Medical Provider Resources
Delegation of Credentialing Form

A) Provider Information

Provider Name (Printed) _____

Provider Phone _____

Provider Email _____

B) Credentialing Agency Information

☐ I will perform my own credentialing. (Skip to section C)

☐ I authorize MPR to share my credentialing information with the following individual. The following individual shall be designated as my credentialing agent. I understand that the credentialing agent will be able to access, modify, and submit information through the MPR Online Application for clinical privileges and/or membership. **I also authorize the following individual to sign on my behalf clinical privilege and membership documents, disclosures, authorizations, and any other type of document submitted for the completion of the MPR Online Application. This includes the use of my electronic signature.**

Delegate Name _____
First Name Last Name

Company Name _____

Address _____
Street Address

_____
City State Zip

Contact Info. _____
Email Address

_____
Phone Number Fax Number

C) Acknowledgement & Agreement

_____ _____
Provider Signature **Date**

Submit signed form to Medical Provider Resources via email below as a .pdf file.

Medical Provider Resources
316-500-1304 phone
GenneferMuzzy@mprcred.com

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