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CCN

CERTIFICATION COMMISSION

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: O HOME O FACILITY			
Company Name (if facility is the preferred mailing address) Company Name (if facility is the preferred mailing address) Number and Street Output City Output Daytime Phone E-mail Address	Apartment Number Apartment Number Apartment Number State/Province ZIP/Postal Code Evening Phone Apartment Number A			
Eligibility and Background Information				
Darken only one choice for each question unless otherwise directed. A. HIGHEST ACADEMIC LEVEL: O High School Graduate O Bachelor's Degree O Some College O Master's Degree O Associate Degree O Other B. YEARS OF EXPERIENCE IN CREDENTIALING/ MEDICAL SERVICES MANAGEMENT: O 3 years O More than 10 years O 4 to 10 years C. PRESENT EMPLOYMENT: O Hospital/Health System O Annbulatory Surgical Center O Managed Care Organization/Health Plan O Credentials Verification Organization O Group Practice	 F. HAVE YOU TAKEN THIS EXAMINATION BEFORE? No 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 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, Lam a momber of NAMSS 			
 O Group Practice D. NUMBER OF PROVIDERS Less than 100 501 - 1,000 100 - 250 More than 1,000 251 - 500 Not applicable E. WHEN DO YOU WISH TO TAKE THE EXAM IN 2014? O Spring O Summer O Fall 	 O 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? O No O Yes IF YES, WHICH CREDENTIALS DO YOU HOLD? (Darken all that apply) O CPHQ O RHIA O RN O CPS O RHIT O Other (specify) 			

Application for Certified Provider Credentialing Specialist Examination

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 <u>at the time of application</u>, (*darken only one response*). Eligibility Requirements

O 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.

O 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 e order to meet eligibility requirements:	mployer including job title to document complete experience in
EMPLOYER:	DATES OF EMPLOYMENT:
CONTACT NAME:	PHONE NO:
 Duties performed (Check all that apply) Performs provider/practitioner credentialing and or privilegin Performs primary source verification Compliance with NCQA/URAC/TJC/HFAP/AAAHC or CMS that apply to provider/practitioner credentialing and privilegin Support of medical services departmental operations By my signature below, I attest that I have been employed during the functions indicated above. 	accreditation and regulatory standards
PRINT NAME:	SIGNATURE:
TITLE:	
CONTACT PHONE NO:	

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Application for Certified Provider Credentialing Specialist Examination

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.	Office Use
Immediate Supervisor Signature: Date:	
Title: Phone:	- 4 4 4 4 5 5 5 5
Organization:	- 6 6 6 6
Address:	
	9 9 9 9

Optional Inform	nation						
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:			Age Range:			Gender:	
O African American	O Hispanic	O White	O Under 25	O 30 to 39	O 50 to 59	O Male	
O Asian							

Candidate Signature

COMPLETE ENTIRE APPLICATION BEFORE SIGNING BELOW.

I attest that I meet the eligibility requirements for the CPCS exam. If found to be ineligible or false information is discovered on this application, I forfeit \$100 of the application fee. Additionally, I understand that I may be subject to an ethics investigation if I am a current NAMSS member.

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: O VISA O MasterCard O 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

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AUTHORIZATION FOR RELEASE OF INFORMATION AND ACKNOWLEDGEMENT OF OBLIGATIONS

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