Dear Provider

Enclosed, please find the credentialing application for **Capital Health Physicians, Inc.,** for your review. Listing current email addresses and fax numbers will assist with processing of your application. Upon completion of all verifications, your application will be submitted to the Credentialing Medical Director and Credentialing/Peer Review Committee for review.

Application:

Application must be completed in its entirety and must be signed and dated within 45 days at the time of submission. All supporting listed below are required.

- ☐ CPPA (California Participating Practitioner Application)
- ☐ W-9 form

Supporting Documents:

- ☐ Proof of DHCS PAVE Registration (Medi-Cal Enrollment Fee-for Service)
- ☐ Addendum A (Capital MSO Practitioner Rights)
- ☐ Addendum B (Claims Disclosure)
- ☐ Curriculum Vitae (Must include 5-year work history. Any 6-month gap in work history should be addressed in written explanation in MM/YY format)
- ☐ Hospital Privilege Status Attestation
- ☐ Current California Professional License, DEA Registration, Current Professions Malpractice insurance coverage ($1M / $3M minimum)
- ☐ Continuing Medical Education Attestation (Applicable to PCP-General Practitioners)
- ☐ Specialty Board Certification Certificate (As applicable)

AHP Additional Documents:

- ☐ Delegation of Services Agreement (PA) or Standardized Procedures (NP)
- ☐ Physician Extender Attestation (PA, NP, and Nurse-Midwife)

Please contact Calibrated HealthCare Network's Credentialing Department with any questions at (909) 242-8194 Ext 8124 or via email at credentialing@calibratedhealthcare.com

Sincerely,

Credentialing Department
Calibrated Health Care Network

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submittedwith this application.

II. Identifying Information

Check if there are any changes and update below. ☐

Last Name:	First Name:	Middle:

Is there any other name under which you have been known? Name(s):		
Home Mailing Address:		
City:	State:	Zip Code:

Telephone Number:	Fax Number:	Cell Number:	Pager Number:
Practitioner Email:	Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):		
Birth Date:	Birth Place:	Race/Ethnicity (optional):	
Driver's License State/Number:	Social Security Number:	Gender: ☐ Male ☐ Female	

Your intent is to serve as a(n):

☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based

Specialty:

Subspecialties:

III. Practice Information

Check if there are any changes and update below. ☐

Practice Name (if applicable):	Department Name (if hospital based):	
Primary Office Address:		
City:	State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:
Federal Tax ID Number:		Name Associated with Tax ID:

Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None

III. Practice Information (Continued)

Check if there are any changes and update below.

Type of practice (check all that apply):

- ☐ Solo Practice
- ☐ Group Practice
- ☐ Single Specialty Group
- ☐ Multi Specialty Group
- ☐ Urgent Care

Primary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Secondary Practice Information

Practice Name (if applicable):	Department Name (if hospital based):		
Secondary Office Address:			
City:		State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	

Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None

Type of practice (check all that apply):

- ☐ Solo Practice
- ☐ Group Practice
- ☐ Single Specialty Group
- ☐ Multi Specialty Group
- ☐ Urgent Care

Secondary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Tertiary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):
Tertiary Office Address:		
City:		Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:
Federal Tax ID Number:		Name Associated with Tax ID:
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None		
Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Single Specialty Group ☐ Multi Specialty Group ☐ Urgent Care		
Tertiary Office Hours of Operation:	Languages spoken by Staff:	
	Languages spoken by Provider:	
Group Medicare PTAN/UPIN #:	Group NPI #:	

Mailing Address

Which of your practices is your primary mailing address? ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other	
If your mailing address is different from your practice address, please provide it:	

IV. Billing Information

Check if there are any changes and update below.

Which of your practices handles your billing? ☐ Primary ☐ Secondary ☐ Tertiary, if none, please provide billing info:		
Billing Company:		
Billing Company Mailing Address:		
City:	State:	Zip Code:
Contact Person:	Telephone Number:	
Federal Tax ID Number:	Name Associated with Tax ID:	

V. Practice Description	Check if there are any changes and update below.
Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ☐Yes ☐ No If so, please list:	
Name	License Number
Physician Assistant Supervisor Name:	License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ☐Yes ☐No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐Primary ☐Secondary ☐Tertiary
		☐Primary ☐Secondary ☐Tertiary
		☐Primary ☐Secondary ☐Tertiary

Please list any clinical services you perform that are not typically associated with your specialty:

Which offices does this apply to: ☐Primary ☐Secondary ☐Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this apply to: ☐Primary ☐Secondary ☐Tertiary

Is your practice limited to certain ages? ☐Yes ☐No If yes, specify limitation:

Which offices does this apply to: ☐Primary ☐Secondary ☐Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company:		
Answering Service Company Address:		
City:	State: Zip Code:	Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training, and Experience _Check if there are any changes and update below.

Medical/Professional Education

Medical School/Professional:	Degree Received:	Graduation Date:
Mailing Address:	Website(if applicable):	
City:	State: Zip Code:	Registrar's Phone Number:

Internship/PGY-1

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Internship:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)		

Residencies/Fellowships Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)		

VII. Medical Licensure & Certifications

Check if there are any changes and update below.

California State Medical License: Number	Issue Date:	Expiration Date:
Drug Enforcement Agency (DEA) Registration Number:	Schedules:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Issue Date
Individual National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:	Individual Medicare PTAN Number:

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

Include certifications by board(s) which are duly organized and recognized by: ● a member board of the American Board of Medical Specialties ● a member board of the American Osteopathic Association ● a board or association with equivalent requirements approved by the Medical Board of California ● a board or association with an Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ☐ Yes ☐ No	
If so, list board(s) and date(s):	

If not certified, describe your intent for certification, if any, and date of eligibility for certification below or in a separate sheet.

Specialty:	Describe here:
Board Name:	
Exam Date:	

VIII. Current Hospital and Other Institutional Affiliations ☐ Check if there are any changes and update below.

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):	

B. Previous Hospital and Other Institutional Affiliations

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

IX. Peer References ☐ Check if there are any changes and update below.

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility where you currently hold privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

X. Work History ☐ Check if there are any changes and update below.

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

XI. Professional Liability

☐ Check if there are any changes and update below.

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐ No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

XII. Professional and Practice Services

_Check if there are any changes and update below.

Are you a Certified Qualified Medical Examiner (QME)of the State Industrial Medical Council? ☐Yes ☐No

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Federal Tax ID:	Type of Service Provided:	Do you have a CLIA certificate? ☐Yes ☐ No
Billing Name:		Do you have a waiver? ☐ Yes ☐ No
CLIA Certificate Number:		CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued)

☐ Check if there are any changes and update below.

Have you or your office received any of the following accreditations, certificates or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)

☐ Medicare Certification

☐ The Medical Quality Commission (TMQC)

☐ Child Health and Disability Prevention Program (CHDP)

☐ Comprehensive Perinatal Services Program (CPSP)

☐ California Children Services (CCS)

☐ Family Planning

☐ Other:

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ☐ Yes ☐ No If so, which Network?

Do you use a practice management system/software? ☐ Yes ☐ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; OR

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; OR

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

☐ 1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND

☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; OR

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; AND

☐ 1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; OR

☐ 2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; OR

☐ 3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____

PRINTED NAME: _____

DATE: _____

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", **please provide full details on a separate sheet of paper.**

1) Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending? ☐ Yes ☐ No

2) Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions by Medicare, Medicaid, or any federal program or is any such action pending? ☐ Yes ☐ No

3) Have your clinical privileges, membership, contractual participation or employment by any medical organization e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with (public) federal programs, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ☐ Yes ☐ No

4) Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), or other health delivery entity or system) while under investigations for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? ☐ Yes ☐ No

5) Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No

6) Have you ever been denied certification/recertification by a specialty board? ☐ Yes ☐ No

7) Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation? ☐ Yes ☐ No

8a) Have you ever been convicted of, or pled guilty to a criminal offence (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense? ☐ Yes ☐ No

8b) Are any such actions pending? ☐ Yes ☐ No

9) Have any judgements been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases? If YES, please complete Addendum B ☐ Yes ☐ No

10) Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If YES, please complete Addendum B ☐ Yes ☐ No

11) Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures? ☐ Yes ☐ No

12) Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such function without risk of compromise ☐ Yes ☐ No

13) Have you ever rendered professional medical services as an employee of staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ☐ Yes ☐ No

14) Is your currently ability to practice impaired by chemical dependency or substance, abuse, including present use of illegal drugs? ☐ Yes ☐ No

15) Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been termination, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ☐ Yes ☐ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

APPLICANT SIGNATURE (Stamp is NOT Acceptable): _____

PRINTED NAME: _____

DATE: _____

Continue to the Next Page for Information Release/Acknowledgements

NOTICE OF PRACTITIONER RIGHTS TO CREDENTIALING
Addendum A

I. Right of Review

As an applicant for credentialing/re-credentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from the outside sources such as liability insurance carriers, Medical Boards, and National Practitioner Data Bank. It does not include review of information that is privileged such as references or recommendations which are protected by law from disclosure.

You may request to view such information at any time by sending a written request via fax or letter to the Manager of Credentialing to the following address:

Calibrated Health Care Network
3633 Inland Empire Blvd, Suite 301
Ontario, California 91764
(909) 242-8194 Ext. 8124
Credentialing@calibratedhealthcare.org

Following receipt of your request, you will be contracted by the Manager or his/her designee, within three (3) working days in order to arrange a date and time for review of the information in the Credentialing Department.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter when information obtained by primary sources caries significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to Calibrated Health Care Network by primary sources, you may correct such information by submitting written notification to the Credentialing at the above cited address/email. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, Calibrated Health Care Network will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of the through letter, fax or phone. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cite above within ten (10) days. Subsequently, a second re-verification of primary source information will be performed by the Credentialing Department.

Print Name: _____

Signature (Stamped signatures Not Acceptable) _____ Date: _____

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to_____herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I: Practitioner Identifying Information		
Last Name:	First Name:	Middle:

II. Case Information			
Patient's Name:	Patient's Gender: ☐ Male ☐ Female		Patient's DOB:
City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:

Location of incident: ☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify):
Relationship to patient (Attending physician, Surgeon, Assistant, Consultant, etc.)
Allegation:
Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐Yes ☐No
If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization.

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name:	Telephone Number:	Fax Number:

III. Status of Lawsuit/Arbitration (check one)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) _____

:_____
PRINTED NAME

_____

DATE:

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.
I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.
In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable)	**PRINTED NAME**	**DATE**

Addenda Submitting;

☐ Addendum B; Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► Go to *www.irs.gov/FormW9* for instructions and the latest information.

Give Form to the requester. Do not send to the IRS.

Print or type.
See Specific Instructions on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ►_____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	Signature of U.S. person ►	Date ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*