SALESFORCE CLINICAL EXTENDER SUBMISSION
ANESTHESIOLOGIST ASSISTANT (AA) or
CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)

https://login.salesforce.com/

The following information is specific to what Audit, Compliance & Education needs in order to assign a CU Medicine billing number.

1. Department will create/update a Clinical Extender record within Salesforce* and attach the following documents:

    A. Copy of signed letter of offer or FRF (required)
    B. Completed copy of Affidavit of Salary Source** (required)
    C. Copy of master's degree
    D. Copy of AA/CRNA national certification
    E. Copy of DEA (if applicable)
    F. Copy of driver's license
    G. Copy of current Colorado license (DORA)
    H. Copy of CV
    I. Copy of Social Security Card

2. All providers must have a National Provider Identifier (NPI). Full-time faculty must update their NPI to list Shanna Smith as the contact person. If a provider does not have an NPI one must be applied for and issued prior to submitting this request.

3. Once the Salesforce record is complete it will first be submitted to the DFA for review and approval before being submitted to ACE for review and approval.

4. The provider will attend CU Medicine Provider Orientation where he/she will sign paperwork. After this is completed his/her CU Medicine billing number will be activated.

* Salesforce help:
    Becca Morgan
    303-493-8341 direct
    303-968-9312 cell phone
    Rebecca.Morgan@cumedicine.us

** The affidavit of salary source must be updated each time the provider's salary source changes.

******* For packet and instructions on how to obtain hospital privileges, please contact the Medical Staff Offices at Children's Hospital Colorado or University of Colorado hospital.

Medicine

ANCILLARY PERSONNEL
AFFIDAVIT OF SALARY SOURCE

Name _____

Title _____

Department_____

Specialty_____

Sources of Salary:
(Please attach a copy of the FRF and complete below. If a portion of the salary is paid from a grant, please attach a copy of the grant.)

SOURCE (Account #)	**EFFECTIVE DATE** (Enter date)	**AMOUNT**	**GRANT NUMBER**
_____	_____	**$**_____	_____
_____	_____	**$**_____	_____
_____	_____	**$**_____	_____
	Total	**$**_____	

Percentage of time spent in patient care _____%.

Approvals:
The above individual functions in the capacity of ancillary personnel, and their salary is not reported on any hospital cost reports. In addition, the above individual does not receive any portion of base salary from a grant that provides reimbursement for patient care services. No change in the sources of salary will be made without written notification given to CU Medicine.

Department Chairman: Name _____

Signature_____

Date_____

Associate Dean – Finance and Administration – School of Medicine:

Signature_____

Date_____