

# MPR ONLINE APPLICATION WALK THROUGHS

We have created walk-through guides to help you navigate through the initial applications, reappointment applications, and document updates.

# STEP 1 – REGISTER FOR AN ACCOUNT

- Go to <https://app.medicalproviderresources.com> and select “Need to register?”
- On the registration screen, select provider or credentialing agent
- Select Provider if you are the Practitioner who needs to add or renew your privileges (this will include scrub techs, MA’s, RN’s, etc).
- Select Credentialing Agent if you are completing the credentialing information on behalf of the practitioner.
- Enter in all your information. In the image below, the red checkmarks are required fields.
  - **If you are a Credentialing Agent**, be sure to enter the credentialing email address and not your email address.
- Hit register. You will get a message that a CVS Specialist will contact you soon.

MPR Credentialing

Log In

Email

Password

PIN

Remember me?

Log in

[Need to register?](#)

[Forgot your password?](#)

[Forgot your PIN?](#)

[Resend email confirmation](#)

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MPR Credentialing

Registration

Provider  Credentialing Agent

First Name

Last Name

Middle Name

Email

Professional Suffix

Specialty

Birth Date

Phone Number

Employer

Register

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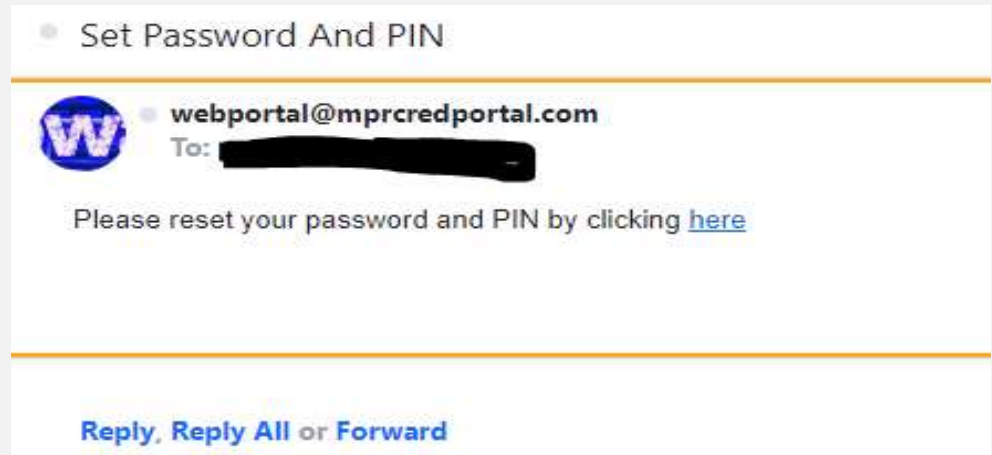
# REGISTER FOR AN ACCOUNT CONTINUED

- Once MPR approves your registration, you will receive an email notification to set your Password and PIN.



**THIS IS A TIME SENSITIVE EMAIL AND WILL ONLY WORK FOR 24 HOURS.**

- Click on the link in your email and enter the information requested.



Set Password and PIN

Email

Password

Confirm Password

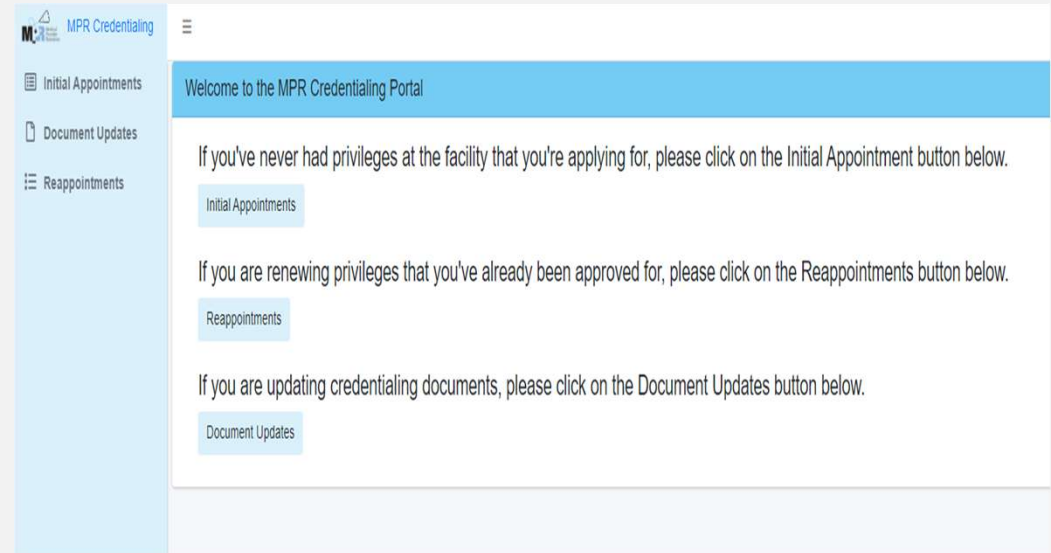
PIN

Confirm PIN

**Congratulations – you are now registered and have access to the online application portal!**

# STEP 2 – LOGGING INTO THE ONLINE PORTAL

- When you log in, you should see this screen. However, on the left-hand side, you will see 3 different tabs – Initial Appointments, Document Updates, and Reappointments.



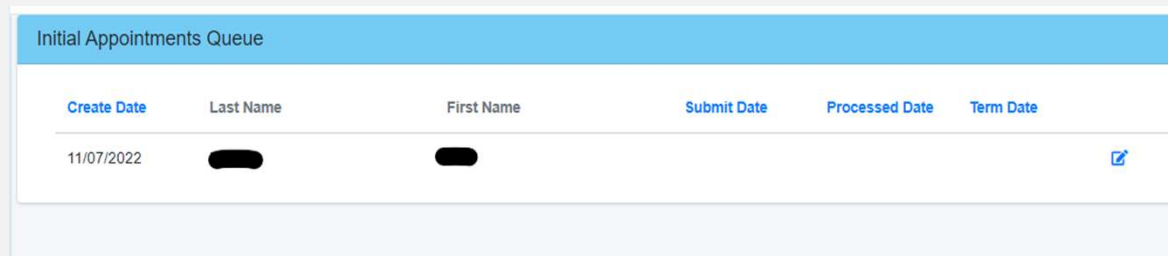
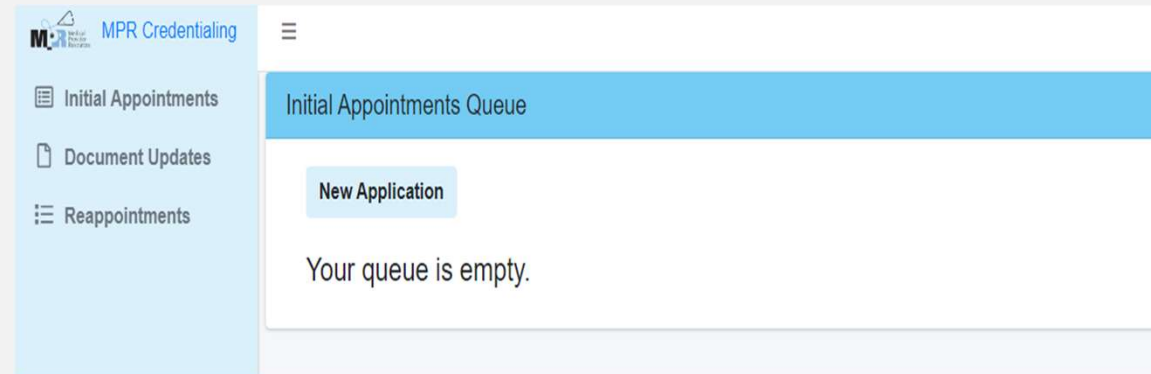
## STOP DO NOT PROCEED WITHOUT READING BELOW!



- A brief description of each tab:
  - **Initial Appointments** – use this tab ONLY if you are requesting privileges at a facility you currently have no privileges at.
  - **Document Updates** – use this tab to upload copies of new DEA's and Malpractice Insurance.
  - **Reappointments** – use this tab ONLY if you currently have privileges but need to renew them (this typically happens every two years).

# INITIAL APPLICATION

- If you are completing an application for the first time, select the click “Initial Appointment” button. You will see one of these two screens.
- If you are starting an application, select “New Application.”
- If you already started an application, it will be listed here, so you can select the little edit box on the far right.
- Please note that you will need to go through the entire application before you can submit it.



The screenshot shows the 'Initial Appointments Queue' page with a table containing one application entry. The table has columns for 'Create Date', 'Last Name', 'First Name', 'Submit Date', 'Processed Date', and 'Term Date'. The entry shows a 'Create Date' of 11/07/2022 and redacted names. An edit icon is visible on the right side of the row.

Create Date	Last Name	First Name	Submit Date	Processed Date	Term Date
11/07/2022	[REDACTED]	[REDACTED]			

# INITIAL APPLICATION

## CREDENTIALING AGENT ONLY

- If you are a provider, you will not see this screen, skip to slide 8.
- Here you will see a list of providers that you are the assigned delegate for.
- If the provider is not on your list, select “Add provider to my roster”
- Download the Delegation of Credentialing form and fill out the information and email it to [sindanispel-borboa@mprcred.com](mailto:sindanispel-borboa@mprcred.com).



Back Add provider to my roster

Providers

### Add Provider to List

Step #1

To add a provider you must download the [Delegation of Credentialing Form](#)

[Click to Download](#)

Step #2

Register provider in MPR Portal

First Name

Last Name

Middle Name

Email

Professional Suffix

Specialty

Birth Date

Phone Number

Employer

[Register](#)

### PLEASE NOTE:

**We will not be able to add a provider to your roster without the completed, signed delegation of credentialing is returned.**

**The signature on the Delegation of Credentialing CANNOT be a typed signature, it needs to be verifiable.**










# INITIAL APPLICATION CREDENTIALING AGENT ONLY

- Once we have the Delegation of Credentialing on file, we will add the provider to your roster.
- To start an application after logging in, select Initial Application, then New Application.
- Here you will see a list of all your providers, find the name you are looking for and select the blue edit button on the far right.

Back Add provider to my roster

### Providers

Show 10 entries Search:

Last Name	1:	First Name	1:
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	
[REDACTED]		[REDACTED]	

Showing 1 to 10 of 134 entries

Previous **1** 2 3 4 5 ... 14 Next

# INITIAL APP – SCREEN 1 PERSONAL INFORMATION

- Enter in the Group that are associated with.
- Enter in all your other information.
- Cell phone is required to move forward!
- Hit Next.

Personal Information

Save Next Cancel

Group: Your group is considered your primary group affiliation and the group to which these privileges are attached.

Medical Provider Resources -

First Name	Middle Name	Last Name	Name Suffix
Gennefer	Marie	Muzzy	
New First Name	New Middle Name	New Last Name	New Name Suffix

Professional Suffixes

Select Add

Maiden Names/Aliases Add

Birth Date Birth City Birth State SSN Gender

mm/dd/yyyy [calendar icon] [text box] Select \*\*\*\*\*6074  Male  Female

NPI Speciality Sub-Specialty CAQH Number

[text box] APRN [dropdown] Select Speciality [text box]

Marital Status Spouse Name

Select [text box]

Languages

Select Add

Home Address Line 1 Home Address Line 2

1102 South Hillside Street MPR

Home City Home State Home Zip Code

Wichita Kansas 67211

Home Phone Cell Phone Email Address

(316) 683-0178 [text box] gennefermuzzy@mprcred.com

Save Next Cancel

No Items to show

When changing your email you will need to re-register to sign into the portal. This will take an internal change at MPR.

Please note – Grayed out areas cannot be edited.

# INITIAL APP – SCREEN 2 SPONSORS

- If you have a sponsoring physician, select Add Sponsor.
- Enter in all the requested information.
- Hit Next.

**Sponsor**

Sponsoring Physician - Non-Physician Only

[Add Sponsor](#) [Next](#) [Previous](#)

**Sponsor**

Facility

First Name  Last Name   New Sponsor

Address Line 1  Address Line 2

City  State  Zip

Phone  Phone Ext  Fax  Email   Inactive

[Save](#) [Cancel](#)

# INITIAL APP – SCREEN 3 EDUCATION AND TRAINING

- You will see ECFMG Number – you do not need to enter this if it is not applicable.
- Select “Add Education/Training”
- You will need to enter in your education/training and select save. If you have more education/training to add, select the “Add Education/Training” again and repeat this process as needed.
- Once all education/training is entered, hit next.



Education/Training

All time periods from entering professional/graduate school are to be accounted for.  
**Add all schools/institutions attended.**

ECFMG Number  ECFMG Date

Education/Training

Type  Degree Earned  From Date  To Date

Do you disagree with the pre-filled dates?  If you disagree, please explain

Institution

Institution Role  Specialty

Institution Contact First Name  Institution Contact Last Name  Institution Contact Phone  Institution Contact Fax  Institution Contact Email

New Contact First Name  Last Name  Phone  Fax  Email

Program Director  Completed Program  Yes  No Not Completed Description  Gap Description

**NOTE: If you did not complete your program, you will need to provide an explanation.**

**You ONLY need to enter any postgraduate education/training.**

**Grayed out areas cannot be edited.**

# INITIAL APP – SCREEN 4 ACADEMIC AFFILIATIONS

Academic Affiliation

Institution

Institution Contact First Name	Institution Contact Last Name	Institution Contact Phone	Institution Contact Fax	Institution Contact Email
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

New Contact

Contact First Name	Contact Last Name	Contact Phone	Contact Fax	Contact Email
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

From Date   To Date

Appointment Title  Department  Position Type

- If you do not have any academic affiliations, please hit next
- If you do have academic affiliations, please select “Add Academic Affiliation” and complete the information in the screen – we will need to know if it is a PT, FT, or Volunteer position and hit save.
- Once all your academic affiliations are entered, hit next.

# INITIAL APP – SCREEN 5 WORK/PRACTICE HISTORY

- You will need to add your work history for the past 5 years.
- Select Add Work/Practice History and enter in all the information and hit save.
- Repeat this process to add all positions you have had in the past 5 years.
- Once all your work/practice history has been added, select next.

Work/Practice History

Organization

Select

Institution Contact First Name Institution Contact Last Name Institution Contact Phone Institution Contact Fax Institution Contact Email

Group Contact (xxx) xxx-xx00 (xxx) xxx-xxxx

New Contact

Contact First Name Contact Last Name Contact Phone Contact Fax Contact Email

Position Held From Date To Date

mm/dd/yyyy mm/dd/yyyy

Save Cancel

**Please Note: Grayed out areas cannot be changed.**

# INITIAL APP – SCREEN 6 HOSPITAL AFFILIATIONS

- If you do not have any Hospital Affiliations, Select no and hit next.
- To enter your Hospital Affiliations, select yes and then “Add Affiliation” and complete all the information and hit save, repeat as needed.
- Once all Hospital Affiliations are entered, hit Next.

**We will need you to enter in all your hospital affiliations for the past 5 years – whether or not the privileges are currently active.**

Medical Staff Memberships/Hospital Affiliations

List all active hospitals/medical institutions to which have applied to any time, were previously a member, or with which you are currently affiliated within the past 5 years.

Are you now or have you been a member of, or held clinical privileges at a hospital/medical facility?  Yes  No



Medical Staff Memberships/Hospital Affiliations

Hospital

Institution Contact First Name	Institution Contact Last Name	Institution Contact Phone	Institution Contact Fax	Institution Contact Email
<input type="text" value="Hospital"/>	<input type="text" value="Main"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="*****"/>

New Contact

Contact First Name	Contact Last Name	Contact Phone	Contact Fax	Contact Email
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Membership Type

From Date

To Date

Staff Category

**Do not add hospitals that you are currently applying for.**

**Please Note: Grayed out areas cannot be changed.**

# INITIAL APP – SCREEN 7 CERTIFICATIONS

- If you do not have any board certifications, select “not applicable to profession or specialty” at the top of the screen and then answer questions A - D.
- If you have a certification, select “I am board certified” and then click “Add Certification” and input all your Board Certification information, repeat as needed.
- Hit Next.

Certifications

Not applicable to profession/specialty

---

Questions

A) Have you been examined by a specialty board, but failed to pass? If Yes, please specify board.  Yes  No

B) If not certified, have you applied for certification examination?  Yes  No

C) If no, do you intend to apply for certification examination?  Yes  No

If Yes enter an explanation

D) Have you been accepted to take the certification examination? If yes, what date(s) are you scheduled to take the examination?  Yes  No

Certifications

**Board Specialty**

Select

**Specialty**

Select

**SubSpecialty**

Select

**Board Certified**

Select

**Certification Number**

**Certified Date**

mm/dd/yyyy

**Recertified Date**

mm/dd/yyyy

**Expiration Date**

mm/dd/yyyy

**Status Description**

**Inactive**

Please Note: Grayed out areas cannot be edited.

# INITIAL APP – SCREEN 8 CME/CEU CREDITS

- Answer the question on this page.
- After answering the question, select “Upload Document” and follow the instructions on the pop-up box to upload your CMEs.
- The only time you should select “Not Applicable” is if you are a recent graduate (enter that date in) or if your privileges do not require CME/CEU – for example, Medical Assistants.
- Once complete, hit Next.

CME/CEU Credits

If not applicable, provide date of recent completion of training.

Are your CME credits congruent with the clinical privileges you are requesting at this time?  Yes  No  Not Applicable

Date of recent completion of training

Save Cancel Upload Document Next Previous

**Date is needed only if you are a recent graduate.**

Upload File

1. Choose File.
2. Upload.
3. Exit when finished uploading.

Choose File No file chosen

Upload

Exit

**CMEs are required for MPR to complete your application.**

# INITIAL APP – SCREEN 9 MILITARY SERVICE

- Answer the first question. If you answer No, hit save and next.
- If you answer yes, select “Add Military Service” and complete the form.
- Hit Next once complete.

**Military Service**

Have you served or are you currently serving in the United States Military?  Yes  No

**Military Service**

<b>Serving Status</b>	<b>Military Branch</b>	<b>From Date</b>	<b>To Date</b>
<input type="text" value="Select"/>	<input type="text" value="Select"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>
<b>Discharge Type</b>	<b>Service Number</b>		
<input type="text" value="Select"/>	<input type="text"/>		
<b>Supervisor Name</b>	<b>Supervisor Phone</b>	<b>Phone Ext</b>	<b>Supervisor Email</b>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

## INITIAL APP – SCREEN 10 LICENSURE

- If you do not have a license, hit next.
- If you have a current or pending license, select add licensure and complete the form and hit save. **DO NOT ENTER EXPIRED LICENSES.**
- If you have multiple licenses, repeat this step until all licenses are entered.
- Once all your licenses have been entered, hit next.

The screenshot shows a form titled "Licensure" with a blue header. The form contains several input fields and buttons:

State	License Type	License Status	License Number	Issue Date	Expiration Date	Failed Reason
<input type="text" value="Select"/>	<input type="text" value="Select"/>	<input type="text" value="Select"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

At the bottom of the form, there are two buttons: "Save" and "Cancel".

**If your license is pending and you do not know your license number, enter "PENDING" and the expiration date 30 days in the future.**

# INITIAL APP – SCREEN II DEA/BNDD REG

- If you do not have a DEA/BNDD, hit next.
- If you have a DEA/BNDD, select “Add DEA/BNDD” and enter your information. Next, hit save.
- Repeat this step for all current DEAs/BNDDs you have.
- Once all information has been entered, hit next.

DEA/BNDD Registration

Controlled Substance	Schedule	Default	State	Number	Issue Date	Expiration Date
Select ▾			Select ▾		mm/dd/yyyy ☐	mm/dd/yyyy ☐
Save		Cancel				

## INITIAL APP – SCREEN 12 LIABILITY INS

- This is where you will enter in all current Malpractice Insurance information.
- Select “Add Professional Liability Insurance”
- Enter in all the information found on the Certificate of Insurance.
- Once all Liability Insurance policies have been entered, hit next.

Professional Liability Insurance

Carrier	Agent Name		
<input type="text" value="Select"/>	<input type="text"/>		
Phone	Fax	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Policy Type	Policy Number	Effective From Date	Effective To Date
<input type="text" value="Select"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>
<input type="button" value="Save"/>	<input type="button" value="Cancel"/>		

**List ALL carriers within the past 120 days. Please upload a copy of your COI(s) in the documents section of this application. This includes the KHCSF for all mandated practitioners practicing in Kansas. To see if you are mandated to participate in KHCSF, please go to <https://hcsf.kansas.gov/insurers/defined-hcps/>**

# INITIAL APP – SCREEN 13 PROFESSIONAL REFERENCE

- Select “Add Reference” and your reference’s information.
- Repeat this step 5 times to enter in all 5 references.
- **An email address for your reference is required.**
- Once all reference information has been entered, hit next.

Professional References

Add Reference Next Previous

Professional references are required by hospital surveyors and a questionnaire with specific required questions will be mailed to these practitioners. **List five (5) practitioners in your same professional discipline (e.g. physician to physician, APRN to APRN, PA to PA, LCSW to LCSW, etc.),** who have personal knowledge of your current clinical abilities, ethical character, health status, and who will provide specific written comments on these matters upon request from the hospital and medical staff authorities. The named providers must have acquired the requisite knowledge through recent observation of your current practice over a reasonable period of time. **None of the individuals that are used for a professional reference should be related to you by a family relationship.** (Possible sources include: Chief of training program, department chair / chief, proctor, mentor, or practitioners in the same specialty). It would be helpful if you could notify these individuals that a professional reference request will be made and request they be attentive to the request. **We must have all contact information.**

Professional References

First Name	Middle Name	Last Name	Professional Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	Select <input type="text"/>
Address Line 1	Address Line 2		
<input type="text"/>	<input type="text"/>		
City	State	Zip Code	
<input type="text"/>	Select <input type="text"/>	<input type="text"/>	
Phone	Fax	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Save Cancel

**Active**

Please mark this box if this person can be used as a **current** professional reference. You must have at least 3 references marked active. **Please note that if this box is not checked, the reference will NOT be contacted.**

**You must enter the provider’s email address. We cannot use a delegate’s email address.**

# INITIAL APP – SCREEN 14 APPLICANT INFORMATION

- Answer all questions on this page.
- If you answer 'yes' to any of these questions, an explanation is required.
- When complete, hit next.

## Applicant Information

Save Next Previous

Cancel

If any of the following questions are answered in the affirmative "yes", please provide a full explanation. If the question does not apply to you, please mark "no."

Have any of the following been voluntarily or involuntarily relinquished, denied, revoked, suspended, not renewed, canceled, placed on probation, subject to disciplinary action, terminated, restricted, sanctioned, limited, reduced, loss of, abolished, excluded assessed penalties; or have you been reported to, had any challenges to, or have proceedings toward any of those ends ever been instituted, or voluntary or involuntarily relinquished any items to these organizations while under investigation of, or in anticipation of any of these actions?:

State License(s) to practice your profession  Yes  No

Controlled Substance Registration Certificate (DEA, CDS, BNDD, etc)  Yes  No

Hospital Staff Membership/Clinic Privileges  Yes  No

Professional Organization Membership or Employment (Local, State, Federal, Foreign)  Yes  No

Medicare/Medicaid or other Government program Participation, HMO, PPO, or other Insurance Plan or Agency Participation  Yes  No

Board/Specialty Certification  Yes  No

Professional Liability Insurance  Yes  No

A. Has your application ever been withdrawn for affiliation or reappointment or renewal of affiliation or for clinical privileges, or renewal of clinical privileges while the application was pending?  Yes  No

B. Have you been denied membership on a hospital medical staff or advancement in medical staff status, or has such a denial ever been recommended by a standing medical staff committee or governing body?  Yes  No

C. Has your request for any specific clinical privilege been denied or granted with stated limitations (aside from ordinary initial requirements of sponsorship) or has such a denial or limitation been recommended by a standing committee or governing body?  Yes  No

D. Do you currently have any limitations to your practice (i.e., patient population, hours, etc.)  Yes  No

If Yes enter an explanation

E. Have you been under investigation by any government agency or department thereof relating to your practice of medicine?  Yes  No

F. Have you been convicted, plead guilty, (court martialled), to a felony, misdemeanor, or any offence reasonably related to your qualifications, functions, or duties as a medical professional, or any offence which is an essential element of fraud, dishonesty, any act of violence or are you under investigation or indictment for an alleged crime in the USA or a foreign country?  Yes  No

G. Have you ever been sanctioned by, charged by, or adversely listed by any federal, state, or local social service agency for any reason?  Yes  No

H. For any reason are you unable to exercise the privileges you have requested and all the services required by the applicable participating practitioner agreement, with or without reasonable accommodations, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?  Yes  No

I. Are you at present named or have you been a party to a professional malpractice suit in which a judgment of liability was entered against you or which was resolved by a settlement from you or your insurer?  Yes  No

J. Are you currently, or have you been a defendant in any civil action or had issues related to qualifications, competence, functions, or duties as a medical professional, or for alleged fraud, or charged in any criminal action arising from an act of violence, child abuse, sexual offense, or sexual misconduct?  Yes  No

K. Have you changed liability insurance carriers in the past five years?  Yes  No

L. Do you currently use illicit drugs, prescription drugs not dispensed, prescribed, or administered by another licensed health care provider, or other chemical substance that would affect your ability to safely exercise the privileges you have requested, and all the services required by the applicable participating facility(ies)?  Yes  No

M. Have you received or been advised to seek treatment for any mental, physical condition (including infectious diseases), or alcohol/drug/chemical dependencies that would affect your ability to safely exercise the privileges you have requested and all the services required by the applicable participating facility(ies)?  Yes  No

Save Next Previous

Cancel

# INITIAL APP – SCREEN 15 FACILITIES

- Select **all** facilities where you are wanting to apply for privileges.
- Once all facilities have been selected, hit next.

Facilities

Next Previous

Show:  entries Search:

Facility

- Andover Ambulatory Surgery Center - Andover, KS 67002
- Ashland Health Center - Ashland, KS 67831
- Aspen Mountain Medical Center - Rock Springs, WY 82901
- Atchison Community Health Clinic - Atchison, KS 66002
- Center For Same Day Surgery - Wichita, KS 67214
- Cheyenne County Hospital - Saint Francis, KS 67756
- Citizens Medical Center, Inc. - Colby, KS 67701
- Clay County Medical Center - Clay Center, KS 67432
- Coffey County Hospital - Burlington, KS 66839
- Comanche County Hospital - Coldwater, KS 67029
- Coronado Surgical Recovery Suites - Henderson, NV 89052
- Cypress Surgery Center - Wichita, KS 67226
- Edwards County Hospital & Health Center - Kinsley, KS 67547
- Ellinwood District Hospital - Ellinwood, KS 67526-1440
- Fredonia Regional Hospital - Fredonia, KS 66736-0579
- Greeley County Hospital - Tribune, KS 67879
- Healthcore Clinic - Wichita, KS 67214
- Hunter Health - Wichita, KS 67214
- Jewell County Hospital - Mankato, KS 66956-0327
- Kansas Heart Hospital - Wichita, KS 67226

Showing 1 to 20 of 57 entries

Previous 1 2 3 Next

# INITIAL APP – SCREEN 16 DOCUMENTS

- This screen is where you will upload all your documents.
- Click on the download button, complete each page, and then click the upload button to attach the document to your application – only one upload per slot is allowed
- All required documents are marked yes – you will not be able to submit your application without all these uploaded.
- Once all documents are uploaded, hit next.

Documents		
Upload Misc. Doc	Next	Previous
Required	Document	Upload Date/Time
Yes	Government Issued Photo ID	<a href="#">Upload</a>
	Current Photograph	<a href="#">Upload</a>
	Current Curriculum Vitae (CV) or Resume	<a href="#">Upload</a>
Yes	Current Malpractice Certificate of Insurance	<a href="#">Upload</a>
	MPR - Application Addendum	<a href="#">Download</a> <a href="#">Upload</a>
	Military OMB #3095-0029 Records Request	<a href="#">Download</a> <a href="#">Upload</a>
	NATSB - Employment Disclosure and Authorization for Background Check	<a href="#">Download</a> <a href="#">Upload</a>
	Kansas Healthcare Stabilization Fund Certificate (MD, DO, DC, DPM, CRNA, PA, NMW, and DDS practicing in Kansas)	<a href="#">Upload</a>
	Training Log of Procedures (If a graduate within the past year)	<a href="#">Upload</a>
	Life Support Certificates	<a href="#">Upload</a>
	Certificates/Other Supporting Documentation	<a href="#">Upload</a>
	MPR - Authorization to Release Information	<a href="#">Download</a> <a href="#">Upload</a>

**CME's are not required to submit the application but are required before MPR can complete the application.**

# INITIAL APP – SCREEN 17 HISTORY GAPS

- If you have any gaps within the past 5 years, they will be highlighted here and an explanation is required.
- If no gaps are present, hit Next.
- To enter an explanation, under Update Gap History, enter the start date, end date, and explanation then select Save Gap. Repeat as necessary.
- Hit Next.

History Gaps - No Gaps Exist

Save Gap Clear Next Previous

Description	Start Date	End Date	Inactive
Education - University of Kansas School of Medicine - KC - Kansas City, KS 66160	08/01/2007	08/01/2011	
Education - University of Kansas School of Medicine - KC - Kansas City, KS 66160	07/01/2012	01/01/2014	
Hospital Affiliation - Comanche County Hospital - Coldwater, KS 67029	07/01/2014	08/25/2023	
Work History - Comanche County Hospital - Coldwater, KS 67029	07/02/2014	08/25/2023	

History Gaps - Gaps Exist

Save Gap Clear Next Previous

Description	Start Date	End Date	Inactive
Education - University of Kansas School of Medicine - KC - Kansas City, KS 66160	08/01/2007	08/01/2011	
Education - University of Kansas School of Medicine - KC - Kansas City, KS 66160	07/01/2012	01/01/2014	
Hospital Affiliation - Comanche County Hospital - Coldwater, KS 67029	07/01/2014	05/11/2023	
Work History - Comanche County Hospital - Coldwater, KS 67029	07/02/2014	05/11/2023	
105 Days Gap Found	05/12/2023	08/25/2023	

Update Gap History

Start Date	End Date	Description	Inactive
<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>	<input type="checkbox"/>

Save Gap Clear Next Previous

# INITIAL APP – SCREEN 18 SUBMIT AND SIGN

- If your application has all the required information and documents, you will see green checkmarks next to each section title and can click and submit.
- If you have a red X, you will need to revisit that page and complete the required information.
- After you have all green checkmarks, you can type in your signature and date of completion.
- NOTE: If you want to expedite your application, click the expedited option.
- At this point, you may be required to submit a payment.



## Sign and Submit Initial Appointment Application

### Previous

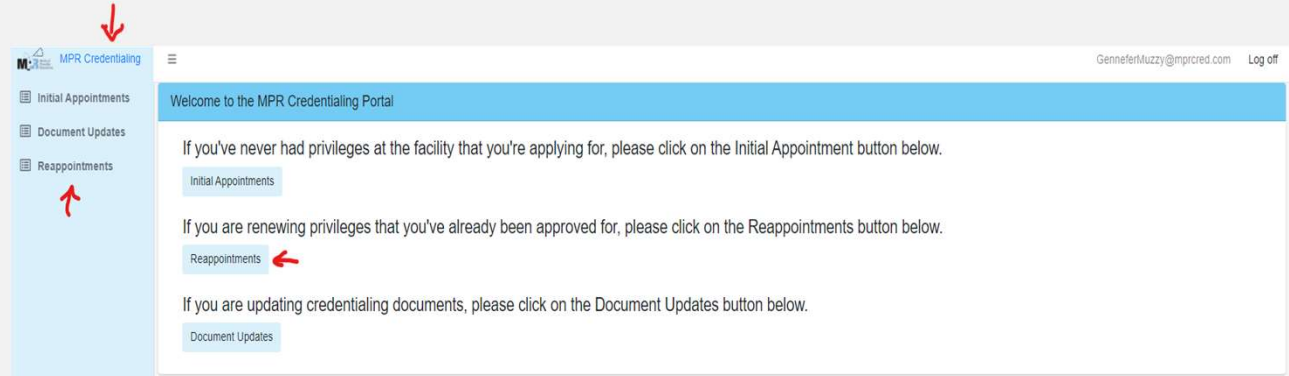
<input checked="" type="checkbox"/> Personal Information	<i>You have not visited the Personal Information</i>
<input checked="" type="checkbox"/> Hospital Affiliations	
<input checked="" type="checkbox"/> Certifications	
<input checked="" type="checkbox"/> CME/CEU Credits	<i>You have not visited the CME/CEU Credits</i>
<input checked="" type="checkbox"/> Licensure	<i>You have not visited the Licensures</i>
<input checked="" type="checkbox"/> DEA/BNDD Reg	<i>You have not visited the DeaBnnd Regs</i>
<input checked="" type="checkbox"/> Liability Insurance	<i>You have not visited the Liability Insurances</i>
<input checked="" type="checkbox"/> Malpractice Claims	<i>You have not visited the Malpractice Claims</i>
<input checked="" type="checkbox"/> References	
<input checked="" type="checkbox"/> Application Information	<i>You have not visited the Applicant Information</i>
<input checked="" type="checkbox"/> Facilities	<i>You have not visited the Facilities</i>
<input checked="" type="checkbox"/> Documents	<i>You must upload all required documents</i>
<input checked="" type="checkbox"/> Education and Training	
<input checked="" type="checkbox"/> Academic Affiliations	<i>You have not visited the Academic Affiliations</i>
<input checked="" type="checkbox"/> Work/Practice History	
<input checked="" type="checkbox"/> Military Service	<i>You have not visited the Military Service</i>
<input checked="" type="checkbox"/> History Gaps	

**PLEASE NOTE: Once you hit submit, you cannot go back and make changes or upload documents. All required documents must be uploaded before you submit your application!!**

**CONGRATULATIONS!  
YOU HAVE COMPLETED AN INITIAL APPLICATION!**

Next, we will go over completing a Reappointment Application.

# REAPPOINTMENT APPLICATION



- There are two ways to get the reappointment section.
  - First, you can select “MPR Credentialing” in the upper left corner. Next, select “Reappointments”
  - Second, you can select “Reappointments” on the left side of the screen.

- Once in the reappointment screen you will see the reappointments that you have coming due. If you are a provider, you will only see your name.

- If you are a credentialing agent and we have received your Delegation of Credentialing form authorizing you as a delegate, you will see the names of all providers who have an upcoming reappointment.

- To start the reappointment, select the edit box on the far-right side of the screen.

The screenshot shows the 'Reappointments Queue' table. At the top left, there is a checkbox labeled 'Include Unsubmitted'. The table has the following columns: 'Reappt Dates', 'Create Date', 'Submit Date', 'Last Name', 'First Name', 'Processed Date', and 'Term Date'. The data rows are as follows:

Reappt Dates	Create Date	Submit Date	Last Name	First Name	Processed Date	Term Date
01/01/2023	11/07/2022	11/07/2022	[REDACTED]	[REDACTED]		11/10/2022
01/01/2023	11/04/2022	11/10/2022	[REDACTED]	[REDACTED]		11/10/2022
02/01/2023	11/10/2022	11/10/2022	[REDACTED]	[REDACTED]		[Edit]
04/01/2023	10/11/2022	11/09/2022	[REDACTED]	[REDACTED]		[Edit]
04/01/2023	10/05/2022	11/07/2022	[REDACTED]	[REDACTED]		[Edit]
05/01/2023	11/07/2022	11/09/2022	[REDACTED]	[REDACTED]		[Edit]

# REAPPT – SCREEN 1 PERSONAL INFORMATION

- NOTE: All the information we have on file from the provider's previous reappointment or initial app, will auto-fill in but you will still need to go through every screen and make sure that no information needs to be updated.
- Check to make sure all information is correct
- We will need the provider's email address entered in this section, not the credentialing email. Cell phone is required.

Personal Information

Save
Next
Cancel

Group

First Name                      Middle Name                      Last Name                      Name Suffix

Professional Suffixes

Add

Maiden Names/Aliases Add

---

Birth Date                      Birth City                      Birth State                      SSN                      Gender

                                           \*\*\*\*\*6789                       Male  Female

NPI                      Specialty                      SubSpecialty                      CAQH Number

Marital Status                      Spouse Name

Languages

Add

---

Home Address Line 1                      Home Address Line 2

Home City                      Home State                      Home Zip Code

Home Phone                      Cell Phone                      Email Address

When changing your email you will need to re-register to sign into the portal. This will take an internal change at MPR.

Sponsoring Physician - Non-Physician Only

Physician Name

Address                      City                      State                      Zip Code

Phone                      Fax                      Email Address

Save
Next
Cancel

# REAPPT – SCREEN 2 SPONSORS

- If you have a sponsoring physician, select Add Sponsor.
- Enter in all the requested information.
- Hit Next.

Sponsor

Sponsoring Physician - Non-Physician Only

Add Sponsor Next Previous

Sponsor

Facility  
Select

First Name Last Name  New Sponsor

Address Line 1 Address Line 2

City State Zip

Phone Phone Ext Fax Email  Inactive

Save Cancel

# REAPPT– SCREEN 3 HOSPITAL AFFILIATIONS

- If you do not have any Hospital Affiliations, Select no and hit next.
- Please check the current hospital affiliations and dates, if anything needs changed, select “edit” and make the changes. You cannot edit grayed out information.
- If there are new affiliations that need to be added, select “Add Affiliation” and complete all the information and hit save. Repeat as necessary.
- Once all Hospital Affiliations are entered, hit Next.

Medical Staff Memberships/Hospital Affiliations

List all active hospitals/medical institutions to which have applied to any time, were previously a member, or with which you are currently affiliated within the past 5 years.

Are you now or have you been a member of, or held clinical privileges at a hospital/medical facility?  Yes  No



Medical Staff Memberships/Hospital Affiliations

Hospital

Institution Contact First Name	Institution Contact Last Name	Institution Contact Phone	Institution Contact Fax	Institution Contact Email
<input type="text" value="Hospital"/>	<input type="text" value="Main"/>	<input type="text"/>	<input type="text"/>	<input type="text" value="*****"/>

New Contact

Contact First Name	Contact Last Name	Contact Phone	Contact Fax	Contact Email
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Membership Type

From Date

To Date

Staff Category

## REAPPT – SCREEN 4 CERTIFICATIONS

- If you do not have any board certifications, select “not applicable” at the top of the screen and hit next.
- Check the current board information for accuracy.
- If changes need to be made, select “edit” and update the information.
- Hit Next.

Certifications

Not applicable to profession/specialty

Questions

A) Have you been examined by a specialty board, but failed to pass? If Yes, please specify board.  Yes  No

B) If not certified, have you applied for certification examination?  Yes  No

C) If no, do you intend to apply for certification examination?  Yes  No

If Yes enter an explanation

D) Have you been accepted to take the certification examination? If yes, what date(s) are you scheduled to take the examination?  Yes  No

# REAPPT – SCREEN 5 CME/CEU CREDITS

- This page will not auto-fill and must be completed before you can submit your application.
- Answer the questions on this page.
- After answering the question, select “Upload Document” and follow the instructions on the pop-up box.
- Once complete, hit Next.

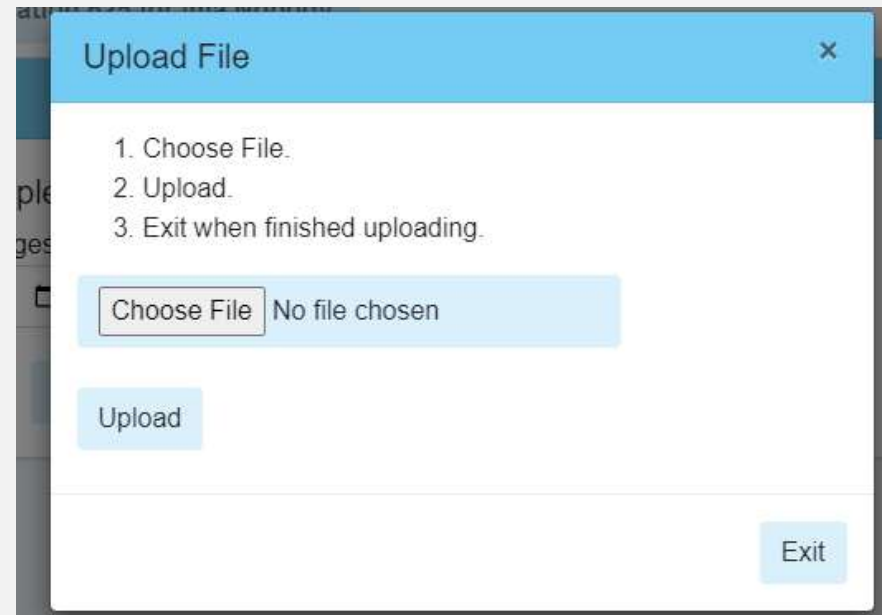


CME/CEU Credits

If not applicable, provide date of recent completion of training.

Are your CME credits congruent with the clinical privileges you are requesting at this time?  Yes  No  Not Applicable

Date of recent completion of training



Upload File

1. Choose File.
2. Upload.
3. Exit when finished uploading.

No file chosen

**The only time you should select “Not Applicable” is if you are a recent graduate (enter that date in) or if your privileges do not require CME/CEU – for example, Medical Assistants.**

# REAPPT – SCREEN 6 LICENSURE

- If you do not have a license, hit next.
- Check the current license information for accuracy.
- If any information needs to be updated, please select “edit” and make the appropriate changes.
- You cannot change any grayed out information.
- Hit next.

The screenshot shows a form titled "Licensure" with a blue header. The form contains several input fields and buttons:

State	License Type	License Status	License Number	Issue Date	Expiration Date	Failed Reason
<input type="text" value="Select"/>	<input type="text" value="Select"/>	<input type="text" value="Select"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text"/>

At the bottom left of the form are two buttons: "Save" and "Cancel".

## REAPPT– SCREEN 7 DEA/BNDD REG

- If you do not have a DEA/BNDD, hit next.
- Verify all recorded information is correct.
- Select “edit” if any information needs to be updated.
- You cannot edit grayed out areas.
- Once all information has been entered, hit next.

### DEA/BNDD Registration

Controlled Substance	Schedule	Default	State	Number	Issue Date	Expiration Date
Select ▾	<input type="text"/>		Select ▾	<input type="text"/>	mm/dd/yyyy <input type="text"/>	mm/dd/yyyy <input type="text"/>
<input type="button" value="Save"/>		<input type="button" value="Cancel"/>				

# REAPPT – SCREEN 8 LIABILITY INS

- Verify we still have the most accurate and up-to-date malpractice insurance.
- If any changes need to be made, select “edit”
- You are not able to edit grayed out areas.
- Once all Liability Insurance policies have been entered, hit next.

Professional Liability Insurance

Carrier	Agent Name		
<input type="text" value="Select"/>	<input type="text"/>		
Phone	Fax	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Policy Type	Policy Number	Effective From Date	Effective To Date
<input type="text" value="Select"/>	<input type="text"/>	<input type="text" value="mm/dd/yyyy"/>	<input type="text" value="mm/dd/yyyy"/>
<input type="button" value="Save"/>	<input type="button" value="Cancel"/>		

# REAPPT – SCREEN 9 LIABILITY INS

- This information will not auto-fill and will need to be completed.
- If you do not have any claims within the past 5 years to report, select “I do not have any claims to report within the past 5 years.”
- Type in the Applicant name in the Applicant Signature slot and enter in the date. **NOTE – If you are a credentialing agent – type in the provider’s name, not your name!**
- If you do have a claims to report, select “Add Malpractice Claim” and fill in all the information. Once complete, hit save – repeat for each claim.
- Once all claims have been entered, select Next.

Malpractice Claims

I do not have any claims to report within the past 5 years

Applicant Signature:

Date:

Save Cancel

Add Malpractice Claim Next Previous

Malpractice Claims

Patient:

Allegation:

Relationship To Patient:

Defendant Type:

Defendant Type Other:

Incident Date:

Incident Location:

Incident County:

Incident State:

Insurance Carrier:

Defense Attorney:

Additional Defendants:

Patient Care:

Claim Status:

Closed Status:

Term Date:

Judgment Status:

Judgment Date:

Settlement Amount:

Reserved Amount:

Save Cancel

**If you do not type in a signature your application will not be processed.**

# REAPPT – SCREEN 10 PROFESSIONAL REFERENCE

- Go through the list of references and make sure that the Provider still wants to use this information for professional references.
- Select “edit” on each reference and make sure that we have an updated/current email address for every reference, select Active.
- Once all reference information has been entered/updated, hit next.

Professional References

Add Reference Next Previous

Professional references are required by hospital surveyors and a questionnaire with specific required questions will be mailed to these practitioners. **List five (5) practitioners in your same professional discipline (e.g. physician to physician, APRN to APRN, PA to PA, LSCSW to LSCSW, etc.),** who have personal knowledge of your current clinical abilities, ethical character, health status, and who will provide specific written comments on these matters upon request from the hospital and medical staff authorities. The named providers must have acquired the requisite knowledge through recent observation of your current practice over a reasonable period of time. **None of the individuals that are used for a professional reference should be related to you by a family relationship.** (Possible sources include: Chief of training program, department chair / chief, proctor, mentor, or practitioners in the same specialty). It would be helpful if you could notify these individuals that a professional reference request will be made and request they be attentive to the request. **We must have all contact information.**

Professional References

First Name	Middle Name	Last Name	Professional Suffix
<input type="text"/>	<input type="text"/>	<input type="text"/>	Select
Address Line 1	Address Line 2		
<input type="text"/>	<input type="text"/>		
City	State	Zip Code	
<input type="text"/>	Select	<input type="text"/>	
Phone	Fax	Email	
<input type="text"/>	<input type="text"/>	<input type="text"/>	

Active  Please mark this box if this person can be used as a **current** professional reference. You must have at least 3 references marked active. **Please note that if this box is not checked, the reference will NOT be contacted.**

Save Cancel

# REAPPT– SCREEN II APPLICANT INFORMATION

- Answer all questions on this page.
- If you answer 'yes' to any of these questions, an explanation is required.
- When complete, hit next.



## Applicant Information

Save Next Previous

Cancel

If any of the following questions are answered in the affirmative "yes", please provide a full explanation. If the question does not apply to you, please mark "no."

Have any of the following been voluntarily or involuntarily relinquished, denied, revoked, suspended, not renewed, canceled, placed on probation, subject to disciplinary action, terminated, restricted, sanctioned, limited, reduced, loss of, abolished, excluded assessed penalties; or have you been reported to, had any challenges to, or have proceedings toward any of those ends ever been instituted, or voluntary or involuntarily relinquished any items to these organizations while under investigation of, or in anticipation of any of these actions?:

State License(s) to practice your profession  Yes  No

Controlled Substance Registration Certificate (DEA, CDS, BNDD, etc)  Yes  No

Hospital Staff Membership/Clinic Privileges  Yes  No

Professional Organization Membership or Employment (Local, State, Federal, Foreign)  Yes  No

Medicare/Medicaid or other Government program Participation, HMO, PPO, or other Insurance Plan or Agency Participation  Yes  No

Board/Specialty Certification  Yes  No

Professional Liability Insurance  Yes  No

A. Has your application ever been withdrawn for affiliation or reappointment or renewal of affiliation or for clinical privileges, or renewal of clinical privileges while the application was pending?  Yes  No

B. Have you been denied membership on a hospital medical staff or advancement in medical staff status, or has such a denial ever been recommended by a standing medical staff committee or governing body?  Yes  No

C. Has your request for any specific clinical privilege been denied or granted with stated limitations (aside from ordinary initial requirements of sponsorship) or has such a denial or limitation been recommended by a standing committee or governing body?  Yes  No

D. Do you currently have any limitations to your practice (i.e., patient population, hours, etc.)  Yes  No

If Yes enter an explanation

E. Have you been under investigation by any government agency or department thereof relating to your practice of medicine?  Yes  No

F. Have you been convicted, plead guilty, (court martialled), to a felony, misdemeanor, or any offence reasonably related to your qualifications, functions, or duties as a medical professional, or any offence which is an essential element of fraud, dishonesty, any act of violence or are you under investigation or indictment for an alleged crime in the USA or a foreign country?  Yes  No

G. Have you ever been sanctioned by, charged by, or adversely listed by any federal, state, or local social service agency for any reason?  Yes  No

H. For any reason are you unable to exercise the privileges you have requested and all the services required by the applicable participating practitioner agreement, with or without reasonable accommodations, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?  Yes  No

I. Are you at present named or have you been a party to a professional malpractice suit in which a judgment of liability was entered against you or which was resolved by a settlement from you or your insurer?  Yes  No

J. Are you currently, or have you been a defendant in any civil action or had issues related to qualifications, competence, functions, or duties as a medical professional, or for alleged fraud, or charged in any criminal action arising from an act of violence, child abuse, sexual offense, or sexual misconduct?  Yes  No

K. Have you changed liability insurance carriers in the past five years?  Yes  No

L. Do you currently use illicit drugs, prescription drugs not dispensed, prescribed, or administered by another licensed health care provider, or other chemical substance that would affect your ability to safely exercise the privileges you have requested, and all the services required by the applicable participating facility(ies)?  Yes  No

M. Have you received or been advised to seek treatment for any mental, physical condition (including infectious diseases), or alcohol/drug/chemical dependencies that would affect your ability to safely exercise the privileges you have requested and all the services required by the applicable participating facility(ies)?  Yes  No

Save Next Previous

Cancel

## REAPPT – SCREEN 12 FACILITIES

- Select the facilities where you want to reappoint.
- You will only see facilities listed where you currently hold privileges.
  - For example, if you have privileges at Ellinwood, Cypress, and Medicine Lodge – you will only see these three facilities listed.
- If you are not renewing at a facility, select the “Remove” checkbox.
- Once all facilities have been selected, hit next.

### Facilities

Next Previous

**Remove**

Ellinwood District Hospital - Ellinwood, KS 67526-1440

Cypress Surgery Center - Wichita, KS 67226

Medicine Lodge Memorial Hospital - Medicine Lodge, KS 67104

# REAPPT – SCREEN 13 DOCUMENTS

- This screen is where you will upload all your documents.
- Click on the upload button to attach the document to your application – only one upload per slot is allowed
- All required documents are marked yes – you will not be able to submit your application without all these uploaded.
- Once all documents are uploaded, hit next.

Documents		
Required	Document	Upload Date/Time
Yes	Current Malpractice Certificate of Insurance	<a href="#">Upload</a>
	MPR - Application Addendum	<a href="#">Download</a> <a href="#">Upload</a>
	MPR - Authorization to Release Information	<a href="#">Download</a> <a href="#">Upload</a>
	Kansas Healthcare Stabilization Fund Certificate (MD, DO, DC, DPM, CRNA, PA, NMW, and DDS practicing in Kansas)	<a href="#">Upload</a>
	Life Support Certificates	<a href="#">Upload</a>
	Certificates/Other Supporting Documentation	<a href="#">Upload</a>
	Satanta District Hospital - Reappointment Paperwork.pdf	<a href="#">Download</a> <a href="#">Upload</a>

# REAPPT – SCREEN 14 SUBMIT AND SIGN


- If your application has all the required information and documents, you will see green checkmarks next to each section title and can click and submit.
- If you have a red X, you will need to revisit that page and complete the required information.
- After you have all green checkmarks, you can type in your signature and date of completion.
- **At this point, you may be required to submit a payment before you can complete the application.**

Sign and Submit Initial Appointment Application

Previous

- ✓ Personal Information
- ✓ Hospital Affiliations
- ✓ Certifications
- ✓ CME/CEU Credits
- ✓ Licensure
- ✓ DEA/BNDD Reg
- ✓ Liability Insurance
- ✓ Malpractice Claims
- ✓ References
- ✓ Application Information
- ✓ Facilities
- ✓ Documents

Applicant Signature



Signature Date

11/10/2022

Submit Cancel

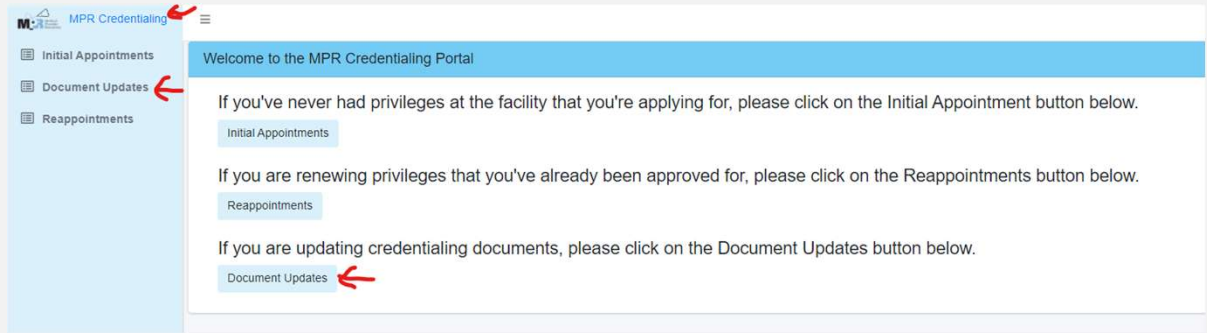
**PLEASE NOTE:** Once you hit submit, you cannot go back and make changes or upload documents. All required documents must be uploaded before you submit your application!!

**CONGRATULATIONS!  
YOU HAVE COMPLETED A REAPPOINTMENT  
APPLICATION!**

Next, we will go over completing Document Updates.

# DOCUMENT UPDATES

- There are two ways to get the document update section.
  - First, you can select “MPR Credentialing” in the upper left corner. Next, select “Document Updates”
  - Second, you can select “Document Updates” on the left side of the screen.
- Once in Document Updates, if you have any upcoming expirable documents, you will see your name here.
- Select the “edit” button on the far right of the screen on the provider you wish to update.



The screenshot shows a table titled 'Document Updates Queue'. It has a checkbox for 'Include Unsubmitted' which is checked. The table has five columns: 'Expiration Date', 'Last Name', 'First Name', 'Submit Date', and 'Processed Date'. There is also a 'Term Date' column. The table contains ten rows of data, all with an expiration date of 01/09/2023. The last name and first name columns are redacted with black boxes. Each row has an edit icon (a pencil) on the far right. At the bottom of the table, there is a pagination control showing '1 2 3 4 5 Next'.

Expiration Date	Last Name	First Name	Submit Date	Processed Date	Term Date
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			
01/09/2023	[REDACTED]	[REDACTED]			

# DOCUMENT UPDATES

- Once in this screen, will see a list of expired Malpractice Policies that MPR has on file for you that need to be renewed.
- Select “edit” and update the Policy Information.
- Select Upload Document and upload the new document.
- PLEASE NOTE: After choosing file, you will need to select “upload” before you hit exit.
- Repeat this for all document updates you have.



Document Updates - Professional Liability Insurance

Add Insurance Next

Edit Upload Document

Carrier	Agent Name			
Phone	Fax			
(877) 974-2742				
Policy Type	Policy Number	Effective From Date	Effective To Date	Inactive
Group		01/01/2022	01/01/2023	<input type="checkbox"/>

Add Insurance Next Previous

Upload File

1. Choose File.
2. Upload.
3. Exit when finished uploading.

Choose File No file chosen

Upload

Exit

Notices are set to go out automatically and will become more frequent as the document expiration date approaches.

**CONGRATULATIONS!  
YOU HAVE COMPLETED DOCUMENT UPDATES!**

We hope that this was helpful and we appreciate your patience with us as we work on the bugs in our application system. If you have any questions or issues, please contact us – we are more than happy to help!

## Extra Information, Tips, and Tricks

- When registering, you will get the message that we will process your registration.
  - We go through the requests individually so it will not be an immediate response – please don't register more than once as this causes delay.
  - Once the registration is approved, you should get an automatic notice with a link to set your pin and password. This does not always come through, so you will also get an email from Sinda Nispel-Borboa with further instructions.
- For Credentialing Agents – when adding a provider to your roster – **DO NOT USE YOUR EMAIL ADDRESS.** Our system only allows one email per registration. By using the credentialing agent email in the provider email account, it locks both accounts and the registration cannot be approved.
- Initial and Reappointment – if you do not upload current CMEs (with the exception on recent graduates) we cannot complete the application. There are two spots to upload CMEs – please use one of these!

## CONTACT INFORMATION

If you have any further questions, please do not hesitate to contact us.

Sinda Nispel-Borboa at [sindanispel-borboa@mprcred.com](mailto:sindanispel-borboa@mprcred.com) or (316) 221-8279

Gennefer Muzzy at [gennefermuzzy@mprcred.com](mailto:gennefermuzzy@mprcred.com) or (316) 500-1304

For Document Updates, contact [documentupdates@mprcred.com](mailto:documentupdates@mprcred.com)