# LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

## DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 10 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

## GENERAL INFORMATION

| Last Name | Suffix | First | Middle | Gender ❑ Male ❑ Female |
|---|---|---|---|---|
| | | | | |

Degree: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ Other_____

| Any other name under which you have been known? (AKA) List | ECFMG Number | UPIN Number |
|---|---|---|
| | | |

| Home Street Address | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Home Phone Number | Pager Number/Answering Service | Home Email Address *(optional)* |
|---|---|---|
| | | |

| Social Security Number | Date of Birth | Birth Place *(City, State)* | Race/Ethnicity *(voluntary)* |
|---|---|---|---|
| | | | |

| NPI - Individual | Medicaid Provider Number | Medicare Provider Number |
|---|---|---|
| | | |

## PRIMARY PRACTICE LOCATION

| Institution/Group/Clinic Name *(If Applicable)* | Office Manager |
|---|---|
| | |

| Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group |
|---|---|---|
| | | |

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

| **Physical Address** | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Office Email | Office Website |
|---|---|
| | |

| Main Phone Number | Appointment Phone Number | Fax Number |
|---|---|---|
| | | |

| **Billing Address** *(Where you want payments sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Billing Email | Fax Number |
| | | | | |

| **Correspondence Address** *(Where you want communications sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Correspondence Email | Fax Number |
| | | | | |

| **Medical Records Address** *(Where you want medical record requests sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Medical Records Email | Fax Number |
| | | | | |

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based
❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

| Office Hours | Mon. _____-_____ | Tues. _____-_____ | Wed. _____-_____ | Thur. _____-_____ | Fri. _____-_____ | Sat. _____-_____ | Sun. _____-_____ |
|---|---|---|---|---|---|---|---|

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ ☐ Provider ☐ Other

## PRIMARY PRACTICE LOCATION CONTINUED

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No

Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other:_____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

| Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify) |
|---|---|

Group, Covering or Collaborating Physician(s):

| Contact Name: | Contact Phone Number: |
|---|---|

## SECOND PRACTICE LOCATION

| Institution/Group/Clinic Name *(If Applicable)* | Office Manager |
|---|---|

| Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group |
|---|---|---|

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

| **Physical Address** | City | State | Zip Code |
|---|---|---|---|

| Office Email | Office Website |
|---|---|

| Main Phone Number | Appointment Phone Number | Fax Number |
|---|---|---|

| **Billing Address** *(Where you want payments sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Billing Email | Fax Number |

| **Correspondence Address** *(Where you want communications sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Correspondence Email | Fax Number |

| **Medical Records Address** *(Where you want medical record requests sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Medical Records Email | Fax Number |

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

| Office Hours | Mon. _____-_____ | Tues. _____-_____ | Wed. _____-_____ | Thur. _____-_____ | Fri. _____-_____ | Sat. _____-_____ | Sun. _____-_____ |
|---|---|---|---|---|---|---|---|

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ ☐ Provider ☐ Other

## SECOND PRACTICE LOCATION CONTINUED

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No

Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other:_____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

| Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify) |
|---|---|
| | |

Group, Covering or Collaborating Physician(s):

| Contact Name: | Contact Phone Number: |
|---|---|
| | |

## THIRD PRACTICE LOCATION

| Institution/Group/Clinic Name *(If Applicable)* | Office Manager |
|---|---|
| | |

| Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group |
|---|---|---|
| | | |

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

| **Physical Address** | City | State | Zip Code |
|---|---|---|---|
| | | | |

| Office Email | Office Website |
|---|---|
| | |

| Main Phone Number | Appointment Phone Number | Fax Number |
|---|---|---|
| | | |

| **Billing Address** *(Where you want payments sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| | | | | |
| City | State | Zip Code | Billing Email | Fax Number |
| | | | | |

| **Correspondence Address** *(Where you want communications sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| | | | | |
| City | State | Zip Code | Correspondence Email | Fax Number |
| | | | | |

| **Medical Records Address** *(Where you want medical record requests sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| | | | | |
| City | State | Zip Code | Medical Records Email | Fax Number |
| | | | | |

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

| Office Hours | Mon. | Tues. | Wed. | Thur. | Fri. | Sat. | Sun. |
|---|---|---|---|---|---|---|---|
| | _____-_____ | _____-_____ | _____-_____ | _____-_____ | _____-_____ | _____-_____ | _____-_____ |

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ ☐ Provider ☐ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

## THIRD PRACTICE LOCATION CONTINUED

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No

Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No
Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other:_____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No
Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

| Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify) |
|---|---|

Group, Covering or Collaborating Physician(s):

| Contact Name: | Contact Phone Number: |
|---|---|

## FOURTH PRACTICE LOCATION

*(If you have more than four locations, attach additional sheets with the following information.)*

| Institution/Group/Clinic Name *(If Applicable)* | Office Manager |
|---|---|

| Tax Identification Number | Effective Date of Provider at this Practice Location | NPI – Group |
|---|---|---|

Name to which Employer Identification Number (EIN) is registered with the IRS ***(IMPORTANT**: must match IRS information exactly)*

| **Physical Address** | City | State | Zip Code |
|---|---|---|---|

| Office Email | Office Website |
|---|---|

| Main Phone Number | Appointment Phone Number | Fax Number |
|---|---|---|

| **Billing Address** *(Where you want payments sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Billing Email | Fax Number |

| **Correspondence Address** *(Where you want communications sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Correspondence Email | Fax Number |

| **Medical Records Address** *(Where you want medical record requests sent)* | | | Contact Person | Phone Number |
|---|---|---|---|---|
| City | State | Zip Code | Medical Records Email | Fax Number |

Type of Practice: ❑ Solo ❑ Multi-specialty Group ❑ Single Specialty Group ❑ Hospital-based ❑ Hospital-employed ❑ Healthplan/Payor-owned

If Hospital-employed or Healthplan/Payor-owned, please indicate owner name:_____

| Office Hours | Mon. _____-_____ | Tues. _____-_____ | Wed. _____-_____ | Thur. _____-_____ | Fri. _____-_____ | Sat. _____-_____ | Sun. _____-_____ |
|---|---|---|---|---|---|---|---|

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location *(other than English)*: _____ _____ ☐ Provider ☐ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

## FOURTH PRACTICE LOCATION CONTINUED

| | | | | |
|---|---|---|---|---|
| Age group(s) treated: | ❑ 0-6 years | ❑ 7-11 years | ❑ 12-18 years | ❑ 19-65 years |
| | ❑ Over 65 | ❑ All Ages | ❑ Other (Specify): _____ | |

| | |
|---|---|
| Are PAs and/or nurse/paraprofessional practitioners used? ❑Yes ❑No | Is this facility wheelchair/ handicapped accessible? ❑Yes ❑No |

Does the office offer handicapped access for: Building: ❑Yes ❑No Parking: ❑Yes ❑No Restroom: ❑Yes ❑No
Other: _____

Accessible by public transportation: Bus: ❑Yes ❑No Courier Service: ❑Yes ❑No Other:_____

Offers services for the disabled: Text Telephony (TTY): ❑Yes ❑No American Sign Language: ❑Yes ❑No
Mental/Physical Impairment Services: ❑Yes ❑No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑Yes ❑No

| | |
|---|---|
| Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify) |

Group, Covering or Collaborating Physician(s):

| | |
|---|---|
| Contact Name: | Contact Phone Number: |

## SPECIALTY & CERTIFICATION

*(as recognized by American Board of Medical Specialties or other national certification body)*
*Please attach a copy of current certification(s).*

Type of Provider: ❑ Primary Care Physician ❑ Physician Specialist ❑ Both ❑ Other Specialty:_____

| | |
|---|---|
| Primary Specialty: | Specialty Board Certified By: |
| Second Specialty: | Specialty Board Certified By: |
| Third Specialty: | Specialty Board Certified By: |

## DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. ***Disclaimer: Use of information may vary by healthcare organization.***

| Primary Location | Second Location | Third Location | Fourth Location |
|---|---|---|---|
| ❑ Specialty<br>❑ Directory | ❑ Specialty<br>❑ Directory | ❑ Specialty<br>❑ Directory | ❑ Specialty<br>❑ Directory |
| ❑ Sub-specialty<br>❑ Directory | ❑ Sub-specialty<br>❑ Directory | ❑ Sub-specialty<br>❑ Directory | ❑ Sub-specialty<br>❑ Directory |
| ❑ Sub-specialty<br>❑ Directory | ❑ Sub-specialty<br>❑ Directory | ❑ Sub-specialty<br>❑ Directory | ❑ Sub-specialty<br>❑ Directory |

## PHO / IPA AFFILIATIONS*

List any other PHO's, IPA's, which you participate in and dates of participation:

**The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

## CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

| Hospital | Location/Address | Type of Privileges | Effective Date MO/YR |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

If you do not have admitting privileges, who admits for you and to what hospital? Please list provider's name, specialty and hospital.

## EDUCATION

*If additional training to what is requested below has been completed, please attach on a separate form.*

| | | |
|---|---|---|
| **Medical/Professional School:** | | |
| City | State | Zip |
| Degree | Year of Graduation | Dates Attended (MO/YR): From: _____ to _____ |
| **Internship: Institution Name** | Type of Training | |
| City | State | |
| University Affiliation | Completed ❑ Yes ❑ No | Dates Attended (MO/YR): From: _____ to _____ |
| **Residency: Institution Name** | Type of Residency | ❑ Clinical ❑ Research |
| City | State | Dates Attended (MO/YR): From: _____ to _____ |
| University Affiliation | Completed: ❑ Yes ❑ No | |
| **Residency: Institution Name** | Type of Residency | ❑ Clinical ❑ Research |
| City | State | Dates Attended (MO/YR): From: _____ to _____ |
| University Affiliation | Completed: ❑ Yes ❑ No | |
| **Fellowship: Institution Name** | Specialty Field | Dates Attended (MO/YR): From: _____ to _____ |
| City | State | Completed ❑ Yes ❑ No |
| | Type of Fellowship | ❑ Clinical ❑ Research |
| **Fellowship: Institution Name** | Subspecialty Fields | Dates Attended (MO/YR): From: _____ to _____ |
| City | State | Completed ❑ Yes ❑ No |
| | Type of Fellowship | ❑ Clinical ❑ Research |

## WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the MONTH and YEAR for each entity listed**. **Work history is critical. Failure to provide this information may delay your credentialing.**

**Code:**

**C** = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments)
**H** = Civilian Hospital Medical Staff Appointment **M** = Military Service (Including Hospital Staff Appointments) **O** = Other

| CODE | NAME AND ADDRESS OF ENTITY | DATE *(From MO/YR to MO/YR)* |
|---|---|---|
| | | / to / |
| | | / to / |
| | | / to / |
| | | / to / |
| | | / to / |
| | | / to / |
| | | / to / |
| | | / to / |

## WORK HISTORY GAP

*In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history.*

**Failure to provide this information may delay your credentialing**

## PROFESSIONAL LICENSES

| Professional Licenses | License Number | Date Obtained | Expiration Date |
|---|---|---|---|
| State License | | | |
| Federal DEA Reg Number | | | |
| State CDS License Number | | | |
| CLIA Certificate | | | |

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?

❑ Yes ❑ No **If yes, a current copy of your CLIA Registration must accompany this application.**

**For Dentists Only** - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?)

❑ Yes ❑ No **If yes, a copy of your Anesthesia Permit must accompany this application.**

**Have you been or are you <u>currently</u> licensed in any other state? If YES, please complete the following:**

License Number State Date Obtained Expiration Date

License Number State Date Obtained Expiration Date

License Number State Date Obtained Expiration Date

**(Please attach a copy of all licenses listed above and additional ones in other states not listed.)**

## REFERENCES

**List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.**
***(References should not be relatives or current partners.)***

Name Specialty Phone Number

Street Address City State Zip

Name Specialty Phone Number

Street Address City State Zip

Name Specialty Phone Number

Street Address City State Zip

Name Specialty Phone Number

Street Address City State Zip

## PROFESSIONAL LIABILITY INSURANCE COVERAGE

| | |
|---|---|
| Name of Carrier: | Policy Number: |
| Address of Carrier: | Phone Number: |
| Amounts Per Occurrence/Aggregate: | Dates of Coverage: |

| | | |
|---|---|---|
| Do you participate in the Louisiana Patients' Compensation Fund? | ❑ Yes | ❑ No |
| Are you self-insured in accordance with the Louisiana Medical Malpractice Act? | ❑ Yes | ❑ No |
| Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation) | ❑ Yes | ❑ No |

**Please attach a copy of the current Certificates of Insurance.**

## GENERAL QUESTIONS

**Please check the appropriate response to the following questions:**
**If you answered YES to any of the questions below, please attach a full explanation on a separate page.**

| | YES | NO | N/A |
|---|---|---|---|
| 1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you? | ❑ | ❑ | ❑ |
| 2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending? | ❑ | ❑ | ❑ |
| 3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence? | ❑ | ❑ | ❑ |
| 4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified? | ❑ | ❑ | ❑ |
| 5. Have your clinical privileges at any hospital or healthcare institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board? | ❑ | ❑ | ❑ |
| 6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)? | ❑ | ❑ | ❑ |
| 7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner. | ❑ | ❑ | ❑ |
| 8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? | ❑ | ❑ | ❑ |
| 9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business?<br>If YES, please enter the ownership percentage _____ and attach a full explanation. | ❑ | ❑ | ❑ |
| 10. Are you presently a named defendant in a pending professional liability lawsuit?<br>If YES, please enter the number of cases _____ and attach a full explanation of each. | ❑ | ❑ | ❑ |
| 11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action?<br>If YES, please enter the number of cases _____ and attach a full explanation of each. | ❑ | ❑ | ❑ |

## REQUIRED ATTACHMENTS

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 9.
- ✓ Current Employer Identification Number (EIN) **and** W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

## STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009 (A) (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

## PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

| | X | |
|---|---|---|
| **Name** *(Please Print)* | **Signature** | **Original Attestation Date** |
| **Second Attestation Date** | | **Third Attestation Date** |

*Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.*