



PROVIDER CREDENTIALING ATTESTATION

Complete the fields below and route for electronic signature.

Provider Name	NPI	TIN

Effective Date	
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I hereby attest to the following:

1. Licensure & Certification	I maintain a current, valid, and unrestricted license to practice in all applicable jurisdictions. Any DEA or controlled substance registrations are current and unrestricted.
2. Professional Standing	I have not been subject to disciplinary action, suspension, or revocation of privileges since my last credentialing, except as disclosed below.
3. Sanctions & Exclusions	I am not currently excluded, debarred, or otherwise sanctioned by federal healthcare programs, the Office of Inspector General, the System for Award Management, or any state or regulatory agency.
4. Malpractice History	I have disclosed all malpractice claims, settlements, or judgments since my last credentialing.
5. Work History	My professional work history is complete and accurate, with all gaps explained.
6. Ability to Perform	I am physically, mentally, and professionally capable of performing the essential functions of my role.
7. Accuracy of Information	All information submitted is true, complete, and accurate to the best of my knowledge.

Acknowledgment: I understand that any misrepresentation or omission may result in denial or termination from the network.

Additional Information

Use the space below to disclose any exceptions or provide supporting details referenced in this attestation.

Signature

Signature	Printed Name	Date
Title	Email	Phone (optional)