Application for
Certified Provider Credentialing
Specialist Examination

Please read the directions in the Candidate Handbook carefully before completing this application.

MARKING INSTRUCTIONS: This form will be scanned by computer, so please make your marks heavy and dark, filling the circles completely. Please print uppercase letters and avoid contact with the edge of the box. See example provided.

```
A B C D E F 1 2 3 4 5 6
```

### Candidate Information

Print your LAST NAME then FIRST NAME then MIDDLE INITIAL

Please provide preferred mailing address:
- HOME
- FACILITY

<table>
<thead>
<tr>
<th>Company Name (if facility is the preferred mailing address)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number and Street</th>
<th>Apartment Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State/Province</th>
<th>ZIP/Postal Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Daytime Phone -</th>
<th>Evening Phone -</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E-mail Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

### Eligibility and Background Information

Darken only one choice for each question unless otherwise directed.

A. **HIGHEST ACADEMIC LEVEL:**
   - High School Graduate
   - Bachelor's Degree
   - Some College
   - Master's Degree
   - Associate Degree
   - Other

B. **YEARS OF EXPERIENCE IN CREDENTIALING/ MEDICAL SERVICES MANAGEMENT:**
   - 3 years
   - More than 10 years
   - 4 to 10 years

C. **PRESENT EMPLOYMENT:**
   - Hospital/Health System
   - Ambulatory Surgical Center
   - Managed Care Organization/Health Plan
   - Credentials Verification Organization
   - Group Practice

D. **NUMBER OF PROVIDERS**
   - Less than 100
   - 100 - 250
   - 251 - 500
   - Not applicable

E. **WHEN DO YOU WISH TO TAKE THE EXAM IN 2014?**
   - Spring
   - Summer
   - Fall

F. **HAVE YOU TAKEN THIS EXAMINATION BEFORE?**
   - No
   - Yes
   If yes, indicate month, year, and name.
   Date (month/year): ___________________________
   Name: _____________________________________

G. **ARE YOU CURRENTLY CERTIFIED AS A CERTIFIED PROFESSIONAL IN MEDICAL SERVICES MANAGEMENT (CPMSM) BY THE CERTIFICATION COMMISSION OF NAMSS?**
   - No
   - Yes
   If yes, indicate month and year of certification.
   Date (month/year): ___________________________
   Note: Certification will be verified.

H. **ARE YOU A CURRENT MEMBER OF NAMSS?**
   - No, I am not a member of NAMSS
   - Yes, I am a member of NAMSS
   Note: Membership will be verified. Membership in NAMSS is not a requirement for certification.

I. **ARE YOU CERTIFIED, REGISTERED, OR LICENSED BY ANY OTHER ORGANIZATION?**
   - No
   - Yes
   IF YES, WHICH CREDENTIALS DO YOU HOLD?
   (Darken all that apply)
   - CPHQ
   - RHIA
   - RN
   - CPS
   - RHIT
   - Other (specify) __________________________

(Complete Page 2)
Eligibility Requirements

This examination is designed to test knowledge on the broad scope of those professionals employed at the level to which the title “Credentialing Specialist” would appropriately apply. Candidates are expected to have current, direct, hands-on involvement in the major processes associated with this aspect of medical services credentialing including the areas covered in the Exam Content Outline in the Candidate Handbook.

Darken the circle next to the eligibility route that you meet at the time of application, (darken only one response).

Eligibility Requirements

❖ I have been employed in the medical services profession for the most recent twelve (12) consecutive months AND for a total of THREE (3) years within the immediate past FIVE (5) year period.
❖ I am a Certified Professional in Medical Services Management (CPMSM) in good standing, AND have been employed in the medical services profession for the most recent twelve (12) consecutive months.

Candidate's Attestation of Eligibility and Experience

To be completed by applicant. – Attach a separate sheet if additional space is required.

NAME: ____________________________________________________________________________________________

EMPLOYER: ___________________________________________ DATES OF EMPLOYMENT: _______________________

TITLE/PHONE NO: _____________________________________________

If applicable, provide name of NAMSS certificant who referred you to apply for exam:

CERTIFICANT REFERRAL NAME: _______________________________________ (Relationship to applicant) ___________

If less than three years with current employer, please list previous employer including job title to document complete experience in order to meet eligibility requirements:

EMPLOYER: ___________________________________________ DATES OF EMPLOYMENT: _______________________

CONTACT NAME: _________________________________________ PHONE NO: ________________________________

Duties performed (Check all that apply)

☒ Performs provider/practitioner credentialing and or privileging
☒ Performs primary source verification
☒ Compliance with NCQA/URAC/TJC/HFAP/AAAHC or CMS accreditation and regulatory standards that apply to provider/practitioner credentialing and privileging
☒ Support of medical services departmental operations

By my signature below, I attest that I have been employed during the timeframe documented and have performed the duties and functions indicated above.

PRINT NAME: ___________________________________ SIGNATURE: _________________________

TITLE: ___________________________________ DATE: ____________________________

CONTACT PHONE NO: __________________________________
Verification of Eligibility and Experience - To be completed by applicant’s immediate supervisor

By my signature below, I attest to and verify that the above-named applicant for this certification examination meets the CPCS eligibility criteria documented on this application.

Immediate Supervisor Signature: __________________________ Date: __________________________
Title: __________________________ Phone: __________________________
Organization: __________________________
Address: __________________________

Optional Information

Note: Information related to race, age, and gender is optional and is requested only to assist in complying with general guidelines pertaining to equal opportunity. Such data will be used only in statistical summaries and will in no way affect your test results.

Race:
❍ African American
❍ Asian
❍ Hispanic
❍ Native American
❍ White
❍ No Response

Age Range:
❍ Under 25
❍ 25 to 29
❍ 30 to 39
❍ 40 to 49
❍ 50 to 59
❍ 60+

Gender:
❍ Male
❍ Female

Candidate Signature

CANDIDATE SIGNATURE: ___________________________________________ DATE: ____________

Credit Card Payment

CREDIT CARD PAYMENT If you want to charge your application fee on your credit card, provide all of the following information.

Name (as it appears on your card): __________________________
Address (as it appears on your statement): __________________________

Charge my credit card for the total fee of: $ ____________
Expiration date (month/year): [____] [____] Card type: ❓ VISA ❓ MasterCard ❓ American Express

Card Number: [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____] [____]
Signature: ___________________________________________ Date: __________________________

Examination Fees
NAMSS Member: $375  Non-Member: $500

Submit this completed application with required documentation, the Authorization/Acknowledgement, and appropriate fee to:
CPCS Certification Examination, NAMSS Dept. 3115, Washington, DC 20042-3115
I authorize the Certification Commission of NAMSS (CCN) to make whatever inquiries and investigations that it deems necessary or appropriate to verify my credentials and professional standing in order for me to qualify to sit for the certification exam for which I am applying. Further, I understand that the CCN will treat the contents of this application as well as all documents relating to certification as confidential, except as necessary to administer the certification program. If I successfully pass the certification examination and attain the CPCS designation, I authorize the CCN to release my name, mailing address, e-mail address, and other contact information to the National Association Medical Staff Services (NAMSS) for the purpose of providing Association information.

I understand that after earning the credential, I am responsible for complying with all obligations for maintaining the credential, including obtaining the required continuing education credits within the specified time period and for making application for renewal of my certification. I further understand that it is my responsibility to inform NAMSS Executive Office of any changes in my contact information.

Content of the exam (exam questions and answer choices) is considered confidential information. As a candidate for the exam, I attest that I will not disclose any confidential information regarding the content of the exam in any form, e.g. written, electronic, verbal, overheard, or observed. I understand that signing this attestation and complying with its terms is required. Furthermore, I acknowledge that I am bound by the Ethics and Code of Conduct Policy for NAMSS Certificants and any other rules of conduct that NAMSS or the CCN may adopt and that violation of any of these may result in disciplinary action, including suspension or revocation of the credential. I agree to cooperate fully in any CCN or NAMSS investigation or proceeding involving alleged misconduct.

I certify that all information provided to satisfy my eligibility to sit for the exam is true, correct, and complete. I fully understand that any significant misstatements or omissions may cause me to be ineligible to sit for the exam and that I will forfeit $100 of the examination fee. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after certification has been awarded to me, may lead to revocation of the credential.

I have read and understand the information provided in the 2014 Candidate Handbook and will abide by the same. I declare that all information provided on my application is true. I understand that I can be disqualified from taking or continuing to sit for an examination or from receiving examination scores, or I may have my examination scores disqualified, if the CCN, in its sole judgment, determines through either proctor observation or statistical analysis that I engaged in collaborative, disruptive, or other inappropriate behavior related to administration of the examination.

I further authorize NAMSS to release my current certification status at any time post-certification upon request (either written or verbal). I acknowledge that it is the policy of NAMSS not to release information regarding the scores obtained on the exams or to release information regarding the number of times a candidate has taken the exams.

Candidate's Signature ___________________________ Date ________________

Candidate's Printed Name ______________________

Application for Certified Provider Credentialing Specialist Examination