CAQH

Date: _____

Name: _____ *Specialty:* _____
*Address:*_____
*City, State Zip:*_____ *IPA:* _____

Enclosed is a standard Personal Participating Physician Application, which needs completing (signature pages cannot be older than 60 days and they must be DATED & SIGNED). Please return legible, completed application within two weeks along with a current copy of the following documents:

❑ Medical License	❑ DEA	❑ Malpractice Insurance Certificate
❑ Proof of current Board Certification	❑ Current Curriculum Vitae (CV)	❑ W-9 Form
❑ **COMPLETE WORK HISTORY OF PRIVATE PRACTICE/GROUP PRACTICE showing Month/Year DATES TO AND Month/Year FROM FOR THE PAST SIX YEARS. THE MOST COMMON DELAYS WITH PROCESSING CREDENTIALING IS INCOMPLETE WORK HISTORY. PLEASE BE SURE TO INCLUDE A MONTH AND A YEAR FROM AND A MONTH AND A YEAR TO FOR WORK HISTORY TO TOTAL >6YEARS, SIMPLY STATING THE YEARS DOES NOT SUFFICE UNLESS IT SHOWS OVER 6 YEARS. ALSO, WORK HISTORY MUST INCLUDE THE CURRENT PRACTICE INFORMATION THAT STARTS ON THE FIRST PAGE OF YOUR APPLICATION.** Your CV does not suffice if it does not show an address and dates to and from (if you have not started practicing with your new group, please show an estimated start date).		
❑ HOSPITAL PRIVILEGE INFORMATION MUST BE COMPLETED ON THE APPLICATION/CAQH TO SHOW HOSPITAL NAME, **STATUS (type of admitting privileges) I.E. ACTIVE, PROVISIONAL, COURTESY, ETC.** – USE SEPARATE SHEET IF NECESSARY BUT PLEASE REMEMBER TO INCLUDE STATUS (ACTIVE, PROVISIONAL, COUTESY, ASSOCIATE).		
❑ Addendum A & if needed addendum B, Professional Liability Action Explanation, which requires completion & a **DETAILED SUMMARY** if you have any 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 7-years		

Instead of completing and sending a paper application, you may provide a valid and current CAQH number along with a copy of the bulleted items listed in the first two rows above, via fax or e-mail. Please make sure that the data is current, and the work history is sufficient. If you have malpractice cases send complete Addendum B; CAQH document for malpractice cases doesn't request detailed summaries.

CAQH Provider # (if applicable) _____

When complete please return to or fax it to our confidential fax #, or mail it to. Should you have any questions please do not hesitate to reach me at

Sincerely,

Physician Name: _____

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, 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 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 business and individuals acting as their agents (collectively, "Healthcare Organizations") for the purpose of evaluating this reapplication and any credentialing 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 patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[2] 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, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action taken or pending 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 taken against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non-renewal 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 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 hereby affirm that the information submitted in this reapplication 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 reapplication or termination of my privileges, employment or participation agreement with the Healthcare Organization. A photocopy of this document shall be as effective as the original; however, current dates are required on pages 8 and 9.

Print Name Here _____

Physician's Signature: _____ **Date:** _____
(Stamped Signature Is Not Acceptable) (Not acceptable if not dated.)

[2]The intent of this release is to apply, at a minimum, protections comparable to those available in California to any action regardless of where such action is brought.