CREDENTIALING REQUIREMENTS

The following are the documents needed to complete the credentialing process for Unified Physicians Network.

1. Completed Provider Application Please note that all pages must be completed or marked as "N/A" if they do not apply.	❑ Completed
2. Copies of the following documents must be provided:	❑ Current State License ❑ Current State Controlled Substance License ❑ Current Federal Narcotic License (DEA) ❑ Current Malpractice Face Sheet ❑ W-9 Form (attached) Please be sure that check name and Tax ID match information on file with the Internal Revenue Service ❑ Board Certificate If you are not Board Certified, attach copies of all CME credits for the last 2 years. ❑ CME Credits (if applicable) ❑ Medical School Certificate ❑ Residency/Internship/Fellowship Certificates ❑ Curriculum Vitae ❑ Professional Liability Explanation Form (if applicable) ❑ ECFMG Certificate (if applicable) ❑ CAQH Number_____ ❑ Copy of Official NPI confirmation letter from NPPES for individual physician and corporation ❑ NPI Submission Form (attached)
3. Signed Contract ***Please note all pages must be initialed by provider or contracting entity.***	❑ Completed
4. Application Fee ***Waived with current CAQH credentials.***	❑ $75.00 per physician

If any of the above information is incomplete or omitted, UPN Credentialing Department will contact the provider or group to obtain missing information. Failure to provide information may result in termination of the credentialing process. Due to the credentialing requirements of the Health Plans, providers may be asked to re-sign the Disclosure Questionnaire and Release Form during the credentialing process. This is necessary for NCQA and URAC compliance.

Physician credentials will be submitted to all Commercial Health Plans for which physician is deemed eligible. Eligibility is based partly on Hospital Affiliation. Physician may <u>not</u> opt out of participation in any Commercial Plans contracted with UPN unless the Health Plan rejects provider during the credentialing process.

STATE OF ILLINOIS

Health Care Professional Credentialing and Business Data Gathering Form

The Health Care Professional Credentials Data Collection Act [410 ILCS 517] requires that this form be collected from health care professionals by hospitals, health care entities, and health care plans which desire to credential such professional. Each hospital, health care entity, and health care plan may also require completion of supplemental forms.

INSTRUCTIONS

This form is for credentialing only. Other forms are required for credentialing and for updating information. YOU ONLY HAVE TO FILL OUT AND SUBMIT WHAT IS REQUESTED BY THE CREDENTIALING ENTITY. PLEASE REFER TO THE INSTRUCTIONS PROVIDED TO YOU BY THE ORGANIZATION YOU ARE APPLYING TO FOR THEIR REQUIREMENTS.

This form has been segmented into two (2) different Chapters, each containing various sections:

Chapter A: Practice and Professional Information
Chapter B: Business Information

As previously noted, please consult the specific credentialing entity instructions for their individual Chapter or Section requirements for submission.

GENERAL INSTRUCTIONS: Wherever this application requests information but does not provide sufficient space to provide a complete response (for example, you have more licenses, specialties, work history, etc.) provide attachments which contain all of the information requested in the relevant section OR duplicate the relevant section as many times as necessary and attach it to the back of this application.

The data marked as "Confidential Information" shall be maintained in confidence to the extent required by law. They may be used by the health care plan, entity or hospital and by their agents for credentialing and internal business purposes. Other data contained in this form may be released.

ATTACHMENTS

Attach forms A-F as needed to support "yes" responses in Section J: Professional History and copies of the following:

- ☐ Curriculum Vitae

CONFIDENTIAL INFORMATION:

- ☐ All Current Professional Licenses
- ☐ Current Federal DEA License, If Applicable
- ☐ Current State Controlled Substance License(s), If Applicable
- ☐ Current Professional Liability Insurance Face Sheet or Declaration of Insurance with Effective Date, Expiration Date and Amount Displayed per Occurrence and In Aggregate
- ☐ Current CLIA Certificate, If Applicable
- ☐ Current W-9s, If Applicable
- ☐ ECFMG Certificate, If Applicable
- ☐ Professional School Diploma, Residency Certificates, Fellowship Certificates, and Board Certifications, As Applicable

AFFIRMATION OF INFORMATION

I represent and warrant that all of the information provided and the responses given are correct and complete to the best of my knowledge and belief. I understand that falsification or omission of information may be grounds for rejection or termination, in addition to any penalties provided by law. I further agree to promptly inform all entities to which this form was sent and not rejected of any change required to be updated by the Health Care Professional Credentialing and Business Data Gathering Update Form.

I understand that this application does not entitle me to participation in any hospital, health care entity, or health plan.

Applicant's Signature	Type or Print Name	Date

** ***PLEASE BE ADVISED THAT EACH HOSPITAL, HEALTH CARE ENTITY,*** **
** ***AND HEALTH CARE PLAN MAY ALSO REQUIRE COMPLETION OF AN*** **
** ***ATTESTATION AND RELEASE OF INFORMATION FORM.*** **

CHAPTER A:
PRACTICE AND PROFESSIONAL INFORMATION

SECTION A. GENERAL INFORMATION

Name: _____
Last First MI Degree

List other names by which you have been known: _____
Last First MI

If you have been known by other names, please explain why your name changed:

_____

_____

Birth Date: _____ Place of Birth: _____
(mm/dd/yy) City State Country

Sex: ☐ Male ☐ Female Language Fluency of Applicant: ☐ English ☐ Other: _____

U.S. Citizen? ☐ Yes ☐ No ☐ Spanish

If no, do you have a legal right to reside permanently and work in the U.S.? ☐ Yes ☐ No

CONFIDENTIAL INFORMATION

Resident Visa No: _____

Social Security Number: _____

Emergency Contact Person: _____
Last First MI

Telephone Number: ( ) _____

Mailing Address: _____
Street City State Zip

Daytime Phone: ( ) _____ Fax Number: ( ) _____

E-Mail Address: _____

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION B. PROFESSIONAL INFORMATION

Illinois Professional License Number: _____

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

_____

Current and Previous Professional License(s) in Other States

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

_____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

_____

State: _____ License #: _____ Exp. Date: _____ (mm/dd/yy)

License Unlimited? Yes ☐ No ☐ → If No, please explain limitation: _____

_____

Check here if you have appended additional information for this section: ☐

Current Federal DEA License Number: _____ ***CONFIDENTIAL INFORMATION***

DEA License Number Expiration Date: _____ License Unlimited? Yes ☐ No ☐

If No, please explain limitation: _____

_____

Check here if you have appended additional information for this section: ☐

Current and Previous State Controlled Substance Number(s):

CONFIDENTIAL INFORMATION

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

State: _____ CS License #: _____ Expiration Date: _____ (mm/dd/yy)

Please identify all limitation related to the above Controlled Substances Number(s) and explain limitation.

_____

_____

Medicare Unique Provider ID# (UPIN): _____

National Provider Identification Number (NPI): _____

Medicaid ID#: _____

X-Ray Certification: State: _____ Certificate #: _____ Expiration Date: _____ (mm/dd/yy)

Check here if you have appended additional information for this section: ☐

COMPLETE FOR EACH SPECIALTY

Specialty I: _____

Are you Board Certified in Specialty I? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty II: _____

Are you Board Certified in Specialty II? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

(Please continue next page)

Specialty/Subspecialty III: _____

Are you Board Certified in Specialty III? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Specialty/Subspecialty IV: _____

Are you Board Certified in Specialty IV? Yes ☐ No ☐

If Yes, name of Certifying Board: _____

Date of Certification: _____ (mm/yy) Date of Recertification (if applicable): _____ (mm/yy)

If No, have you taken or are you scheduled to take the specialty boards certification? Yes ☐ No ☐

If Certifying Boards taken, give date: _____ (mm/yy) Certification Expiration Date, if Any: _____ (mm/yy)

If not taken, date scheduled to take Specialty Boards: _____ (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION C. PROFESSIONAL LIABILITY INSURANCE

Please provide information on all professional liability insurance carriers from whom you have received coverage in the past 10 years.

CURRENT PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ (mm/dd/yy) Expiration Date: _____ (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____ (mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage? ☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

PREVIOUS PROFESSIONAL LIABILITY INSURANCE

CONFIDENTIAL INFORMATION:

Carrier: _____

Address: _____
Street City State Zip

Policy Number: _____ Original Effective Date: _____ Expiration Date: _____
(mm/dd/yy) (mm/dd/yy)

Policy Limits: Per Occurrence: $ _____ Aggregate: $ _____

Retroactive Date: _____
(mm/dd/yy)

What type of coverage do you have? ☐ Claims Made ☐ Occurrence

Has any judgment or payment of claim or settlement amount exceeded the limits of this coverage?
☐ Yes ☐ No

SECTION D. EDUCATION AND TRAINING

If there are any gaps in your training (greater than 30 days), or if you have not completed any portion of your training, please explain on a separate sheet of paper and attach to this application.

MEDICAL/PROFESSIONAL SCHOOL

Institution Name: _____

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Degree: _____ Year Graduated: _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

If you are a graduate of a foreign medical school, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

Date Issued: _____ Serial Number for ECFMG: _____
mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If you attended more than one medical/professional school, please check here and attach an explanation that duplicates the information requested above: ☐

INTERNSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of internship: ☐ Rotating ☐ Straight → If straight, please list specialty: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than one internship, please check here and attach additional information that duplicates the information requested above: ☐

FIRST RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of residency: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

SECOND RESIDENCY

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of residency: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than two residencies, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

FIRST FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of fellowship: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

SECOND FELLOWSHIP

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates attended: From: _____ To: _____
mm/yy mm/yy

Type of fellowship: _____

Did you successfully complete this program? ☐ Yes ☐ No → If no, please attach an explanation.

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.) ←

If more than two fellowships, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (MOST RECENT)

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

TEACHING EXPERIENCE/FACULTY APPOINTMENT (PREVIOUS)

Institution Name: _____

Department Chair or Program Director: _____
Last Name First Name MI Degree

Mailing Address: _____
Street City State Zip

Telephone Number: ( ) _____ Fax Number: ( ) _____

Dates: From: _____ To: _____ Rank/Position, if applicable: _____
mm/yy mm/yy

Were you the subject of any disciplinary action during your attendance at this institution? ☐ Yes ☐ No

(Attach an explanation of a "Yes" answer.)

If more than two teaching experiences/faculty appointments, please check here and attach additional information that duplicates the information requested above: ☐

(Please continue next page)

MEMBERSHIP STATUS – USE FOR SECTIONS E, F, AND G

Please use the following key to indicate membership status in Sections E (Hospital Membership – Current and Pending), F (Hospital Membership – Previous), and G (Ambulatory Surgery Center Practice) below.

A. Active	E. Suspended / Terminated/ Resigned	I. Provisional
B. Courtesy	F. Active Provisional Staff	J. Affiliate
C. Consulting	G. Senior Staff	K. Pending
D. Adjunct	H. Associate	L. Other (Specify)

SECTION E. HOSPITAL MEMBERSHIP - CURRENT AND PENDING

Please list all hospitals at which you are a member of the Medical Staff and have clinical privileges or have applications for privileges pending. (Include additional sheets if more than three hospitals.)

A. Primary Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ **To Present**
From (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: ( ) _____

Department Telephone #: ( ) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

B. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: ( ) _____

Department Telephone #: ( ) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

C. Other Hospital

Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: ( ) _____

Department Telephone #: ( ) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

Check here if you have appended additional information for this section: ☐

SECTION F. HOSPITAL MEMBERSHIP – PREVIOUS

Please list all hospitals where you previously held privileges other than during your Internship/Residency/Fellowship. Use the Membership Status key listed prior to Section E. (Include additional sheets if more than three hospitals.)

A. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: ( ) _____

Department Telephone #: ( ) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

B. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: ( ) _____

Department Telephone #: ( ) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

C. Hospital Name: _____

Address: _____
Street City State Zip

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Department/Division: _____ Medical Staff Office FAX #: ( ) _____

Department Telephone #: ( ) _____

Any Limitations in Your Area of Specialty at this Hospital? _____

_____

Check here if you have appended additional information for this section: ☐

SECTION G. AMBULATORY SURGERY CENTER PRACTICE

Please list all ambulatory surgery centers where you currently have or previously had privileges. Use the Membership Status key at the top of page 13. (Include additional sheets if more than three ambulatory surgery centers.)

A. Primary Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: ( ) _____ Fax Number: ( ) _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

B. Other Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: ( ) _____ Fax Number: ( ) _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

C. Other Ambulatory Surgery Center

ASC Name: _____

Address: _____
Street City State Zip

Telephone: ( ) _____ Fax Number: ( ) _____

Membership Status: _____ Dates: _____ To: _____
From (mm/yy) To (mm/yy)

Check here if you have appended additional information for this section: ☐

SECTION H. WORK HISTORY

List chronologically (most recent first) all work engagements (including employment, self-employment, service as an independent contractor, and military service). Do not duplicate internship, residency, and fellowship information previously reported. If there is any gap of greater than 30 days in chronology, explain it on a separate page.

Current work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to Present**
(mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Previous work place: ______________________________

Address: ______________________________
Street City State Zip

Telephone: ( ) ________ Fax Number: ( ) ________

Title or Professional Occupation: ______________________________

Time in this employment: From: ________ **to:** ________
(mm/yy) (mm/yy)

Check here if you have appended additional information for this section: ☐

(Please continue next page)

SECTION I. PROFESSIONAL REFERENCES

Please list the names of three individuals who have personal knowledge (within the past 12 months) of your current clinical abilities, ethical character and interpersonal skills and who would be willing to provide this information upon request. Do not list partners or department chairpersons. Do not list relatives or people listed elsewhere in this credentialing form.

CONFIDENTIAL INFORMATION

1. Name:_____ Title:_____
Last First MI Degree

Specialty:_____

Mailing Address:_____
Street City State Zip

Telephone: (___)_____ Fax Number: (___)_____

Relationship: _____ Years Known:_____

2. Name:_____ Title:_____
Last First MI Degree

Specialty:_____

Mailing Address:_____
Street City State Zip

Telephone: (___)_____ Fax Number: (___)_____

Relationship: _____ Years Known:_____

3. Name:_____ Title:_____
Last First MI Degree

Specialty:_____

Mailing Address:_____
Street City State Zip

Telephone: (___)_____ Fax Number: (___)_____

Relationship: _____ Years Known:_____

(Please continue next page)

SECTION J. PROFESSIONAL HISTORY: CONFIDENTIAL

ADVERSE OR OTHER ACTIONS

Submit with all applications. Please answer the following questions to the best of your knowledge with a "yes" or "no." If you answer "yes" to any question(s) please complete Form A. Please make copies of Form A as needed and complete one form for each "yes" answer.

1. Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to probation either voluntarily or involuntarily, or has your application for a license ever been withdrawn? ☐ Yes ☐ No

2. Have you ever been reprimanded and/or fined, been the subject of a complaint and/or have you been notified in writing that you have been investigated as the possible subject of a criminal, civil or disciplinary action by any state or federal agency which licenses providers? ☐ Yes ☐ No
☐

3. Have you lost any board certification(s), and/or failed to recertify? ☐ Yes ☐ No

4. Have you been examined by a Certifying Board but failed to pass? ☐ Yes ☐ No

5. Has any information pertaining to you, including malpractice judgments and/or disciplinary action, ever been reported to the National Practitioner Data Bank (NPDB) and/or any other practitioner data bank? ☐ Yes ☐ No

6. Has your federal DEA number and/or state controlled substances license been restricted, limited, relinquished, suspended or revoked, either voluntarily or involuntarily, and/or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action with respect to your DEA or controlled substance registration?☐ ☐ Yes ☐ No

7. Have you, or any of your hospital or ambulatory surgery center privileges and/or membership been denied, revoked, suspended, reduced, placed on probation, proctored, placed under mandatory consultation or non-renewed? ☐ Yes ☐ No

8. Have you voluntarily or involuntarily relinquished or failed to seek renewal of your hospital or ambulatory surgery center privileges for any reason? ☐ Yes ☐ No

9 Have any disciplinary actions or proceedings been instituted against you and/or are any disciplinary actions or proceedings now pending with respect to your hospital or ambulatory surgery center privileges and/or your license?☐ ☐ Yes ☐ No

10. Have you ever been reprimanded, censured, excluded, suspended and/or disqualified from participating, or voluntarily withdrawn to avoid an investigation, in Medicare, Medicaid, CHAMPUS and/or any other governmental health-related programs?☐ ☐ Yes ☐ No

11. Have Medicare, Medicaid, CHAMPUS, PRO authorities and/or any other third party payors brought charges against you for alleged inappropriate fees and/or quality-of-care issues?☐ ☐ Yes ☐ No

12. Have you been denied membership and/or been subject to probation, reprimand, sanction or disciplinary action, or have you ever been notified in writing that you are being investigated as the possible subject of a criminal or disciplinary action by any health care organization, e.g. hospital, HMO, PPO, IPA, professional group or society, licensing board, certification board, PSRO, or PRO?☐ ☐ Yes ☐ No

13. Have you withdrawn an application or any portion of an application for appointment or reappointment for clinical privileges or staff appointment or for a license or membership in an IPA, PHO, professional group or society, health care entity or health care plan prior to a final decision to avoid a professional review or an adverse decision? ☐ Yes ☐ No

PROFESSIONAL LIABILITY ACTIONS

If you answer yes to any question(s) in this section please complete FORM B. Please make copies of FORM B if needed, and complete one for each yes answer.

1. Have any professional liability judgments ever been entered against you? ☐ Yes ☐ No

2. Have any professional liability claim settlements ever been paid by you and/or paid on your behalf? ☐ Yes ☐ No

3. Are there any currently pending professional liability suits, actions and/or claims filed against you? ☐ Yes ☐ No

4. Has any person or entity ever been sued for your clinical actions? ☐ Yes ☐ No

LIABILITY INSURANCE

If you answer yes to this question please complete FORM C.

Have you ever been denied or voluntarily relinquished your professional liability insurance coverage, and/or have had your professional liability insurance coverage canceled, non-renewed or limits reduced ? ☐ Yes ☐ No

CRIMINAL ACTIONS

If you answer yes to any question(s) in this section please complete FORM D. Please make copies of FORM D if needed, and complete one for each yes answer.

1. Have you been charged with or convicted of a crime (other than a minor traffic offense) in this or any other state or country and/or do you have any criminal charges pending other than minor traffic offenses in this state or any other state or country? ☐ Yes ☐ No

2. Have you been the subject of a civil or criminal complaint or administrative action or been notified in writing that you are being investigated as the possible subject at a civil, criminal or administrative action regarding sexual misconduct, child abuse, domestic violence or elder abuse? ☐ Yes ☐ No

MEDICAL CONDITION

If you answer yes to this question please complete FORM E.

Do you have a medical condition, physical defect or emotional impairment which in any way impairs and/or limits your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No

CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

If you answer yes to any question(s) in this section please complete FORM F. Please make copies of FORM F if needed, and complete one for each yes answer.

1. Are you currently engaged in illegal use of any legal or illegal substances? ☐ Yes ☐ No
2. Do you currently overuse and/or abuse alcohol or any other controlled substances? ☐ Yes ☐ No
3. If you use alcohol and/or chemical substances, does your use in any way impair and/or limit your ability to practice medicine with reasonable skill and safety? ☐ Yes ☐ No
4. Are you currently participating in a supervised rehabilitation program and/or professional assistance program which monitors you for alcohol and/or substance abuse? ☐ Yes ☐ No

INVESTMENTS

In the last five (5) years have you and/or a member of your family purchased or made an investment in (other than securities of a publicly traded company), or otherwise have a business interest in any clinical laboratory, diagnostic or testing center, hospital, surgicenter, and/or other business dealing with the provision of ancillary health services, equipment or supplies? ☐ Yes ☐ No

If Yes, please provide explanation: _____

_____

_____

_____

_____

(Please continue next page)

CHAPTER B:
BUSINESS INFORMATION

SECTION K. PRIMARY SITE INFORMATION

Please provide the following information for the primary site at which you practice.

Primary Site

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( ) Main Telephone Number

Office Administrator – Last First MI

( ) Beeper Number

( ) FAX Number

E-mail

( ) Emergency Number

( ) Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

_____ _____ _____

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ( )
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____
Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ( )
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Name: ____
Last First MI Degree

Specialty: ______________________________________

Address: ______________________________________ Telephone: ( )
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ______________________________________ Specialty: ________________
Last First MI

Name: ______________________________________ Specialty: ________________
Last First MI

Name: ______________________________________ Specialty: ________________
Last First MI

SECTION L. PRIMARY SITE TAX INFORMATION

Please provide the following information for your Primary Site. Include tax information for each business arrangement you use at this site. (Please include additional sheets if more than four applicable business arrangements.)

Business Arrangement #1

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

Business Arrangement #2

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

Business Arrangement #3

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

Business Arrangement #4

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

SECTION M. ADDITIONAL SITE INFORMATION

Please provide the following information for each additional site at which you practice.

Site #

Group/Business Name

Building Name

Office Address – Number and Street – Suite

City County State Zip

( ) Main Telephone Number

Office Administrator – Last First MI

( ) Beeper Number

( ) FAX Number

E-mail

( ) Emergency Number

( ) Answering Service

Specialty practiced at this site:

Is your practice restricted within your specialty (e.g., by age or type of patient)? ☐ Yes ☐ No

If yes, describe the restrictions:

Briefly describe your practice at this location, including any special practice focus or equipment:

Are you currently accepting new patients at this location? ☐ Yes ☐ No

If yes, describe any restrictions (e.g., appointment type, patient type):

Please provide the number of active patients enrolled with you at this site:

Please provide the number of patient visits you have at this site per year:

Indicate your office schedule at this location in the following table. Write your specific hours in the appropriate spaces for each day:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Hours	to	to	to	to	to	to	to

Please indicate standard patient waiting times to schedule an appointment at this site for:

	New Patient	Existing Patient
Emergency Care		
Urgent Care		
Symptomatic Care (e.g., sore throat)		
Routine Visits (e.g., blood pressure check)		
Preventive Routine Care (e.g., school or annual physical)		

Please provide the following regarding your practice at this site:

Maximum Number of Appointments per Hour		
Average Waiting Time in Office (from scheduled appointment time to actual examination)		
Average Response Time for Returning Patient Calls:	Acute or Urgent Situation:	
	Emergency Situation:	
	Routine Call:	

Please check all procedures you perform at this site:

☐ Age-appropriate immunizations	☐ EKG	☐ Drawing blood
☐ Tympanometry/audiometry screening	☐ X-rays	☐ Minor surgery
☐ Pulmonary function studies	☐ Flexible sigmoidoscopy	☐ Laceration repair
☐ Office gynecology (routine pelvic/PAP)	☐ Asthma treatment	☐ Allergy skin testing
☐ Osteopathic /Chiropractic manipulation	☐ IV hydration/treatment	☐ Physical Therapy

List any special skills or qualifications you or your office staff have that enhance your ability to practice medicine or treat certain patients or classes of patients. List separately any special language skills, such as fluency in a foreign language or proficiency in sign language.

Special Skills of Practitioner: _____

Special Skills of Staff: _____

Languages Spoken by Practitioner: _____

Languages Written by Practitioner: _____

Languages Spoken by Staff: _____

Languages Written by Staff: _____

Is this practice site handicapped accessible (check all that apply)?

☐ Building ☐ Parking ☐ Wheelchair ☐ Restroom

Does this site employ paraprofessionals for direct patient care? ☐ Yes ☐ No

If yes, is supervision always provided on premises during paraprofessionals' direct patient care?

☐ Yes ☐ No

Do the paraprofessional(s) bill under any of your Tax ID Numbers? ☐ Yes ☐ No

If yes, list Tax ID Numbers used: ***CONFIDENTIAL INFORMATION***

_____ _____ _____

Lab Service at this site? ☐ Yes ☐ No

If yes, check whether: ☐ Primary ☐ Secondary ☐ Tertiary

CLIA Waiver: ☐ Yes ☐ No

If yes, CLIA Expiration Date: ________________

Please provide the following information about physician(s)/practitioner(s) who provide coverage for patients enrolled at this site when you are not available.

Name: ____
Last First MI Degree

Specialty: ____

Address: ____ Telephone: (   ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ____ Telephone: (   ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________________

Name: ____
Last First MI Degree

Specialty: ____

Address: ____ Telephone: (   ) __________
Street City State Zip

Availability: ☐ Days ☐ Nights ☐ Weekends ☐ Holidays

CONFIDENTIAL INFORMATION: Tax ID #: ________________________

Please provide the following information about physician(s)/practitioner(s) who practice in this office:

Name: ____ Specialty: ________________
Last First MI

Name: ____ Specialty: ________________
Last First MI

Name: ____ Specialty: ________________
Last First MI

SECTION N. ADDITIONAL SITE TAX INFORMATION

Please provide the following information for each additional site at which you practice. Include tax information for each business arrangement you use at this site. (If there is more than one additional site, or more than five business arrangements at any one site, please copy and complete this page for each additional site and business arrangement.)

Business Arrangement #1

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

Business Arrangement #2

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

Business Arrangement #3

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

Business Arrangement #4

Name of Business Arrangement On SS4 or W-9 Form: _____

Type of Arrangement (e.g., solo or group practice, IPA, PHO): _____

CONFIDENTIAL INFORMATION: Tax ID for this Arrangement: _____

Billing Address, if Different from Primary Site: _____

Telephone Number, if Different from Primary Site: (___) _____

End Credentialing and Business Data Gathering Form.
Attach Forms A-F As Required.

FORM A – ADVERSE AND OTHER ACTIONS

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

Indicate the number of ONE of the questions in Section J to which you answered "yes": Question Number: ____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

_____

_____

_____

_____

_____

B. Provide an explanation of any actions taken. Please include the date the action was taken.

_____

_____

_____

_____

_____

C. Provide the current status of the issue.

_____

_____

_____

_____

_____

D. If known: Contact: _____

Department/Committee: _____

Address: _____
Street City State Zip

Telephone: ( ) _____

Signature: _____ **Date:** _____

FORM B – PROFESSIONAL LIABILITY ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Plaintiff's Name: _____
Last First MI

If court case, Case Name & Case Number: _____

_____

B. Your Involvement in the Care (Attending, Consulting, Etc.): _____

C. Your Status in the Case (Sole Defendant, Co-Defendant, Ownership Interest in Provider Practice Name in Suit, Etc.): _____

D. Allegations, including Patient Outcome, if Available: _____

_____

_____

_____

E. Date of Incident (mm/yy): _____ F. Date Filed (mm/yy): _____

G. Date Case Closed (mm/yy): _____

Resolution Case: ☐ Dismissed ☐ Judgment ☐ Arbitration ☐ Other
☐☐ Settlement out of Court ☐ Pending ☐ Mediation

H. Amount Paid on Your Behalf (if any): $ _____

I. Professional Liability Insurer Name (if one was involved): _____

J. Insurer Telephone Number: ( ) _____ K. Policy Number: _____

L. Insurer Address (Street, City, State, Zip Code):

_____

_____

Signature: _____ **Date:** _____

FORM C – LIABILITY INSURANCE

DUPLICATE this form as necessary to complete a separate sheet for EACH action or allegation. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. **History of Professional Liability Insurance (Please check One)**

☐ Canceled Voluntarily ☐ Non-Renewed

☐ Canceled Involuntarily ☐ Application Denied

B. Carrier Name: _____

C. Carrier Telephone Number: ( ) _____

D. Policy Number: _____

E. Carrier Address (Street, City, State, Zip Code):

_____

_____

F. Dates of Coverage: From (mm/yy): _____ To (mm/yy): _____

G. Circumstances Involved: _____

_____

Signature: _____ **Date:** _____

FORM D – CRIMINAL ACTIONS

DUPLICATE this form as necessary to complete a separate sheet for EACH incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Date of Incident (mm/yy): _____

B. Date of Complaint or Conviction (mm/yy): _____

C. Date of Resolution (mm/yy): _____

D. Type of Resolution (Dismissed, Plea Bargain, Misdemeanor, Felony): _____

E. Allegation(s): _____

F. Details of Incident: _____

G. Actions Taken Against You: _____

H. Current Status of Situation: _____

I. Medical Practice Privileges Affected as a Result of This Situation: _____

Signature: _____ **Date:** _____

FORM E – MEDICAL CONDITION

DUPLICATE this form as necessary to complete a separate sheet for EACH condition. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

A. Describe this medical condition: _____

_____

_____

_____

_____

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

_____

C. What is the current status of your condition? _____

_____

_____

_____

D. Provide the name and address of your personal physician/health care provider who can provide information about your health condition.

Name **Telephone Number**

_____ ( ) _____
Last First MI Degree

_____ ( ) _____
Last First MI Degree

Signature: _____ **Date:** _____

FORM F – CHEMICAL SUBSTANCES OR ALCOHOL ABUSE

DUPLICATE this form as necessary to complete a separate sheet for EACH chemical substance incident. Use reverse side of this form if additional space is needed.

Applicant Name: _____
Last First MI

Describe the substance you use:

_____

A. To what extent does, or could, your use of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

_____

_____

B. Monitored by State Board Mandate (Name and Address)

_____

_____

_____

C. Monitored Voluntarily (Name and Address)

_____

_____

_____

D. Other information about the current status of your use of substances:

_____

_____

E. Abstinent since (mm/yy): _____

F. Provide the name and address of your personal physician/health care provider who can provide information about your treatment for alcohol or chemical substance use and can comment on what impact (if any) it has on your current/future professional practice.

Name: _____

Address: _____
Street City State Zip

Telephone: ( ) _____

Signature: _____ **Date:** _____

IMPORTANT NOTICE

The next 6 pages are the Health Plans own version of the Attestation and Release form, W-9 Tax form, and NPI Submission form. Humana, Harmony, and HMOI (Blue Cross Blue Shield) require that these be completed.

It is imperative that you comply with this requirement by affixing your signature & date ("providers"). This helps ensure a timely credentialing process by the following health plans for your continued network participation and avoid return of you application.

National Provider Identifier (NPI) Submission Form

Section 1 – Provider General Information

_____, _____ ____ _____

Physician's/Provider's Last Name First Name MI Degree/Title

Tax ID Number:_____

Section 2 – NPI Information

National Provider Identifier (NPI)#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

NOTE: *YOU MUST SUBMIT A COPY OF THE LETTER OR E-MAIL FROM THE ENUMERATOR VERIFYING NPI ASSIGNMENT*

Please mail or fax your completed form and a copy of the enumerator's letter or confirmation e-mail as soon as possible to the following location:

Unified Physicians Network
5215 Old Orchard Road
Suite 340
Skokie, IL 60077-1042
Attention: Credentialing Coordinator
Fax #: 847-676-6983

Section 3 – Primary Office Address

Address 1_____

City:_____State:_____Zip Code:_____

Phone No:_____Fax No:_____Provider E-mail Address:_____

Section 4 – Contact Information

Name of Individual Completing Form:_____

Phone No: _____Fax No:_____Contact E-mail Address:_____

For Office Use Only

Form **W-9**
(Rev. January 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► .....

☐ Exempt from backup withholding

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

Requester's name and address (optional)

City, state, and ZIP code

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 your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. *If the account is in more than one name, see the chart on page 4 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. person (including a U.S. resident alien).

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 on page 4.)

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

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note. *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

For federal tax purposes you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Foreign person. If you are a foreign person, do not use Form W-9. Instead, use the appropriate Form W-8 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity not subject to backup withholding, give the requester the appropriate completed Form W-8.

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments (after December 31, 2002). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester, or

2. You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

3. The IRS tells the requester that you furnished an incorrect TIN, or

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate Instructions for the Requester of Form W-9.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

Sole proprietor. Enter your individual name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

Limited liability company (LLC). If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, enter the owner's name on the "Name" line. Enter the LLC's name on the "Business name" line. Check the appropriate box for your filing status (sole proprietor, corporation, etc.), then check the box for "Other" and enter "LLC" in the space provided.

Other entities. Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

Note. You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).

Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

Note. If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.

Exempt payees. Backup withholding is not required on any payments made to the following payees:

1. An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2),

2. The United States or any of its agencies or instrumentalities,

3. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities,

4. A foreign government or any of its political subdivisions, agencies, or instrumentalities, or

5. An international organization or any of its agencies or instrumentalities.

Other payees that may be exempt from backup withholding include:

6. A corporation,

7. A foreign central bank of issue,

8. A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States,

9. A futures commission merchant registered with the Commodity Futures Trading Commission,

10. A real estate investment trust,

11. An entity registered at all times during the tax year under the Investment Company Act of 1940,

12. A common trust fund operated by a bank under section 584(a),

13. A financial institution,

14. A middleman known in the investment community as a nominee or custodian, or

15. A trust exempt from tax under section 664 or described in section 4947.

The chart below shows types of payments that may be exempt from backup withholding. The chart applies to the exempt recipients listed above, 1 through 15.

IF the payment is for . . .	**THEN** the payment is exempt for . . .
Interest and dividend payments	All exempt recipients except for 9
Broker transactions	Exempt recipients 1 through 13. Also, a person registered under the Investment Advisers Act of 1940 who regularly acts as a broker
Barter exchange transactions and patronage dividends	Exempt recipients 1 through 5
Payments over $600 required to be reported and direct sales over $5,000 [1]	Generally, exempt recipients 1 through 7 [2]

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation (including gross proceeds paid to an attorney under section 6045(f), even if the attorney is a corporation) and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees; and payments for services paid by a Federal executive agency.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-owner LLC that is disregarded as an entity separate from its owner (see *Limited liability company (LLC)* on page 2), enter your SSN (or EIN, if you have one). If the LLC is a corporation, partnership, etc., enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local Social Security Administration office or get this form online at *www.socialsecurity.gov/online/ss-5.pdf*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses/* and clicking on Employer ID Numbers under Related Topics. You can get Forms W-7 and SS-4 from the IRS by visiting *www.irs.gov* or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Writing "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded domestic entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, and 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). Exempt recipients, see *Exempt From Backup Withholding* on page 2.

Signature requirements. Complete the certification as indicated in 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account [1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor [2]
4. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee [1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner [1]
5. Sole proprietorship or single-owner LLC	The owner [3]
For this type of account:	**Give name and EIN of:**
6. Sole proprietorship or single-owner LLC	The owner [3]
7. A valid trust, estate, or pension trust	Legal entity [4]
8. Corporate or LLC electing corporate status on Form 8832	The corporation
9. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
10. Partnership or multi-member LLC	The partnership
11. A broker or registered nominee	The broker or nominee
12. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or "DBA" name on the second name line. You may use either your SSN or EIN (if you have one). If you are a sole proprietor, IRS encourages you to use your SSN.

[4] List first and circle the name of the legal trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.)

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons who must file information returns with the IRS to report interest, dividends, and certain other income paid to you, mortgage interest you paid, the acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA, or Archer MSA or HSA. The IRS uses the numbers for identification purposes and to help verify the accuracy of your tax return. The IRS may also provide this information to the Department of Justice for civil and criminal litigation, and to cities, states, and the District of Columbia to carry out their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You must provide your TIN whether or not you are required to file a tax return. Payers must generally withhold 28% of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to a payer. Certain penalties may also apply.

Blue Cross Blue Shield of Illinois
300 East Randolph Street
Chicago, Illinois 30301-3099

To Practitioners applying for Participation with HMO and Point of Service product:
Submit this attention; signed & dated with State of Illinois Health care Professional Credentialing/Recredentialing and Business Data Gathering Form

ATTESTATION FOR PROVIDER CREDENTIALING

I authorize **Blue Cross** and Blue Shield of Illinois **"BCBSIL"** to consult with hospital administrator, members of hospital medical staffs, professional liability carriers, managed care organizations, the National Practitioner Data Bank, and other persons or entities to obtain information concerning my qualifications, including, but not limited to, my professional qualifications, background, abilities, competence and my practice history.

I consent to the release to **BCBSIL** of any and all information that may be relevant to an evaluation of my qualifications, Including information about disciplinary actions and information that might otherwise be considered confidential or privileged.

I authorize **BCBSIL** to release this information, as well as quality assurance data relating to me, to medical groups, independent practice associations and similar entities contracting with **BCBSIL** and as authorized under state and federal law or regulation.

I release **BCBSIL** and any and all persons or entities providing information about me to **BCBSIL** from any and all liability connected with or arising from the release of such information, provided that such party (ies) was acting in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that I have the burden of providing adequate information to **BCBSIL** to demonstrate my qualifications. I understand and agree that any misstatement or material omission in this application will constitute grounds for rejection of my application or summary dismissal as a partcipating provider in any and all managed care networks contracting with **BCBSIL**.

If any material changes occur in the Information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify **BCBSIL** or the appropriate subsidiary or affiliate within ten (10) days of said occurrence. Failure to comply with this obligation may constitute grounds for rejection of my application or summary dismissal as a participating provider in any and all managed care networks contracting with **BCBSIL**.

I agree that a photocopy of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original.

I attest that the information contained in this application is correct and complete.

Physician Signature _____ Date _____

Physician Name (Please Print) _____ License Number _____

Attestation/Consent Release Form

HARMONY
HEALTH PLAN

Provider Acknowledgement, Authorization and Attestation

(Any alteration or failure to sign and date this *form may* result in *delay in y*our *application* process)

I hereby give permission to Harmony Health Plan. inc. directly and/or Through its Credentialing designee; to request information regarding my professional credentials and qualifications from educational facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, slate regulatory and licensing departments, professional liability
y Insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications. credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Harmony Health Plan, Inc., and its Credentialing designee. and their respective officers, directors, representatives, employees and agent from any and all liability for any damages, costs and expenses which may result from the gathering or good faith use of the information gathered during the credentialing process.

I hereby authorize the education facilities, the chief(s) of the clinical department(s) of the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, and state regulatory and licensing departments. Professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Harmony Health Plan. Inc. directly *and/*or through its Credentialing designee. including otherwise privileged or confidential material relative to my professional qualifications, credentials. past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. If applicable, I hereby authorize the Physician Recovery Network or applicable recovery program to release to Harmony Health Plan, Inc information regarding my health status and participation slates in any treatment program(s). I hereby further release and agree to hold harmless all such entities referenced In the previous sentence. their representatives, employees, and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that the photocopy or facsimile of this document with my signature may be accepted by any person or *entity* from which such information is sought with the same authority as the original, and I specifically waive written notice *from* any such entities or individuals who may provide information based upon this authorized request

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection *of* this application by Harmony Health Plan, Inc and may result in denial of *my* application or termination of my participation in Harmony Health Plan, Inc. I further understand that any representation, misstatement or omission fr*om* this application. if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to Inform Harmony Health Plan. Inc in writing within 15 days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf. and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, l consent to the inspection of my patient records for Plan Members as necessary for peer and utilization review purposes and agree to be bound by the participation agreement. credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by the Harmony Health Plan, Inc to evaluate my credentialing application. This includes Information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 8 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Harmony Health Plan, inc. to allow a provider to review references or recommendations or other information that is peer-review protected.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Harmony Health Plan. Inc may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I represent the information provided in or attached to this application is accurate and complete. I attest to either having adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state, financial responsibility requirements. I certify that I hold a full, unrestricted license to practice medicine in the slate in which I reside. ı agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to Harmony Health Plan. Inc through its Credentialing designee. and I agree I will continue to maintain active admitting and staff privileges at a Harmony Health Plan, Inc participating hospital.

This attestation statement must be signed no more than 180 days prior to the credentialing decision. If the credentialing review decision takes place more than 180 days after the signature below, provider must re-sign and date this application page attesting that all application information remains current, complete and correct.

I hereby authorize Physician Recovery Network or applicable recovery program to release Harmony Health Plan, Inc information regarding my health status in any treatment program(s).

Your signature is required to complete this application. Stamped signatures are not acceptable.
This health c*are* organization does not discriminate on the basis of race, c*olor,* and national origin, age. or disability.

Name (Please Print *or Type)*	Signature	Date

HUMANA HEALTH PLANS

CONSENT AND RELEASE FORM FOR _____

(Please Print Applicant's Name)

I hereby apply for privileges to participate with (Humana Health Plans) and its affiliates that underwrite or administer health plans (hereafter severally and collectively as the "Plan") as requested in this application and I am willing to make myself available for interviews in regard to said application

***I acknowledge and agree* that**; (a) Privileges to participate as a provider with the Plan is not a right; and (b) By applying for privileges with the Plan I am agreeing to comply with the terms and conditions of the Participation Agreement ("Agreement"), whether signed by me or not, pursuant to which I am rendering services to Plan Members either as a direct contractor, subcontractor, independent contractor, or covering physician.

As an applicant, I agree to produce adequate information for proper evaluation of my professional qualifications. I also agree to update the Plan with current information regarding all responses and/or questions contained in this application and/or information obtained through the credentialing process as such information becomes available and any additional information as requested by the Plan or its authorized representatives. Failure to produce such information will prevent my application from being evaluated and acted upon, and may affect any existing privileges I have with the Plan

Information given, in or attached to this application is accurate and complete to the best of my knowledge. As a condition to making this application, any misrepresentation or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of request for participation. In the event that participation has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of participation with the Plan.

For the purpose of obtaining and maintaining credentialing or privileges with the Plan, I agree to hold harmless and from any and all liability, the Plan, its authorized representatives and any third parties, for any acts performed in good faith and without malice relating to any communications or disclosures of any kind, involving me which are performed, otherwise privileged or confidential information. Such information may relate to, but not be limited to information sharing on my professional qualifications, credentials, clinical competence and any other matter which might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of a health care facility on an ongoing basis.

It is understood *by* both parties hereto that any and all information obtained by the Plan shall be confidential to the fullest extent permitted by law, regardless of whether my membership and privileges are approved or subsequently terminated, except as otherwise provider herein or in the separate participation agreement under which I will provide services to Plan members.

The term "Plan and its authorized representatives" means the corporation(s) with which I have applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating my credentials; or acting upon my application: the members of the Plan's Board and their appointed representatives, the Chief Executive Officer or his designees, other Plan employees, consultants to the Plan, delegated credentialing entities, the Plan's attorney and his/her partners, associates or designees. The term "third parties" means all individuals, including appointees to the Plan's medical staffs, hospitals, other physicians or health practitioners, nurses, government agencies, organizations, professional liability insurance carriers, associations, partnerships, and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Plan or its authorized representatives or who have requested such information from the Plan and its authorized representatives.

As *a condition* of the Plan's acceptance of my application for participation privileges and in support of the Plan's commitment to continuous quality improvement and peer review, I hereby authorize the Plan and its authorized representatives to disclose and communicate with my employer, partners or affiliates, as applicable in relation to my provision of medical and related health care services to Plan members, regarding actions or information relating to the Plan credentialing, re-credentialing and/or quality management programs.

I hereby acknowledge that this Consent and Release Form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

Applicant's Signature: _____ Date: _____