencies. Do NOT include your training facilities.

Input the following fields of information:
- Do/Did you have hospital privileges?
- Facility Location
- Facility Name
  - Quick Tip: Inputting the first letters of the school name will prompt pre-population of facility name and address information.
- Address (Medical Staff Office)
- Telephone/Fax Number
- Department/Department Name
- Department/Division Director Name
- Do/Did you have full, unrestricted privileges?
Are/Were your privileges temporary?
- Privileges Status
- Appointment/Expiration Date
- Is this your primary facility?
- Of your total annual admissions, what percentage is to this hospital?

Select the “Next” button to continue to the “Professional Liability: Coverage and Claims History” section.
Input the following fields of information:

- Do you have a Sovereign Immunity document?
- Do/Did you have professional liability coverage within the past ten (10) years?
- Are you self-insured?
- Carrier Location
- Carrier Name
- Address
- Telephone/Fax Number
- Type of Policy
- Type of Coverage
- Policy Holder Name
- Policy Number
- Does this policy include tail coverage?
Has this carrier excluded any specific area of practice or procedures from your coverage?

- Amount of Coverage per Occurrence
- Amount of Aggregate Coverage
- Original Effective (Retroactive) Date
- Effective/Expiration Date
  - Quick Tip: The Effective Date is the date that your current policy became effective. It is not the date that the policy was originally issued.

- Was this policy involved in a malpractice claim?

Quick Tips:
- Enter all professional liability coverage and claims history information. For claims made against you at any time provide information for each case under Professional Liability Claims History.
- Ensure that your current professional liability coverage is not going to expire within the next 60 days.

Select the “Next” button to continue to the “Work History: Military” section.

**Work History: Military History (Figure 1001.17)**

Input the following fields of information:
- Have you served in the U.S. Military?

Select the “Next” button to continue to the “Work History: Employment” section.
Input the following fields of information:

☑ Do you have a work history since completion of your education/training?
   ☐ Employment Location
   ☐ Practice/Employer Name
   ☐ Contact Name
   ☐ Address
   ☐ Telephone/Fax Number
   ☐ Email Address
   ☐ Contact Method
   ☐ Position Held
   ☐ Start/End Date
   ☐ Reason for Leaving
   ☐ Do/Did you have a collaboration agreement with a licensed physician?

Quick Tips:
  o Minimum of five years of healthcare relevant work history is required. If you have practiced fewer than five years, please provide full relevant work history from the time of initial licensure.
  o Select the “Save This Record” button in order to save the employment record.
  o To add additional employment records select the “Add New” button.

Select the “Next” button to continue to the “Work History: Employment Gap” section.
Do you have any time periods or gaps in training or work history that have occurred since graduation from professional school?

- Start/End Date
- Gap Reason
- Detailed Explanation

Quick Tip: Create an Employment Gap record for gaps greater than 6 months.

Select the “Next” button to continue to the “Work History: Professional References” section.
Work History: Professional References (Figure 1001.20)

Input the following fields of information:
- Reference Name
- Degree
  - Quick Tip: Inputting the first letters of the Degree will prompt pre-population.
- Primary Specialty
- Contact Method
- Address
- Telephone/Fax Number
- Mobile Number
- Email Address
- Association Start/End Date
- Relationship

Select the “Next” button to continue to the “Work History: Professional Organizations” section.
Input the following fields of information:

- Do/Did you belong to any Professional Organizations or Societies?
  - Organization Name
  - Effective/Terminations Date

Select the “Next” button to continue to the “Practice Information: Credentialing Contact” section.
Input the following fields of information:

- Preferred Method of Contact
  - Quick Tip: This will be used for application follow-up.
- Credentialing Contact Name
  - Quick Tip: Designate a single contact for your credentialing information.
- Address
- Telephone/Fax Number
- Mobile Number
- Email Address

Select the “Next” button to continue to the “Practice Information: Practice Location” section.
Quick Tips:

- Once you have completed all required information in the “General Information” tab, other tabs (i.e., Contacts, etc.) will be activated. You must complete all required information on all 9 tabs to save a complete “Practice Location” record.
- Complete a record for each practice location.
- Select the “Make Primary” option to indicate the required primary location.

Input the following fields of information:

- Has your Office/Credentialing Manager added all your practice locations?
  - Quick Tip: By selecting yes, you are indicating that you will not enter additional practice locations other than the ones entered by the Office/Credentialing Manager. Confirm that your office manager has entered all practice locations. By selecting no, you are indicating that you will enter additional practice locations other than the ones entered by the Office/Credentialing Manager.
Primary Group/Practice Name/Affiliation
  - Quick Tip: The Insurer will use this information as it appears in their provider directories.
Primary Location
Address
Telephone/Fax Number
Practice Email Address
Date Joined/Future Start Date
Practice Type
Practitioner Profile
  - Quick Tip: Type the first few letters of the Provider Type and an autofill will prompt. Click on the correct type, and then click the “Add to List” button. Repeat to add more Provider Types.
Group/Corporate Name as it appears on W-9, if different from Physician Group/Practice Name
Tax ID
Type of Tax ID
Name Affiliated with Tax ID
Primary Tax ID
Do you have a Group NPI Number for this location?
Group NPI Number
Group NPI Number Effective Date
Group Medicare Number
Date you saw your first Medicare patient at this location

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:

- I am the contact person for office related matters
- Name
  - Quick Tip: Office Manager/Business Office Contact Name
- Address
- Telephone/Fax Number
- Email address
- Mobile Number

Billing Contact

- Same as Office Manager/Business Office Contact
- Name
- Address
- Telephone/Fax Number
- Email address
- Mobile Number
- Do you have electronic billing capability?
- Check Payable To
  - Quick Tip: Must be consistent with your W-9

Remittance Contact

- Same as Billing Contact
- Same as Office Manager/Business Office Contact
- Remittance Contact Name
Quick Tip:
- Select your start and end time for each day. If your office closes part of the day (i.e., closed for lunch), select “Split Day and select the hours your practice is closed in the row marked “Closed.”

Input the following fields of information:
- Hours of Operation
- Patient Appointment Telephone Number (If different than listed practice telephone number)
- Does this location have 24 hours/7 days per week telephone coverage?

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:

- Select your open practice status
  - Quick Tip: Type the first few letters of the Patient Acceptance Type. Click on the correct type and then click the “Add to List” button. Repeat to add more Patient Acceptance Types
- If patient acceptance varies by health plan, please explain:
- Are there any practice limitations at this location?

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:
- Select all languages that your staff speaks
- Select all languages that your staff writes
  - Quick Tip: Type the first few letters of the language. Click on the correct language, and then click the “Add to List” button. Repeat to add more languages types.

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:

- Does this location meet ADA accessibility requirements?
  - If Yes, please select from the following:
    - Quick Tip: Type the first few letters of the Accessibility Handicap Type.
      Click on the correct type, and then click the “Add to List” button.
      Repeat to add more Accessibility Handicap Types.

- Does this location offer other services for the disabled?
  - If Yes, please select from the following:
    - Quick Tip: Type the first few letters of the Accessibility Disabled Type.
      Click on the correct type, and then click the “Add to List” button.
      Repeat to add more Accessibility Disabled Types

- Is this location accessible by public transportation?
  - If Yes, please select from the following:
    - Quick Tip: Type the first few letters of the Accessibility Transport Type.
      Click on the correct type, and then click the “Add to List” button.
      Repeat to add more Accessibility Transport Types.

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:

- Do you provide laboratory services at this location?
  - If Yes, please select from the following:
    - Quick Tip: Type the first few letters of the accrediting/certifying programs. Click on the correct type, and then click the “Add to List” button. Repeat to add more accrediting/certifying programs.

- Does this location have a CLIA Waiver?
  - CLIA Waiver Number
  - Expiration Date

- Does this location have a CLIA Certificate?
  - CLIA Certificate Number
  - Expiration Date

- Do you provide radiology services at this location?
  - Please list all X-ray certifications
    - Quick Tip: Type the first few letters of the X-ray certification. Click on the correct type, and then click the “Add to List” button. Repeat to add more X-ray certifications.

- FDA/Radiology (Mammography) Certification Number for this location:
Quick Tip: The FDA/Radiology (Mammography) Certification Number is issued by the Food and Drug Administration.

☐ Select all services offered at this location.
  o Type the first few letters of the services offered. Click on the correct type, and then click the “Add to List” button. Repeat to add more services.

☐ Is anesthesia administered at this location?
  o Quick Tip: Type the first few letters of the anesthesia offered. Click on the correct type, and then click the “Add to List” button. Repeat to add more anesthesia types.

☐ Provider Name
☐ Degree
  o Quick Tip: Type the first few letters of the Degree, this will prompt pre-population.

☐ List any additional procedures provided at this location (including surgical procedures).

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:

- Do mid-level practitioners (nurse practitioners, nurse midwives, physician assistants, registered nurse first assistant, etc.) care for patients at this location?
- Name
- Mid-level Practitioner Degree
  - Quick Tip: Type the first few letters of the Degree, this will prompt pre-population.
- Primary License State
- Primary License Number

Select the “Save/Update” button, and then select the “Go to Next Practice Tab” hyperlink.
Input the following fields of information:

- Do you have any partners/associates at this location?
  - Name
  - Practitioner Degree
  - NPI Number
  - Specialty
  - Primary License State

- Does this partner/associate cover you?

Select the "Save/Update" button. Continue to the "Practice Information: Covering Colleagues" section by selecting the "Next" button.
Practice Information: Covering Colleagues (Figure 1001.32)

Input the following fields of information:
- Do you have any covering colleagues who are not partners or associates at any of your practice locations?

Select the “Next” button to continue to the “Practice Information: Unique Circumstances” section.

Practice Information: Unique Circumstances (Figure 1001.33)

Quick Tip:
- Explain any unique circumstances concerning your practice locations or the method by which you render healthcare services (i.e., you only render services in patients’ homes).

Select the “Save/Update” button to continue to the “Disclosure” section.
Disclosure: (Figure 1001.34)

- Answer the practitioner attestation questions.

Select the “Next” button to continue to the “Audit: Application Checklist" section.

Audit: Application Checklist (Figure 1001.35)

If you have successfully fulfilled the application requirements your screen will read, “Required items have been filled in, please proceed..."

Select the “Next” button to continue to the “Audit: Application Documents” section.
Audit: Application Documents (Figure 1001.36)
In this section, you will upload all supporting documentation.

Download all required documents (if applicable).
- Select the “Manage Documents” hyperlink or the “green arrow” icon to upload supporting documents this will prompt the window in Figure 1001.40.
- Select the “Choose File” button, navigate to the files location and select the “open” button on the lower right-hand side. Next, select the “Upload” button.

Quick Tip:
- Review that your supporting documents are current and match the information in your application. To change your application information, click the “Back” button to return to the “Application Checklist” section.

Manage Documents (Figure 1001.37)
You will then need to input the following information:

- Type
- Title
- Description

Quick Tip:
- By selecting the “Type” field you will be presented with various document categories (1001.38). Select your document category and type, and then select the “Add” button to assign the document type to your file. This action will autofill “Type” and “Title,” lastly, add a description to the document.

![Figure 1001.38](image_url)

Once you have uploaded all supporting documents select the “Next” button to continue to the “Attestation and Signature” section.
Attestation and Signature: Attestation (Figure 1001.39)

To complete your application, please read and agree to the following attestation and release agreement.

You must click the "I Attest" button to certify that you have carefully reviewed all information, including supporting documentation, contained within your ProviderSource™ application and that all information provided is true, correct, current and complete, to the best of your knowledge.

By clicking "I Attest", you also acknowledge that you must create an electronic signature in order to complete your application.
Attestation and Signature: Signature (Figure 1001.40)

- Input your signature by drawing your signature using the mouse or by using the keyboard.
  - Quick Tip: Please use your mouse to draw in a legible signature below or type in your full name as it appears on your application. By typing your name you will be electronically attesting the application.
- Lastly, select the “I Attest” button.

Figure 1001.40

If your submission was successful your screen will read: “Thank you for submitting your application. It will be reviewed for completeness and you will be contacted if additional information is needed.”
To download the completed credentialing application, please select the PDF hyperlink.

Figure 1001.41
Medversant Provider Support Center Information:
ProviderSource™ Support Center: Phone: 855-252-4314
Email: support@medversant.com
Help Desk Hours: Monday – Friday: 6 AM – 5 PM (PST)