Appendix L – Psychiatry/Psychology Credentialing Attachment

INSTRUCTIONS

PURPOSE:

Form DHS 1139A shall be used by health care providers who have specialties of psychiatry/psychology. This form shall be submitted with a completed DHS 1139, Medicaid Application/Change Request Form.

INSTRUCTIONS:

1.	Name:	Self-explanatory
2.	Business Address:	Self-explanatory
3.	Place of Birth/Birth date:	Self-explanatory
4.	Hawaii Resident:	Self-explanatory
5.	Confirmation of Certification & Licensing: • If yes, then provide State of Certification	Self-explanatory
6.	Denial of Certification & licensing: • If yes, then list State of denial	Self-explanatory
7.	Suspension or Revoked License: • If yes, attach statement	Self-explanatory
8.	Education:	Self-explanatory
9.	Experience:	Self-explanatory
10.	Do you hold an American Board Certification for your specialty? : • If yes provide date of certification	Self-explanatory
11.	Are you an A. P. A. Member? : • If yes what type of membership?	Self-explanatory
12.	Hospital privileges?	Self-explanatory
13.	Affiliation with any clinic?	Self-explanatory
14.	Private Practitioner?	Self-explanatory

Provider First Name and Last Name or DBA: _____
Be sure to include this identification at the bottom of every page.