



LEADING HOSPITALS.
TRUSTED CARE.

Credentials Support Center
4900 South Monaco Pkwy
Suite 240
Denver, CO 80237
Phone 303-584-2140
Fax 866-789-8020

Request for Application

All fields must be complete

Requestor's Information (if different than applicant)

Name:
Email:
Telephone:

Delivery Preference

FedEx: Home or Office
Email to: Applicant
 Requestor

Applicant's Information

Anticipated start date:
Is applicant employed or managed by HCA/HealthONE LLC? Yes No
If Yes: Employee Contract
Is the applicant currently in residency or fellowship training? Yes-completion date: _____ No

HOSPITALS

- North Suburban Medical Center
 Active Affiliate
- Presbyterian/St Lukes & Rocky Mtn Hosp for Children
 Active Affiliate
- Rose Medical Center
 Active Affiliate
- Sky Ridge Medical Center
 Active Affiliate
- Spalding RehabHospital
 Active Affiliate
- Swedish Medical Center
 Active Affiliate
- The Medical Center of Aurora & Centennial Medical Plaza
 Active Affiliate

SURGERY CENTERS

- Centrum Surgery Center
Anes - A&PM only
- Clear Creek Surgery Center
Anes - PAS only
- Lakewood Surgery Center
Anes - A&PM only
- Lincoln Surgery Center
Anes - Only by invitation
- Lowry Surgery Center
Anes - MDA, CAC & AAC only
- Midtown Surgery Center
- MSK Surgery Center
- North Suburban Surgery Center

- Red Rocks Surgery Center
Anes - PAS only
- Rocky Mtn Surgery Center
Anes - SCA only
- Rose Surgery Center
- Sky Ridge Surgery Center
Anes - MDA, SDA, CAC, Peak & PAC only
- Urology Surgery Center
Anes - PAS only

Applicant's Complete Name (First/Middle/Last):
Degree/Credentials (i.e., MD, DO, DPM, CRNA, CFA):
Date of Birth: _____ SSN: _____ NPI (10 digits): _____
Applicant's Email (required for upcoming online service enhancements):
Specialty: _____ Subspecialty: _____
Board Status: Registered Candidate Certified

Home Address (Required, don't leave it blank!)

Applicants Address/Suite:
City/State/Zipcode: _____ Phone: _____

Group/Company Address

Address type: Credentialing Address Group Address (check all that apply)
Group/Company Name: _____ Contact Email: _____ (if different from the requestor)
Contact: _____ Phone: _____
Address/Suite: _____ Fax: _____
City/State/Zipcode: _____

Comments:

**HealthONE will assess an application processing fee upon receipt of your application.
Initial applications are \$300 and reappointments/updates are \$150.
Return to credentialing.apps@healthonecares.com or 1-866-789-8020**