Call Coverage Application Form

This application is to be complete by the non-contracted provider and returned to Heraya Health for approval and prior to treating Heraya members.

This form should be typed or legibly printed. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please submit the following, along with the application:

- ❑ A copy of Professional Liability declaration page of Insurance Policy
- ❑ A copy of DEA Certificate, if applicable

Questions pertaining to the completion of this application or submission procedures should be directed to Provider Relations staff, 503-203-8333 or 800-449-9479.

PLEASE COMPLETE:

I am requesting authorization to provide Call Coverage for the following Heraya Provider:

Name: _____

Specialty circle one: DC ND LAc LMT

Dates of coverage: From:_____ To:_____

Submit request (and questions if any) to Heraya in any of the following methods:

- Email: ps@herayahealth.com
- Fax: 877-482-2856
- Mail: 6600 SW 105th Avenue, Suite 115, Beaverton, OR 97008

I. Call Coverage Provider Information

Last Name	First Name	Middle Name	Suffix	Degree(s)

Social Security Number	Gender	Birth Date	Birth Place

Tax ID Number	Name affiliated with Tax ID Number	NPI Number

Home Address	City	State	Zip

	Home Phone

II. Call Coverage Provider Information

Name of Practice Affiliation or Clinic Name Associated with Primary Office	Primary Office Phone Number	Primary Office Fax Number

Primary Office Address	Pager
	E-mail

Office Mailing Address (if different from Primary)	City	State	Zip

Are you able to accept new patients within two working days?	Y [ ] N[ ]

III. Professional/Medical Education (Attach additional sheets if necessary)

Institution Name	Degree Received	Graduation Date

Address	City	State	Zip

Did you successfully complete this program?	Yes [ ] No [ ] (If "No", please explain on a separate sheet.)

IV. Board Certification

Are you board or otherwise professionally certified?	Yes [ ] No [ ] If Yes, fill out below information. If no, skip to Section V.

Name of Issuing Board	Specify	Date Certified	Expiration Date (if any)

V. Healthcare Licensure, Registration and Certifications (Attach certificate if applicable)

Professional License Number	Issue Date	Expiration Date	Current State

Professional License Number	Issue Date	Expiration Date	Current State

VI. Drug Enforcement Administration (DEA) Registration Number

Does not apply:	Yes [ ] No [ ] If Yes, skip to Section VII.

Drug Enforcement Administration (DEA) Registration Number	Expiration Date

VII. Professional References

List two (2) professional references, preferably from your primary discipline, not including relatives. NOTE: References must be from individuals who, through recent observation, are directly familiar with your work.

Name	Specify Relationship	Phone Number	
Address	City	State	Zip
Name	Specify Relationship	Phone Number	
Address	City	State	Zip

VIII. Professional Liability

Current Insurance Carrier	Policy Number		
Mailing Address	City	State	Zip

Per Claim Amount $	Aggregate Amount $	Date Began	Expiration Date

Printed Name Date

Signature