CHAPTER 38C

MANAGED CARE PLANS

Authority

N.J.S.A. 26:2S–7.1 through 7.3.

Source and Effective Date

R.2003 d.456, effective December 1, 2003 (operative May 29, 2004).
See: 35 N.J.R. 355(a), 35 N.J.R. 5378(a).

Chapter Expiration Date

Chapter 38C, Managed Care Plans, expires on December 1, 2008.

Chapter Historical Note

Chapter 38C, Managed Care Plans, was adopted as R.2003 d.456, effective December 1, 2003 (operative May 29, 2004). See: Source and Effective Date.

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SUBCHAPTER 1. PHYSICIAN CREDENTIALING

8:38C–1.1 Scope and purpose

(a) This subchapter applies to all carriers offering managed care plans, and the agents that carriers may use for purposes of credentialing or recredentialing physicians on behalf of the carriers.

(b) This subchapter establishes a credentialing and recredentialing form pursuant to the authority set forth at N.J.S.A. 26:2S–7.1, to be accepted by all carriers offering managed care plans for the purpose of credentialing and recredentialing physicians who seek to participate in a carrier's provider network, including physicians employed by hospitals or other health care facilities.

(c) This subchapter establishes alternative, acceptable means by which carriers offering managed care plans may credential and recredential physicians.

8:38C–1.2 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Carrier" means an insurance company authorized to transact the business of insurance in this State and doing a health insurance business in accordance with N.J.S.A. 17B:17–1 et seq., a hospital service corporation authorized to do business pursuant to N.J.S.A. 17:48–1 et seq., a medical service corporation authorized to do business pursuant to N.J.S.A. 17:48A–1 et seq., a health service corporation authorized to do business pursuant to N.J.S.A. 17:48E–1 et seq., or a health maintenance organization authorized to transact business pursuant to N.J.S.A. 26:2J–1 et seq.

"Credentialing" means the process of collecting and validating the professional qualifications of a physician and evaluating those qualifications against a carrier's standards of qualifications for participation in the carrier's health care provider network for the carrier's managed care plans.

"Credentials data" means information, attachments, or answers to questions required by a carrier to complete the credentialing or recredentialing of a physician.

"Department" means the Department of Health and Senior Services.

"Managed care plan" means a health benefits plan (as health benefits plan is defined at N.J.S.A. 26:2S–1 et seq.), that integrates the financing and delivery of appropriate health care services to covered persons by arrangement with participating providers, who are selected to participate on the basis of explicit standards, to furnish a comprehensive set of health care services and financial incentives for covered persons to use the participating providers and procedures provided for in the plan.

"New Jersey Universal Physician Application" means the form developed by the Department and set forth in the Appendix to this subchapter as Exhibit 1.

"New Jersey Physician Recredentialing Application" means the form developed by the Department and set forth in the Appendix to this subchapter as Exhibit 2.

"Physician" means a person who is licensed by the State Board of Medical Examiners in accordance with the provisions of Title 45 of the Revised Statutes.

"Prepopulate" means to pre-print requested information derived from a database on a form prior to distributing the document to the target population for review, completion and correction, as appropriate.

"Recredentialing" means the process by which a physician's information related to his or her credentials is updated and re-verified for purposes of determining whether the physician shall continue to participate in the carrier's health care provider network.

8:38C–1.3 Credentialing standards

(a) Carriers that offer managed care plans shall accept the New Jersey Universal Physician Application, as set forth in Exhibit 1 of the Appendix to this subchapter and incorporated herein by reference, for the purpose of credentialing physicians who seek to participate in the carrier's network(s).

(b) Carriers that offer managed care plans may continue to use another physician credentialing application form but shall inform physicians that a downloadable version of the New Jersey Universal Physician Application is available through the Department's website www.state.nj.us/health or indicate where physicians may obtain a hard copy of the New Jersey Universal Physician Application.

1. When a physician makes an oral inquiry concerning a credentialing application, then a carrier's response concerning the availability of the New Jersey Universal Physician Application may be oral; however, any mailing of the carrier's credentialing application form as a follow-up to the oral request shall include a written notice referencing the availability of the New Jersey Universal Physician Application, and information on how to access the application.

2. When a physician inquires in writing concerning a credentialing application, then the carrier shall include with its credentialing application form a written notice referencing the availability of the New Jersey Universal Physician Application and information on how to access the application.

3. Carriers shall not require providers to use the carrier's credentialing form in lieu of the New Jersey Universal Physician Application in order to participate in the carrier's network(s).

(c) As an alternative to the requirements set forth in (a) or (b) above, carriers may access information about a physician from a recognized, national credentialing database, data bank or repository of health care providers subject to the following conditions:

1. Carriers shall not require providers to use a national database in lieu of one of the forms set forth in (a) or (b) in order to participate in the carrier's network(s).

2. The database shall include credentialing data commonly requested by carriers, hospitals and other health care entities and credentials verification organizations for purposes of credentialing and shall minimize the need for the collection of additional credentials data.

3. The database shall be accessible to physicians at no cost.

4. The database shall be accessible to physicians through multiple methods including electronic and paper formats.

5. The database shall incorporate adequate security features to ensure that credentials data submitted by physicians and provided for review shall remain confidential, as provided by law, and shall not be released without the written consent of the physician.

i. An electronic signature or other similar alternative that acknowledges the physician's consent to the release of credentials data shall satisfy the written consent requirement.

6. The database shall, at a minimum, collect the following physician credentialing information:

i. Education and degrees;

ii. Specialty, if applicable;

iii. Board certification status;

iv. Hospital affiliations;

v. Office hours;

vi. Whether accepting new patients;

vii. Liability insurance coverage;

viii. Languages spoken;

ix. Professional references; and

x. State and Federal license and/or registration number.

7. The database shall require physicians to provide all information concerning any license actions, sanctions or restrictions; professional sanctions from any source; felony conviction(s) and malpractice claim history from settled or closed case(s).

8. The database shall require the physician to attest to the completeness and accuracy of the information provided.

9. The database shall require primary and secondary source verification for all licenses, board certifications, registrations and insurance.

10. Nothing set forth in this subsection shall preclude a carrier from consulting a national database to verify data submitted in accordance with subsection (a) or (b).

8:38C–1.4 Recredentialing standards

(a) Carriers that offer managed care plans shall accept the New Jersey Physician Recredentialing Application, as set forth in Exhibit 2 of the Appendix to this subchapter and incorporated herein by reference, for the purposes of recredentialing physicians who seek to continue to participate in the carrier's network(s).

(b) A carrier that offers managed care plans may continue to use another physician recredentialing application form for renewal of credentialing if the carrier prepopulates the form with the individual information of each physician to whom the form is sent.

1. Carriers electing to use a prepopulated recredentialing application shall inform physicians of the availability of the New Jersey Physician Recredentialing Application, downloadable through the Department's website www.state.nj.us/health or indicate where physicians may obtain a hard copy of the New Jersey Physician Recredentialing Application.

i. When a physician makes an oral inquiry concerning a recredentialing application, then the carrier's response concerning the availability of the New Jersey Physician Recredentialing Application may be oral; however, any mailing of the carrier's recredentialing application form as a follow-up to the oral request shall include a written notice referencing the availability of the New Jersey Physician Recredentialing Application, and information on how to access the application.

ii. When a physician inquires in writing concerning a recredentialing application, then the carrier shall include with its recredentialing application form a written notice referencing the availability of the New Jersey Physician Recredentialing Application, and information on how to access the application.

2. Carriers electing to use a prepopulated recredentialing application form shall modify the form as necessary to provide physicians with space on the form to correct, add or update any incorrect or missing information.

3. Carriers shall not require a physician to use the carrier's recredentialing form in lieu of the New Jersey Universal Physician Recredentialing Application in order to continue to participate in the carrier's network(s).

(c) Carriers may send the prepopulated form electronically or in paper format, and shall be capable of accepting any revisions to the prepopulated form in the same format in which it was distributed; however, a carrier shall not require that a physician be capable of accepting the prepopulated form electronically, nor shall the carrier require that revisions to the prepopulated form be submitted electronically by a physician.

(d) As an alternative to using the recredentialing form set forth in (a) above or a prepopulated form as set forth in (b) above, carriers may utilize update and recredentialing information obtained from a national credentialing database, data bank or repository of health care providers.

1. The election by the carrier to use a national credentialing database, data bank or other repository of health care providers shall be subject to the conditions set forth at N.J.A.C. 8:38C–1.3(c).

8:38C–1.5 Right to request additional information

(a) Use or acceptance by a carrier of the New Jersey Universal Physician Application form, the New Jersey Physician Recredentialing form or the election by the carrier to obtain information from a national credentialing database, data bank or repository of health care providers shall not be construed to restrict the right of a carrier to request additional information necessary for credentialing or recredentialing.

1. Notwithstanding (a) above, a carrier shall not request information that duplicates information already requested on the New Jersey Universal Physician Application form, or as part of the national credentialing database, data bank or repository of health care providers.

2. A request by a carrier or other qualified entity for primary or secondary source verification shall not be considered a request for duplicative information, or otherwise prohibited.

8:38C–1.6 Enforcement

(a) The Department is authorized to impose the following remedies to enforce the provisions of these rules.

1. Imposition of a monetary penalty for each violation in an amount determined by the Commissioner in accordance with N.J.S.A. 26:2S–16; and/or

2. Other remedies for violations of statutes, as provided by State and Federal law.

EXHIBIT 1

New Jersey Universal Physician Application

(Please type or print)

SECTION 1

Personal Information

Physician Name - Last	First	M.I.	(Jr., Sr., etc.)	Professional Degree(s) (MD, DO, DDS, DMD, DPM, DC)	Social Security Number
Other name used: Years associated with former name:	Other name used: Years associated with former name:			Date of Birth (mm/dd/yyyy)	Gender ☐ Male ☐ Female

HOME Mailing Address	City	State	ZIP Code	Are you eligible to work in the United States? ☐ Yes ☐ No

Practice Location Information

Type of Service Provided: ☐ Primary Care Specialist ☐ Non-Primary Care Specialist

Physician Group Name/Practice Name to appear in the directory		Group/Corporate name as it appears on W-9, if different from Group Name/Practice Name		
Primary Office Address - Street		City	State	ZIP Code
Primary Office Telephone Number	Primary Office Fax Number	Primary Office Email Address		Tax ID Number and Associated Individual Group Number and Name (for this location)

Are you currently practicing at the location above? ☐ Yes ☐ No If No, what is your expected start date? _____

Other Office Address - Street Do you want this site listed in the Directory? ☐ Yes ☐ No		City	State	ZIP Code
Telephone Number	Fax Number	Email Address		Tax ID Number and Associated Individual Group Number and Name (for this location)
Other Office Address - Street Do you want this site listed in the Directory? ☐ Yes ☐ No		City	State	ZIP Code
Telephone Number	Fax Number	Email Address		Tax ID Number and Associated Individual Group Number and Name (for this location)
Correspondence Office Address - Street		City	State	ZIP Code
Telephone Number	Fax Number	Email Address		

If you have additional offices, please submit an attachment containing the above information and check this box ☐

License and Other Identification Numbers

License Information – Include all license(s) and certifications in all States where you are currently or have previously been licensed

	State(s) of Registration	Do you currently practice in this state?	License/Certificate Number	Expiration Date	N/A
License					
License					

Licenses, Continued

DEA Registration Certificate					
CDS Registration Certificate					
Other CDS/DEA (specify)					

UPIN	National Provider Identifier (when available)	Are you a participating Medicare Provider? ☐ Yes ☐ No	Medicare Provider Number(s)	Are you a participating Medicaid Provider? ☐ Yes ☐ No	Medicaid Provider Number(s)
International Medical Graduates: Are you certified by the Educational Council for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No		If yes, ECFMG Number		ECFMG Issue Date	

Medical Education

School Issuing Professional Degree (Medical, Dental Chiropractic)	Degree	Attendance Dates
Address(es)	City	State/Country

If you attended additional schools, please submit attachment containing the above information and check this box ☐

Post-graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment		Institution Name	Address	
City	State/Country	Specialty	Start Date (month/year)	End Date (month/year)
Post-graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment		Institution Name	Address	
City	State/Country	Specialty	Start Date (month/year)	End Date (month/year)
Post-graduate Education ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment		Institution Name	Address	
City	State/Country	Specialty	Start Date (month/year)	End Date (month/year)

If you completed additional training, please submit attachment containing the above information and check this box ☐

Other Graduate Level Education for which a degree was obtained – type of program (Psychology, Public Health, MBA, etc.)		Institution Name	Address
City	State/Country	Degree Obtained	Date of Graduation (month/year)

Professional/Medical Specialty Information

Primary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board

Initial Certification Date	Recertification Date(s) (if applicable)	Expiration Date (if applicable)	Do you wish to be listed in the directory under this specialty? HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No

If not Board certified, indicate any of the following that apply:

☐ I have taken exam, results pending for _____(board)

☐ I am intending to sit for the Boards on _____ (date)

☐ I am not planning to take Boards

Professional/Medical Specialty Information, Continued

Secondary Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board

Initial Certification Date	Recertification Date(s) (if applicable)	Expiration Date (if applicable)	Do you wish to be listed in the directory under this specialty?
			HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No

If not Board certified, indicate any of the following that apply:
☐ I have taken exam, results pending for _____(board)
☐ I am intending to sit for the Boards on _____ (date)
☐ I am not planning to take Boards

Additional Specialty	Board Certified? ☐ Yes ☐ No	Name of Certifying Board

Initial Certification Date	Recertification Date(s) (if applicable)	Expiration Date (if applicable)	Do you wish to be listed in the directory under this specialty?
			HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No

If not Board certified, indicate any of the following that apply:
☐ I have taken exam, results pending for _____(board)
☐ I am intending to sit for the Boards on _____ (date)
☐ I am not planning to take Boards

Additional Areas of Professional/practice interest or focus (HIV/AIDS, etc.) List

Hospital Affiliations and Privileges

Do you have hospital privileges? ☐ Yes ☐ No
If you do not admit patients, what admitting arrangements do you have? _____

If you have privileges, please answer the section below. Include all hospitals where you have privileges.

Primary Hospital where you have admitting privileges	Address	City	State	ZIP Code	Telephone

Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges:	Are Privileges Temporary? ☐ Yes ☐ No	Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?

Other Hospital where you have privileges	Address	City	State	ZIP Code	Telephone

Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges:	Are Privileges Temporary? ☐ Yes ☐ No	Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?

Other Hospital where you have privileges	Address	City	State	ZIP Code	Telephone

Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges:	Are Privileges Temporary? ☐ Yes ☐ No	Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?

Additional Hospital where you have privileges	Address	City	State	ZIP Code	Telephone

Full Unrestricted Privileges ☐ Yes ☐ No	Type of Privileges:	Are Privileges Temporary? ☐ Yes ☐ No	Of the total number of admissions to all hospitals in the past year, what percentage is to this specific hospital?

If you have additional hospital affiliations, please submit attachment containing the information above and check this box ☐

List all other hospitals where you have previously had privileges:

Hospital name	Address	City	State	ZIP Code	Dates of affiliation
Hospital name	Address	City	State	ZIP Code	Dates of affiliation

If you have other previous hospital affiliations, please submit attachment containing the information above and check this box ☐

Work History

Include chronological work history since completion of training

Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date
Practice/Employer Name	Address	City	State	ZIP Code	Start Date/End Date

For additional work history, please submit attachment containing the above information and check this box ☐

Please provide an explanation of any gaps greater than six months in each work history

Date:	Explanation:
Date:	Explanation:

Are you currently on active military duty or on military reserve? ☐ Yes ☐ No

References

Please provide three professional references that are not partners in your own group practice and are not relatives

Name	Address	City	State	ZIP Code

Professional Liability Insurance Coverage

Self-Insured? ☐ Yes ☐ No	Name of Current Malpractice Insurance Carrier or Self-Insured entity		Effective Date	Expiration Date
Address	City	State	ZIP Code	Telephone Number
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier
Name of Previous Malpractice Insurance Carrier if with current carrier less than 5 years			Effective Date	Expiration Date
Address	City	State	ZIP Code	Telephone Number
Policy Number	Amount of Coverage Per Occurrence	Amount of Coverage Aggregate	Type of Coverage ☐ Individual ☐ Shared	Length of time with carrier

Status/Role in Practice

☐ Owner	☐ Partner	☐ Employee
☐ Officer	☐ Shareholder	

Interests in Outside Clinical Lab(s)		
If you own/co-own, or have interests in any other outside clinical lab, please fill in below		
Legal Billing Name	TIN (Attach copy of W-9)	Clinical description
Please provide a summary pattern for this business		

Office Coverage	
(List names of colleague(s) providing regular coverage and his or her specialty(ies).)	
Name	Provider Specialty

Partners	
List full names of all partners in your practice (attach list for large group):	
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)
Name (Last Name, First Name, M.I.)	Name (Last Name, First Name, M.I.)

Other Practice Information (specify for each site)

For additional office sites, please submit attachment containing the information below and check this box ☐

Office Address:	**Office Address:**
Type of Practice: ☐ Solo ☐ Single Specialty Group ☐ Multi-Specialty Group	Type of Practice: ☐ Solo ☐ Single Specialty Group ☐ Multi-Specialty Group
Office Manager or business office staff contact: Name:_____ Phone Number:_____ Fax Number:_____	Office Manager or business office staff contact: Name:_____ Phone Number:_____ Fax Number:_____
Credentialing contact (if different from above): Name:_____ Phone Number:_____ Fax Number:_____ Email:_____ Address:_____ City:_____ State:_____ ZIP Code:_____	Credentialing contact (if different from above): Name:_____ Phone Number:_____ Fax Number:_____ Email:_____ Address:_____ City:_____ State:_____ ZIP Code:_____
Billing Information: Billing representative's name:_____ Address:_____ City:_____ State:_____ ZIP Code:_____ Phone Number:_____ Fax Number:_____ Email:_____ Department Name if Hospital Based:_____ Who check should be payable to:_____ Do you have capability for electronic billing? ☐ Yes ☐ No	Billing Information: Billing representative's name:_____ Address:_____ City:_____ State:_____ ZIP Code:_____ Phone Number:_____ Fax Number:_____ Email:_____ Department Name if Hospital Based:_____ Who check should be payable to:_____ Do you have capability for electronic billing? ☐ Yes ☐ No

Office Business Hours (hours patients are seen):

Day(s)	No Office Hours	Morning	Afternoon	Evening
Monday	☐			
Tuesday	☐			
Wednesday	☐			
Thursday	☐			
Friday	☐			
Saturday	☐			
Sunday	☐			

Office Business Hours (hours patients are seen):

Day(s)	No Office Hours	Morning	Afternoon	Evening
Monday	☐			
Tuesday	☐			
Wednesday	☐			
Thursday	☐			
Friday	☐			
Saturday	☐			
Sunday	☐			

After hours, back office phone number for health plan business use only:_____	After hours, back office phone number for health plan business use only:_____
Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions	Do you provide 24 hour/7 day a week phone coverage for this site? ☐ Yes ☐ No If yes, indicate type: ☐ Answering service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions

Do you accept new patients into the practice? ☐ Yes ☐ No Accept all new patients? ☐ Yes ☐ No Accept existing patients with change of payor? ☐ Yes ☐ No Accept new patients from physician referral? ☐ Yes ☐ No Accept new Medicare patients? ☐ Yes ☐ No Accept new Medicaid patients? ☐ Yes ☐ No If this information varies by health plan, please provide explanation:_____	Do you accept new patients into the practice? ☐ Yes ☐ No Accept all new patients? ☐ Yes ☐ No Accept existing patients with change of payor? ☐ Yes ☐ No Accept new patients from physician referral? ☐ Yes ☐ No Accept new Medicare patients? ☐ Yes ☐ No Accept new Medicaid patients? ☐ Yes ☐ No If this information varies by health plan, please provide explanation:_____
Are there any practice limitations? ☐ Yes ☐ No If Yes, indicate limitations below: Sex: ☐ Male only ☐ Female Only ☐ N/A Patient age limitations (please list ages): ☐ N/A_____ List other limitations:_____	Are there any practice limitations? ☐ Yes ☐ No If Yes, indicate limitations below: Sex: ☐ Male only ☐ Female Only ☐ N/A Patient age limitations (please list ages): ☐ N/A_____ List other limitations:_____
Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐ Yes ☐ No If yes, provide the following information for each staff member: Name:_____ Professional Designation:_____ State License Number:_____ Name:_____ Professional Designation:_____ State License Number:_____ (Please attach a list of any additional mid-level practitioners)	Do mid-level practitioners such as nurse practitioners, physician assistants, midwives, social workers or other non-physician providers care for patients in your practice? ☐ Yes ☐ No If yes, provide the following information for each staff member: Name:_____ Professional Designation:_____ State License Number:_____ Name:_____ Professional Designation:_____ State License Number:_____ (Please attach a list of any additional mid-level practitioners)
Non-English Languages spoken by health care provider:_____ Non-English Languages spoken by office personnel:_____ Are interpreters available? ☐ Yes ☐ No If yes, specify languages:_____	Non-English Languages spoken by health care provider:_____ Non-English Languages spoken by office personnel:_____ Are interpreters available? ☐ Yes ☐ No If yes, specify languages:_____
Does this office meet ADA accessibility standards? ☐ Yes ☐ No	Does this office meet ADA accessibility standards? ☐ Yes ☐ No
Does this site provide handicapped accessibility for each of the following: Building ☐ Yes ☐ No Parking ☐ Yes ☐ No Restroom ☐ Yes ☐ No Other:_____	Does this site provide handicapped accessibility for each of the following: Building ☐ Yes ☐ No Parking ☐ Yes ☐ No Restroom ☐ Yes ☐ No Other:_____
Does this site have other services for the disabled? ☐ Yes ☐ No If yes, indicate type: Text Telephony - TTY ☐ Yes ☐ No American Sign Language - ASL ☐ Yes ☐ No Mental/physical impairment services ☐ Yes ☐ No Other:_____	Does this site have other services for the disabled? ☐ Yes ☐ No If yes, indicate type: Text Telephony - TTY ☐ Yes ☐ No American Sign Language - ASL ☐ Yes ☐ No Mental/physical impairment services ☐ Yes ☐ No Other:_____
Is this site accessible by public transportation? ☐ Yes ☐ No If yes, indicate type: Bus ☐ Yes ☐ No Subway ☐ Yes ☐ No Regional Train ☐ Yes ☐ No Other:_____	Is this site accessible by public transportation? ☐ Yes ☐ No If yes, indicate type: Bus ☐ Yes ☐ No Subway ☐ Yes ☐ No Regional Train ☐ Yes ☐ No Other:_____
Does this site provide childcare services? ☐ Yes ☐ No	Does this site provide childcare services? ☐ Yes ☐ No
Does this office qualify as a minority business enterprise? ☐ Yes ☐ No	Does this office qualify as a minority business enterprise? ☐ Yes ☐ No
Do you or does someone in your office have the following certifications? (indicate for each office location):	
BLS - Basic Life Support? ☐ Yes ☐ No Expiration Date: _____	ACLS - Advanced Cardiac Life Support? ☐ Yes ☐ No Expiration Date: _____
BLS - Basic Life Support? ☐ Yes ☐ No Expiration Date: _____	ACLS - Advanced Cardiac Life Support? ☐ Yes ☐ No Expiration Date: _____

ALSO - Advanced Life Support in OB? ☐ Yes ☐ No Expiration Date: _____	PALS – Pediatric Advanced Life Support? ☐ Yes ☐ No Expiration Date: _____	ALSO - Advanced Life Support in OB? ☐ Yes ☐ No Expiration Date: _____	PALS – Pediatric Advanced Life Support? ☐ Yes ☐ No Expiration Date: _____
ATLS - Advanced Trauma Life Support? ☐ Yes ☐ No Expiration Date: _____	NALS – Neonatal Advanced Life Support? ☐ Yes ☐ No Expiration Date: _____	ATLS - Advanced Trauma Life Support? ☐ Yes ☐ No Expiration Date: _____	NALS – Neonatal Advanced Life Support? ☐ Yes ☐ No Expiration Date: _____
CPR – Cardio-Pulmonary Resuscitation? ☐ Yes ☐ No Expiration Date: _____		CPR – Cardio-Pulmonary Resuscitation? ☐ Yes ☐ No Expiration Date: _____	
Does this site provide any of the following services on site (indicate for each office location):			
Laboratory Services? ☐ Yes ☐ No Certificate of participation from CLIA or another accrediting/certifying program (AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE) program (If yes, please list):_____	Radiology Service ☐ Yes ☐ No X-ray certification? ☐ Yes ☐ No If yes, include Type: _____	Laboratory Services? ☐ Yes ☐ No Certificate of participation from CLIA or another accrediting/certifying program (AAFP, COLA, CAP, Medical Laboratory Evaluation (MLE) program (If yes, please list):_____	Radiology Service ☐ Yes ☐ No X-ray certification? ☐ Yes ☐ No If yes, include Type: _____
EKG's? ☐ Yes ☐ No	Care of minor lacerations? ☐ Yes ☐ No	EKG's? ☐ Yes ☐ No	Care of minor lacerations? ☐ Yes ☐ No
Pulmonary function testing? ☐ Yes ☐ No	Allergy injections? ☐ Yes ☐ No	Pulmonary function testing? ☐ Yes ☐ No	Allergy injections? ☐ Yes ☐ No
Allergy skin testing? ☐ Yes ☐ No	Office gynecology (routine pelvic/pap?) ☐ Yes ☐ No	Allergy skin testing? ☐ Yes ☐ No	Office gynecology (routine pelvic/pap?) ☐ Yes ☐ No
Drawing Blood? ☐ Yes ☐ No	Age appropriate immunizations? ☐ Yes ☐ No	Drawing Blood? ☐ Yes ☐ No	Age appropriate immunizations? ☐ Yes ☐ No
Flexible sigmoidoscopy? ☐ Yes ☐ No	Tympanometry/audiometry screening? ☐ Yes ☐ No	Flexible sigmoidoscopy? ☐ Yes ☐ No	Tympanometry/audiometry screening? ☐ Yes ☐ No
Asthma treatment? ☐ Yes ☐ No	Osteopathic manipulation? ☐ Yes ☐ No	Asthma treatment? ☐ Yes ☐ No	Osteopathic manipulation? ☐ Yes ☐ No
IV hydration/treatment? ☐ Yes ☐ No	Cardiac stress tests? ☐ Yes ☐ No	IV hydration/treatment? ☐ Yes ☐ No	Cardiac stress tests? ☐ Yes ☐ No
Physical therapy? ☐ Yes ☐ No		Physical therapy? ☐ Yes ☐ No	
Additional Office Procedures Provided (including surgical procedures): _____ _____		Additional Office Procedures Provided (including surgical procedures): _____ _____	
Is anesthesia administered in your office? ☐ Yes ☐ No If so, what category of anesthesia do you use? Specify the class or category. _____ Who administers it?_____		Is anesthesia administered in your office? ☐ Yes ☐ No If so, what category of anesthesia do you use? Specify the class or category. _____ Who administers it?_____	

Patient Scheduling	
What is patient wait time for emergency care?	What is patient wait time for scheduling routine care?
What is patient wait time for urgent care?	What is average wait time for patients between waiting room and examination?
What is patient wait time for symptomatic care?	What is average wait time in minutes for returning a patient's call?
What is patient wait time for scheduling routine visits?	

Required Attachments or Supplemental Information:
Please attach hard copy or scanned documents of the following:
• Copy(ies) of DEA registration certificate(s)
• Copy of state Controlled Dangerous Substance (CDS) registration certificate(s)
• Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and provider's name
• Copy(ies) of W-9(s) for verification of each tax identification number used
• Copy of workers compensation certificate of coverage, if applicable

SECTION II - DISCLOSURE QUESTIONS

Please answer each question and include an explanation for any question answered yes.

Licensure		
1. Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?	☐ Yes	☐ No
2. Have you ever received a reprimand or been fined by any state licensing board?	☐ Yes	☐ No
Hospital Privileges and Other Affiliations		
3. Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records 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, or governing board?	☐ Yes	☐ No
4. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	☐ Yes	☐ No
5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	☐ Yes	☐ No
Education, Training and Board Certification		
6. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, 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?	☐ Yes	☐ No
7. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?	☐ Yes	☐ No
8. Have any of your board certifications or eligibility ever been revoked?	☐ Yes	☐ No
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	☐ Yes	☐ No
DEA or CDS Certification/Authorization		
10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	☐ Yes	☐ No
Medicare, Medicaid or other Governmental Program Participation		
11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, subject to a recovery action or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐ Yes	☐ No
Other Sanctions or Investigations		
12. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	☐ Yes	☐ No
13. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐ Yes	☐ No
14. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	☐ Yes	☐ No
15. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action?	☐ Yes	☐ No
16. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	☐ Yes	☐ No
Professional Liability Insurance Information and Claims History		
17. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	☐ Yes	☐ No
18. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	☐ Yes	☐ No

Malpractice Claims History		
19. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, provide information for each case on the attached form located at the end of the Disclosure questions (list all separately). **For any malpractice actions, please complete addendum and check this box** ☐	☐ Yes	☐ No
Criminal/Civil History (Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all relevant circumstances, including the nature of the crime.)		
20. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional?	☐ Yes	☐ No
21. Have you ever been arrested, charged or indicted for, convicted of, pled guilty to, or pled nolo contendere to any felony, crime or other offense in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?	☐ Yes	☐ No
22. Have you ever been court-martialed for actions related to your duties as a medical professional?	☐ Yes	☐ No
Ability to Perform Job		
23. Are you currently engaged in the illegal use of drugs? ("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.)	☐ Yes	☐ No
24. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐ Yes	☐ No
25. Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?	☐ Yes	☐ No
26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?	☐ Yes	☐ No

Please provide information below for Malpractice Actions indicated for Disclosure Question #19.
Date of occurrence:_____ Date claim was filed:_____
Claim/case status:_____
Professional liability carrier involved:_____ Address:_____ Phone Number:_____ Policy Number:_____
Amount of award or settlement and amount paid:_____
Method of resolution: ☐ dismissed ☐ settled (with prejudice) ☐ settled (without prejudice) ☐ judgment for defendant(s) ☐ judgement for plaintiff(s) ☐ mediation or arbitration
Description of allegations:_____
Were you primary defendant or co-defendant?_____
Number of other co-defendants_____
Your involvement in case (attending, consulting, etc.)_____
Description of alleged injury to the patient:_____
To the best of your knowledge, is this case included in the National Practitioner Data Bank (NPDB)? ☐ Yes ☐ No

Please provide information below for any Disclosure Questions in Section II answered Yes.	
Question Number	Please Explain:

SECTION III - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with_____(indicate managed care company(s) to which you are applying) (hereinafter, 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.

Authorizations

Investigation Concerning Application for Participation: I hereby authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); 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 all records and documents relating to such an investigation.

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.

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.

Releases

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.

_____
Providers Initials and Date

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 applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

Attestation

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that the information provided on this application may be shared with appropriate State and federal agencies.

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 understand and agree that submitting false, misleading or incomplete information may result in the imposition of administrative, civil and/or criminal sanctions, in accordance with State and federal law.

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature _____

Name _____
(Please print or type.)

Social Security Number _____

Date _____

EXHIBIT 2

New Jersey Physician Recredentialing Application

(Please type or print)

All sections must be completed fully or clearly marked as "not applicable."
No area should be left blank.

SECTION 1

Personal Information

Physician Name - Last	First	Middle	UPIN	Social Security #

Corporate Name (If different from name above)	Professional Degree(s)

Practice Location Information - Primary Office

Primary Office Address	City	State	Zip Code

Telephone Number	FAX Number	Tax ID Number and Associated Individual Group Number & Name

Non-English Languages Spoken (Health Care Provider)	Non-English Languages Spoken (Office Staff)	Handicap Access: ☐ Yes ☐ No

Continuing Education

Please list all continuing education for the past two years.

Course Name	Location	Date Taken	# of CME/CEUs

Professional/Medical Specialty Information

Primary Specialty	Board Certified? ☐ Yes ☐ No

Professional Certificates, Licenses, Identification Numbers

Are you a member of your State Medical Society? ☐ Yes ☐ No

Primary State License Number:	State:	Expiration Date:

List any additional licenses (current or expired) within the last 15 years:

License Number:	State:	Expiration Date:

Professional Certificates, Licenses, Identification Numbers, continued	
Federal DEA Number:	Expiration Date:
CDS Number:	Expiration Date:

Hospital Affiliations			
Primary Admitting Facility:		From:	To:
Type of Appointment (Active, Courtesy, etc.):		Specialty:	
Additional Facilities:			
Name	Specialty	From/To	Restrictions

Professional Liability Insurance Coverage		
Current Malpractice Insurance Carrier (Name and Address)		
Policy Number	Period of Coverage	Coverage Limits Per Occurrence Aggregate

Additional Office Information		
Address	City	State and Zip
Phone	FAX	E-mail Address
Does this office have capability for electronic billing? ❑ Yes ❑ No		

SECTION II - DISCLOSURE QUESTIONS

Please answer each question. If you respond "yes" to any of the questions listed below, please provide an explanation on a separate sheet of paper. If any question does not apply, please write in "N/A".

Licensure		
1. Has your license to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation or have you ever been subject to a consent order, probation or any conditions or limitations by a state licensing board?	❑ Yes	❑ No
2. Has your federal or state narcotics license ever been suspended, limited, revoked, voluntarily suspended or not renewed, or has probation ever been invoked?	❑ Yes	❑ No
3. Have you ever received a reprimand or been fined by any state licensing board?	❑ Yes	❑ No
Hospital Privileges and Other Affiliations		
4. Have your clinical privileges at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records 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 or governing board?	❑ Yes	❑ No
5. Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?	❑ Yes	❑ No

6. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs or PHOs)?	❑ Yes	❑ No
Education, Training and Board Certification		
7. Have you ever been placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, fellowship, preceptorship or other clinical education program?	❑ Yes	❑ No
8. If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program?	❑ Yes	❑ No
9. Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in an internship, residency, fellowship, preceptorship or other clinical education program?	❑ Yes	❑ No
10. Have any of your board certifications or eligibility ever been revoked?	❑ Yes	❑ No
11. Have you ever chosen not to re-certify or voluntarily suspended your board certification(s) while under investigation?	❑ Yes	❑ No
DEA or CDS Certification/Authorization		
12. Have your federal and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal or voluntarily relinquished?	❑ Yes	❑ No
Medicare, Medicaid and Other Governmental Program Participation		
13. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to any other federal or state governmental health care plans or programs?	❑ Yes	❑ No
Other Sanctions or Investigations		
14. Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	❑ Yes	❑ No
15. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	❑ Yes	❑ No
16. Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?	❑ Yes	❑ No
17. Has a patient, employee, or co-worker ever accused you of sexual harassment or other illegal misconduct that resulted in an investigation, sanction or other formal action?	❑ Yes	❑ No
18. During your military career, if applicable, have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility or agency, voluntarily terminated or resigned while under investigation by a hospital/ healthcare facility of any military agency?	❑ Yes	❑ No
Professional Liability Insurance Information		
19. Has your professional liability insurance coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	❑ Yes	❑ No
20. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	❑ Yes	❑ No

Malpractice Claims History		
21. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated or litigated)? If yes, please provide the following information for each case (list each action separately). • Date of occurrence • Claim/case status • Date claim was filed • Professional liability insurance carrier involved (Include name, address, phone number and policy number) • Amount of award or settlement and amount paid: • Method of Resolution: ❑ Dismissed ❑ Judgment for defendant(s) ❑ Settled (with prejudice) ❑ Mediation/Arbitration ❑ Judgment for plaintiff(s) ❑ Settled (without prejudice) • Description of allegations • Indicate whether you were primary defendant or co-defendant • Number of other co-defendants • Indicate your involvement in the case (attending, consulting, etc.) • Description of alleged injury to the patient.	❑ Yes	❑ No
Criminal/Civil History (Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be based upon all the relevant circumstances, including the nature of the crime.)		
22. Have you ever been convicted of, pled guilty to, or pled nolo contendre to any felony in the last ten years or been found liable or responsible for or named as a defendant in any civil offense that is reasonably related to your qualifications, competence, functions or duties as a medical professional?	❑ Yes	❑ No
23. Have you ever been convicted of, pled guilty to, or pled nolo contendre to any felony in the last ten years or been found liable or responsible for or been named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense of sexual misconduct?	❑ Yes	❑ No
24. Have you ever been indicted in any civil or criminal suit?	❑ Yes	❑ No
25. Have you ever been court-martialed for actions related to your duties as a medical professional?	❑ Yes	❑ No
Ability to Perform Job		
26. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?	❑ Yes	❑ No
27. Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of a drug 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 an 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. section 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.)	❑ Yes	❑ No
28. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	❑ Yes	❑ No
29. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	❑ Yes	❑ No
30. Do you have Professional Liability (Malpractice) Insurance coverage in force? (If no, please explain below.)	❑ Yes	❑ No

SECTION III - AUTHORIZATION, ATTESTATION AND RELEASE

I understand and agree that, as part of the recredentialing process for participation and/or clinical privileges at or with the above-referenced managed care company (hereinafter referred to at the "Entity") and any of the Entities affiliates, I am required to provide sufficient and accurate information for proper evaluation of my current licensure, relevant training and experience, clinical competence, health status, moral character and any other criteria used by the Entity for determining initial and ongoing eligibility for participation. Each Entity and its representatives, employees or agent(s) acknowledge that the information herein obtained 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 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.

Authorizations

Investigation Concerning Application for Participation: I hereby authorize the following individuals, including the Entity, its representatives, employees, designated agent(s); the Entity's designated affiliates and their representatives, employees or agent(s); the Entity's designated professional credentials verification organization (hereinafter collectively referred to as "Agents") to investigate information, including 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 all records and documents relating to such an investigation.

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 and 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 and physical condition, alcohol or chemical dependency, diagnosis and treatment, ethics, or any other matter reasonably 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.

Release and Exchange of Disciplinary Information: I authorize any third party at which I currently have Participation or had Participation and/or the third-party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities with which I have Participation, 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 acknowledged that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Releases

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 third party in connection with the credentialing process. This release shall be in addition to, and in on way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

_____
Provider's Initials and Date

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 to any person, entity or governmental agency that executes an appropriate confidentiality agreement or

has a legal right to know under any state or federal law. I understand and agree that this Authorization, Attestation and Release is irrevocable for as long as this application is pending and, if accepted for Participation, for so long as the participating provider agreement remains in force and effect. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

Attestation

I certify that all information provided by me in this application is true, correct and complete to the best of my knowledge and belief and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (by a written or electronic signature). I further 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).

_____
Provider's Initials and Date

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature:_____

Name:_____
(Please type or print)

Social Security Number:_____

Date:_____