

**Sandhills Physicians, Inc./Doctors Direct Healthcare
Submission of Uniform Application**

YOUR APPLICATION MUST BE LEGIBLE AND IN BLUE OR BLACK INK ONLY

To ensure timely credentialing of your providers, please provide the following:

Complete the attached “Data Form” and include with your submitted application.

All applications submitted to Sandhills Physicians, Inc. and Doctors Direct Healthcare (SPI and DDHC) **must** include everything that is listed on page 2 of the Uniform Application to participate as a Health Care Practitioner.

In addition to the above instructions, you must also provide a current copy of the provider’s Curriculum Vitae (CV), which includes the months as well as the years on all education and work history. (New NCQA standard effective July 2004) SPI and DDHC require any gaps greater than 30 days in the education and work history be explained in writing and attached to the application.

The application must be **completely** filled out. There **should not** be any blank spaces. If it does not apply to the provider, **you must** write “not applicable” or “N/A” in that box. Months as well as years are mandatory within the application as well. “See CV” or “See Curriculum Vitae” **are not** acceptable within the application. All areas of the application should be completed.

The Attestation Statement that the provider has signed **should not** be greater than 30 days old.

There should be four (4) references provided with the complete address, phone number and fax number.

Please note that all incomplete applications will be returned.

You may direct questions of concern to Gray-Ling Clark, Credentialing Specialist, at 910-920-2507 Ext 223.

Please contact our office for the appropriate application fee(s) before submitting.

Return application and applicable fee(s) to:
Sandhills Physician, Inc
3035-N Boone Trail Centre
Fayetteville, North Carolina 28304
Attention: Gray-Ling, Credentialing

Personal Data Form

Please Print Clearly in Blue or Black Ink Only.

Personal Data:

Part I

Name: _____ Title: _____ Specialty: _____

Home Address: _____ City: _____ State: _____ Zip _____

Date of Birth: _____ Place of Birth: _____ Sex: Male Female

Primary Office Data:

Part II

Name of Practice: _____

Physical Address: _____ City: _____ State: _____ Zip _____

Billing Address: _____ City: _____ State: _____ Zip _____
(If different from physical address)

Office Phone: _____ Fax Phone: _____ email: _____

Administrative Contact: _____ Title: _____

Credentials:

Part III

Are you a Board Certified Physician? Yes No If no, when did you become
"board eligible"? Date: _____

List the hospital that you have admitting/courtesy privileges:

Name of Facility: _____ Status: _____

Name of Facility: _____ Status: _____

Name of Facility: _____ Status: _____

If you are a solo practitioner, do you have a contractual relationship with a SPI provider who
provides evening and weekend hospital coverage for you? Yes No

Are all the physicians within your practice board certified? Yes No

Certified _____ # Non-Certified _____

Claim/Carrier Information:

Part IV

(All numbers are required for enrollment)

Federal Tax ID#: _____ Medicare/Medicaid Number: _____

Individual NPI#: _____ *Facility's NPI Number: _____
(Required unless you are a sole proprietor)

***A sole proprietor have the option of using one NPI to represent him or her as an individual or choose to have two different NPIs – one for the individual and one for the solo practice. Staff of the sole proprietor must include the facility's NPI, as well as their individual NPI.**