Provider Application

CORRECT NUMBERS AND LETTERS A	ВС	1 2 3	3 CORRE	ст Х	INCORRECT MARKS	Ž .	•	COM	I AUTOMATI MON ABBRE CORRECTI	VIATIONS, A	AND ZIP CO	DE MATCH	IING. PLEASI	=	
Instructions Read all instructions carefully prior to submitting your application.	2. Use a 3. Print le 4. Do not 5. Compl 6. Some	ete only the blue or blue or blue or blue or blue egibly and enter mo ete all sections.	sing delays his application ack ink ball-painside the bound than 1 chapter ctions that ar "codes" to has asterisks (*)	point pen coxes provi- aracter per re applicabaselp you ea	only. Do no ded based r box. If no le to you. asily report	ot use a d upon ecessa t inform	a penc the ex ry, wri	il or a fe amples te outsid (e.g., sch	It-tip pen. given abov le the prov nools, lang	ve. vided spac guages). (ces. Code lists	are fou			
SECTION 1	Persona	l Inform	nation and	d Profes	sional I	Ds									
Provider Type			st is found on parted 3-digit code d.*			Y	ES	NO	E.G. PATHO	LOGISTS, A	NESTHESI	OLOGISTS	E INPATIENT , ER PHYSIC ASSISTANT,	IANS, NUF	
Name Do not use nicknames															
or initials, unless they are part of your legal	LAST NAME*												St	JFFIX (JR, I	11)
name.															
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General															
Information	GENDER*	MALE	E FEMA	LE		DATE O	F BIRTI	4* M	M D	DY	ΥΥ	Υ			
Only enter a Foreign National Identification															
Number if you do not have a SSN. Do not															
enter National Provider Identification (NPI) Number here.	CITY OF BIRTH	'									STATE (BIRTH		COUNTRY OF BIRTH		
Code lists are found on pages 36-43. Enter the	SSN*					FORE	GN NAT	IONAL IDEI	NTIFICATION	NUMBER (FN	IIN)		FNIN COUNT	RY OF ISS	UE
associated 3-digit code in the space provided.	ENTER ALL NO LANGUAGES Y														
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Home Address															
	NUMBER		STREET										APT NUMBER		
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	CITY										STATE		ZIP CODE		
	TELEPHONE														
NOTE: CAQH will use this method for application follow-up.	E-MAIL														
The second secon	FAX							PREFERR	ED METHOD	OF CONTA	CT*	E-MAIL	FAX		
						20	76								

	* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REC	QUIRE FOLLOW-UP.
Section 1	Personal Information and Professional IDs (Continu	ued)
Professional IDS Include all state licenses, DEA Registration and State Controlled Dangerous	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE
Substance (CDS) certification numbers.		
Provide all current and previous licenses/ certifications.	CDS CERTIFICATE NUMBER CDS STATE OF REGISTRATION	CDS ISSUE DATE M M D D Y Y Y Y CDS EXPIRATION DATE
Non-licensed	CDS STATE OF REGISTRATION	CDS EXPIRATION DATE
professionals should enter certification/ registration number in the space provided for license number.	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? NO	LICENSE ISSUING STATE M M D D Y Y Y Y LICENSE ISSUE DATE M M D D Y Y Y Y
If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	LICENSE STATUS LICENSE TYPE	Code list is found on page 36; use provider type codes. Enter 3
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? NO	LICENSE ISSUING STATE MM MDDYYYYY LICENSE ISSUE DATE MM DDYYYYY LICENSE EXPIRATION DATE
	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS LICENSE TYPE	Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
Other ID Numbers If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.		THOUT HYPHENS) THOUT HYPHENS) THOUGH AND A HARM THE STATE AND A HARM T
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Section 2	Education and Training
Undergraduate	UNDERGRADUATE SCHOOL
School(s)	
Provide the appropriate information for the	OFFICIAL NAME OF UNDERGRADUATE SCHOOL
school that issued your undergraduate degree	
and all schools attended.	ADDRESS
allonada.	
	CITY STATE ZIP/POSTAL CODE
Professional	CITY STATE ZIP/POSTAL CODE
School(s)	
Provide the appropriate information for the	COUNTRY TELEPHONE FAX
school that issued your	
professional degree.	START DATE END DATE (GRADUATION DATE) DEGREE AWARDED
Fifth Pathway Graduates please complete the following sections: U.S. School that issued your	DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? YES NO
certificate, the Non-U.S. School where you	GRADUATE TYPE*:
attended, and the Fifth Pathway institution where you completed your training on	U.S. OR CANADIAN GRADUATE NON-U.S./CANADIAN GRADUATE FIFTH PATHWAY GRADUATE
Supplemental Page 20.	U.S. OR CANADIAN SCHOOL
Code lists are found on pages 36-43. Enter the associated 3-digit code	SCHOOL CODE (U.S./ CANADIAN ONLY) NAME OF U.S./ CANADIAN SCHOOL:
in the space provided. If you have additional	MMYYYY
Undergraduate or Professional Schools to report, use the	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS YES NO
Education Supplemental Form on page 20.	SCHOOL?
	NON - U.S. OR CANADIAN SCHOOL
	OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL
	ADDRESS
	CITY COUNTRY POSTAL CODE
	START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED
	DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? YES NO

ion. INSTITUTION/HOSPITAL NAME (USE BOTH LINES IF REQUIRED) In all ining NUMBER STREET COUNTRY TELEPHONE COUNTRY TELEPHONE DID YOU COMPLETE THIS TRAINING PROGRAM AT THIS YES NO NOTIFY (IF NOT, PLEASE USE THE SPACE BELOW TO EXPLAIN.) List each department separately, if applicable. List Internship/ Residency, Fellowship and Other programs separately. DEPARTMENT/SPECIALTY (DO NOT ABBREVIATE) NAME OF DIRECTOR NAME OF DIRECTOR NAME OF DIRECTOR START DATE NAME OF DIRECTOR NAME OF DIRECTOR START DATE NAME OF DIRECTOR NAME OF DIRECTOR START DATE		and Trai	ıııııg	(001)	illiue	u)														
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Section 3	Professio	nal / M	ledical	Specia	lty Ir	form	nation	1												
Primary Specialty	SPECIALTY				INITIA FICATIO DAT	N M	М	D [Y	/ Y	<u> </u>		/	BI TH	O YOU WISH TO E LISTED IN HE DIRECTORY NDER THIS	НМО		YES	1	NO
Code lists are found on pages 36-43. Enter the	BOARD CERTIFIED?	YES	NO	RECERTI	DAT	E	М)	Ί	<u> </u>			SI	PECIALTY?	PPO		YES	ı	NO
ssociated 3-digit code n the space provided.	CERTIFYING BOARD			EXPIRAT (IF APP	ON DAT		М	D [)	/ \	/	Y \	<u> </u>			POS		YES		NO
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Secondary Specialty	SPECIALTY			CEI	RTIFICAT	TIAL TION ATE	Л М	D	D	Υ	Υ	Υ	Υ		DO YOU WISH T BE LISTED IN THE DIRECTOR	HM	0	YES		N
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pages 36-43. Enter the associated 3-digit code in the space provided.	CERTIFYING BOARD				ATION D		и М	D	D	Υ	Υ	Υ	Υ			POS	S	YES		N
If you have additional Professional / Medical Specialties to report,	IF NOT BOARD		RESULTS				I INTE	END TO	SIT F	OR AN						INTEND TO		м.		_
use the Additional Specialties Supplemental Form on	CERTIFIED (SELECT ONE)	PENDIN	IG FOR			N	 /1 М	D	D	Υ	Υ	Υ	Υ							
page 22.	IF YOU INDICATI	ED THAT YO	OU DID NOT	INTEND TO T	AKE A C	ERTIFY	NG BOA	RD EXA	M, PL	EASE	JSE T	HE								
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Section 3	Professi												OW-01 .										
Certifications	Do you hold t	the following	certific	cations	? If y	es, pro	vide e	xpirat	on da	ates.													
				EXPIRA	TION	ATE					ADV	I IEE				EXP	IRATIO	ON DAT	ΓE				
	BASIC LIFE SUPPORT?*	YES	NO	M	М	D D	Υ	Υ	Υ	Υ		ORT IN		YES	NO	M	M	D	D	Υ	Υ	Υ	Υ
	CPR?*	YES	NO	М	M	D D	Υ	Υ	Υ	Υ	LIFE	TRAUMA ORT?*		YES	NO	M	M	D	D	Υ	Υ	Υ	Υ
	ADV CARDIAC LIFE SPT?*	YES	NO	М	М	D D	Υ	Υ	Υ	Υ	ADVA	ATRIC INCED SPT?*		YES	NO	M	M	D	D	Υ	Υ	Υ	Υ
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Provide additional areas of professional practice interest,																							
activities, procedures, diagnoses or populations.																							
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CHECK HERE TO																							
JSE THE OFFICE MANAGER AND	FIRST NAME																						M.I.
ADDRESS OF THE PRIMARY PRACTICE LOCATION AS THE																							
CREDENTIALING NFORMATION.	NUMBER		8	STREET															SUITE	/BUILI	DING		
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Even if you checked the boxes above,	TELEPHONE							FAX															_
please provide the e-mail address, if available.	E-MAIL ADDRES	ss																			Ш		
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 4	Practice	e Loca	tion Ir	nform	atio	n																			
Primary	NOTE: IF YOU CREDENTIAL	J INDICATE	D THAT Y	YOU PRA	ACTICI BOVE.	E EXCL SECTION	USIVEL'	Y WIT	THIN T	THE IN	PATIE NK. YO	NT SE	TTING	ON I	PAGE D TO	1, YC SECT	U ARE	ON P	Y REC	QUIRE 1.	р то с	COMPL	ETE T	HE	
Practice Location	CURRENTLY				ı	F NO, W	HAT IS		_		_														
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If you have additional																									
practice locations, use the Supplemental	PHYSICIAN GI	POLID / DD /	CTICE NA	ME TO A	DDEAD	IN DIPE	CTORY	(DO I	NOT A	BBDE\	(IATE)*														
Practice Location Information Form on	THISICIAN	KOOI 71 KA	OHOL NA	INIE TO A	LAN	IN DIKE	CTORT	(501	101 A	BBIKE															
pages 25-29.																									
NOTE: "O are a real	GROUP / COR	PORATE NA	AME AS IT	APPEAR	SONV	V-9, IF D	IFFERE	NT FR	OM A	BOVE	DO NO	T ABB	REVIA	(TE)						1					
NOTE: "General Correspondence" refers																									
to any correspondence that might be sent to the	NUMBER*			STREET	*																SUIT	E/BUIL	DING		
provider that does not solely relate to creden-																									
tialing or billing	CITY*																	STA	TE*		ZIP C	ODE*			
information.	SEND GENER CORRESPON- DENCE HERE?		YES	NO							-														
TIP Your Individual Tax ID is assumed to be	DENCE HERE				TE	LEPHON	IE*									FAX									
your Primary Tax ID unless you specify																									
otherwise to the right.	OFFICE E-MAI	L ADDRES	s																						
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	INDIVIDUAL T	AX ID					GRO	JP TA	X ID								(ONE	UNLT)							
Office Manager									1																
or Business																									
Office Staff Contact	LAST NAME*								1																
List each contact separately. You may	FIRST NAME*						_																		M.I.
use the check boxes below for convenience.																									
Do not write instructions like "see	TELEPHONE*							FAX																	
above". These																									
responses will be rejected and will	E-MAIL ADDR	ESS																							
require follow-up.																									
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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 4 **Practice Location Information** (Continued) DO MID-LEVEL PRACTITIONERS (NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, ETC.) CARE FOR PATIENTS IN YOUR PRACTICE?* **Mid-Level** YES NO **Practitioners** (IF YES, PLEASE PROVIDE THE INFORMATION BELOW) PRACTITIONER LAST NAME PRACTITIONER FIRST NAME МΙ PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER FIRST NAME M.I. PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER FIRST NAME мі PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER FIRST NAME PRACTITIONER STATE PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER LAST NAME PRACTITIONER FIRST NAME M.I. PRACTITIONER TYPE (E.G., PA, CNP, NP) PRACTITIONER LICENSE / CERTIFICATE NUMBER PRACTITIONER STATE

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 4 **Practice Location Information** (Continued) LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE Partners/ **Associates** Code lists are found on COVERING LAST NAME SPECIALTY pages 36-43. Enter the COLLEAGUE (Y/N)? associated 3-digit code in the space provided. FIRST NAME PROVIDER TYPE If you have additional partners/associates at THIS location, use the Partner/Associate COVERING LAST NAME SPECIALTY Supplemental Form on COLLEAGUE page 23. Photocopy as necessary. Be certain to check "Primary FIRST NAME PROVIDER TYPE Location" at the top of the page. SPECIALTY LAST NAME COVERING COLLEAGUE (Y/N)? FIRST NAME PROVIDER TYPE LIST ALL COVERING COLLEAGUES THAT ARE NOT PARTNERS/ASSOCIATES AT THIS PRACTICE Covering **Colleagues** Code lists are found on SPECIALTY LAST NAME pages 36-43. Enter the associated 3-digit code in the space provided. FIRST NAME PROVIDER TYPE If you have additional covering colleagues that are not partners at THIS location, use the Covering Colleagues SPECIALTY LAST NAME Supplemental Form on page 24. Photocopy as necessary. Be certain FIRST NAME to check "Primary PROVIDER TYPE Location" at the top of the page. SPECIALTY LAST NAME FIRST NAME PROVIDER TYPE Section 5 **Hospital Affiliations** DO YOU HAVE HOSPITAL IF YOU DO NOT ADMIT PATIENTS, WHAT **Admitting** TYPE OF ADMITTING ARRANGEMENTS DO **Arrangements** PRIVILEGES? YOU HAVE? 3087

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 5 Hospital Affiliations (Continued) PRIMARY HOSPITAL Hospital **Privileges** If applicable, list all HOSPITAL NAME hospital affiliations. List primary hospital, then other current NUMBER SUITE/BUILDING STREET affiliations, followed by previous affiliations in chronological order. CITY STATE ZIP CODE If you have additional hospital privileges, use the Supplemental TELEPHONE Hospital Privileges Form on page 30. **DEPARTMENT NAME** DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S FIRST NAME ARE PRIVILEGES TEMPORARY? **FULL, UNRESTRICTED** YES NO YES NO PRIVILEGES? TIP Be certain your AFFILIATION START DATE AFFILIATION END DATE admission percentages OF YOUR TOTAL ANNUAL % add up to 100% for ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? current hospitals. ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY) Otherwise, you will have to correct this OTHER HOSPITAL error. HOSPITAL NAME NUMBER SUITE/BUILDING CITY ZIP CODE STATE **TELEPHONE** DEPARTMENT NAME DEPARTMENT DIRECTOR'S LAST NAME DEPARTMENT DIRECTOR'S FIRST NAME FULL, UNRESTRICTED PRIVILEGES? ARE PRIVILEGES TEMPORARY? YES YES NO AFFILIATION START DATE AFFILIATION END DATE OF YOUR TOTAL ANNUAL % ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED. PROVISIONAL. TEMPORARY) PLEASE EXPLAIN TERMINATED AFFILIATION

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 7 Work History and References (Continued) **Work History** Do not list current positions. Those TELEPHONE should be listed in Section 4. Include a chronological COUNTRY START DATE END DATE work history for the REASON FOR DEPARTURE (IF APPLICABLE) past 10 years. A longer period may be required by your healthcare entity If you have additional work history, use the **WORK HISTORY** Supplemental Work History Form on page PRACTICE / EMPLOYER NAME NUMBER SUITE/BUILDING CITY STATE ZIP/POSTAL CODE TELEPHONE COUNTRY CODE START DATE **END DATE** REASON FOR DEPARTURE (IF APPLICABLE) WORK HISTORY PRACTICE / EMPLOYER NAME SUITE/BUILDING NUMBER STREET CITY ZIP/POSTAL CODE TELEPHONE START DATE REASON FOR DEPARTURE (IF APPLICABLE)

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* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 8 **Disclosure Questions Disclosure** LICENSURE Questions Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, YES denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any con-Answer all questions. ditions or limitations by any state or professional licensing, registration or certification board?* For any "Yes" response, provide an YES NO Has there been any challenge to your licensure, registration or certification?* explanation on the Supplemental Disclosure Question HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS Explanation Form on Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever page 34. been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for YES reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, Allied Health or governing board?* **Providers** YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?* If you are an Allied Health Provider and you do not believe a Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action. YES question is applicable by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?* to you, you should answer the question **EDUCATION, TRAINING AND BOARD CERTIFICATION** "NO". Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, resi-YES dency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?* NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status YES as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?* YES NO Have any of your board certifications or eligibility ever been revoked?* 8. 9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?* DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been chal-10. YES lenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?* MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or other-YES wise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?* OTHER SANCTIONS OR INVESTIGATIONS Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa-12. YES tion or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?* To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare 13 YES Integrity and Protection Data Bank?* Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, 14 YES NO OSHA, etc.)?* Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or 15. YES NO resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or 16. YES agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?* PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your YES individual liability history?* Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance 18 YES carrier, based on your individual liability history?*

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

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YES

YES

accommodation?

Section 8 **Disclosure Questions** (Continued) **Disclosure** MALPRACTICE CLAIMS HISTORY Questions Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* YES 19 Answer all questions. If yes, provide information for each case. For any "Yes" response, provide an **CRIMINAL/CIVIL HISTORY** explanation on the Supplemental Disclosure Question NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?* 20. YES Explanation Form on page 34. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor YES NO traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, compe-21. **IMPORTANT** If you answered "Yes" tence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual to question #19, you must complete the YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?* Supplemental Malpractice Claims Explanation Form on Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or page 35 for each credentialing organization based upon all the relevant circumstances, including the nature of the crime. malpractice claim. **ABILITY TO PERFORM JOB** Are you currently engaged in the illegal use of drugs?* YES ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the func-YES 24. tions of your job with reasonable skill and safety?*

NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agents; the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the application, Attestation and Release is

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*	Name (print)*	
M M D D Y Y Y		
DATE SIGNED*		
	3094	

Professional IDs Supplemental Form

* REQUIRED RESPONSE (IF THIS PAGE IS USED). NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

Section 1	Personal Information and Professional IDs	
Professional IDs Include all additional state licenses, DEA Registration and State Controlled Dangerous	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE
Substance (CDS) certification numbers. Provide all current and previous licenses/ certifications. If you need to report additional Professional IDs, photocopy this page as needed and submit as instructed.	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION CDS CERTIFICATE NUMBER	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE CDS ISSUE DATE
	CDS STATE OF REGISTRATION	M M D D Y Y Y Y CDS EXPIRATION DATE
	CDS CERTIFICATE NUMBER CDS STATE OF REGISTRATION	M M D D Y Y Y Y CDS ISSUE DATE M M D D Y Y Y Y CDS EXPIRATION DATE
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? Code list is found on page 36; use license status codes. Enter 3-digit code in space provided.	LICENSE ISSUING STATE M M D D Y Y Y Y LICENSE ISSUE DATE M M D D Y Y Y Y LICENSE EXPIRATION DATE Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	LICENSE STATUS LICENSE TYPE STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? NO	LICENSE ISSUING STATE M M D D Y Y Y Y LICENSE ISSUE DATE M M D D Y Y Y Y
	Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS LICENSE TYPE	LICENSE EXPIRATION DATE Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.

Section 5	Hospital Affiliations
Hospital Privileges	OTHER HOSPITAL
Use this form to continue listing hospitals where you currently have privileges.	HOSPITAL NAME
	NUMBER STREET SUITE/BUILDING
If you need to report additional space for Hospital Privileges,	CITY STATE ZIP CODE
photocopy this page as needed and submit as instructed.	TELEPHONE FAX
TIP Be certain your admission percentages	DEPARTMENT NAME
add up to 100% for current hospitals. Otherwise, you will have to correct this	DEPARTMENT DIRECTOR'S LAST NAME
error.	DEPARTMENT DIRECTOR'S FIRST NAME
	M M Y Y Y Y M M M Y Y Y FULL, UNRESTRICTED YES NO ARE PRIVILEGES PRIVILEGES? AFFILIATION START DATE AFFILIATION END DATE
	OF YOUR TOTAL ANNUAL ADMISSIONS, WHAT PERCENTAGE IS TO THIS HOSPITAL? ADMITTING PRIVILEGE STATUS (E.G. NONE, FULL UNRESTRICTED, PROVISIONAL, TEMPORARY)
	PLEASE EXPLAIN TERMINATED AFFILIATION
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I	3105

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