WellCare

Collaborative Practice Information for Allied Health Professional Dependent Practitioners

Name of Allied Health Professional License Type Specialty

Location where member services are to be provided:

Type of member services to be provided:

Name of Collaborating Physician (please print) Specialty

Signature of Collaborating Physician Date

Collaborating Physician is a Plan participating provider ☐ Yes ☐ No

A copy of t he protocol submitted to the state licensing body may be substituted for this form.

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Practitioner Name: _____

APPLICANT'S RELEASE AND HOLD HARMLESS

By applying for participation, I accept the following conditions. These conditions shall remain in effect for the duration of any term of participation I may be granted:

I acknowledge that the Company may at its sole discretion share or disclose the information provided in the credentialing and re-credentialing process to affiliates and subsidiaries or other related entities of WellCare Health Plans, Inc.

(1) I extend immunity to, and release from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures involving me, which are made, taken or received by the Company or its authorized representatives, in good faith, relating, but not limited to matters or inquiries concerning professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, ethics or behavior; or any other matter that might directly or indirectly have an effect on my competence, on patient care or on the orderly operation of this health care organization.

(2) I authorize the Company and its authorized representatives to consult with any third party who may have information bearing on my professional qualifications (credentials). This authorization includes the right to inspect or obtain clinical privileges, documents, recommendations, reports, statements or disclosures relating to such questions. I also expressly authorize said third parties to release this information to the Company and its authorized representatives upon request.

(3) The term "Company and its authorized representatives" means any of the following individuals who have any responsibility for obtaining or evaluating my credentials or acting upon my application:

a. members of the Board and its appointed representatives;
b. the Chief Executive Officer or his/her designee;
c. all appointees to medical staff committees;
d. other Company employees;
e. consultants to the Company;
f. the Company's attorney and members of his/her firm, associates or designee;
g. any delegated or sub delegated agency with which the Company contracts for credentialing purposes.

(4) The term "third parties" means the following:

a. government agencies;
b. malpractice insurance carriers;
c. peer references;
d. hospital affiliations;
e. any delegated or sub-delegated agency with which the Company contracts for credentialing purposes.

_____ _____

SIGNATURE OF APPLICANT DATE

_____

PRINTED NAME