PROVIDER CREDENTIALING

APPLICATION CHECK LIST

Please make sure all the following document copies are included with your credentialing application:

_____ W-9 Form

_____ NPI (National Practitioner Identifier documentation) Form

_____ California License

_____ DEA Certificate (if applicable)

_____ Malpractice Insurance Face Sheet

_____ Curriculum Vitae with work history/employment in mm/yy format

Please return the completed application with all requested documents by email to:

credentialing@goldencoastmso.com

For questions or assistance completing the CPPA, please contact the credentialing department.

California Participating Physician Application

This application is submitted to: _____ , herein, this Healthcare Organization [1]

I. INSTRUCTIONS

reference the question being answered. Please do not use abbreviations. Current copies of the following documents must be submitted with this application:

- State Medical License (s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	**First:**	**Middle:**
Is there any other name under which you have been known? Name (s)		
Home Mailing Address:	**City:**	
	State:	**ZIP:**
Home Telephone Number:	**E-Mail Address:**	
Home Fax Number:	**Pager Number:**	
Birth Date: / **Birth Place (City/State/Country):**	**Citizenship (If not a United States citizen, please include copy of Alien Registration Card).**	
Social Security No.:	**Gender :** D **Male** D **Female**	
Specialty:	**Race/Ethnicity [2] (voluntary):**	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	**Department Name (If Hospital Based):**	
Primary Office Street Address:	**City:**	
	State:	**ZIP:**
Telephone Number:	**Fax Number:**	
Office Manager/Administrator:	**Telephone Number: ( )**	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	

1 As used in the Information release/Acknowledgment Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above
2 This information will be used for consumer purposes only.

Physician Name: _____

Secondary Office Street Address:	**City:**	
	State:	**ZIP:**
Office Manager/Administrator:	**Telephone Number: ( )**	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	
Teriary Office Street Address:	**City:**	
	State:	**ZIP:**
Office Manager/Administrator:	**Telephone Number: ( )**	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	**Federal Tax ID Number:**	
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	**Degree Received:**		**Date of Graduation: (mm/yy)**
Mailing Address:	**City:**	**State:** **County:**	**ZIP:**

V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Medical School:	**Degree Received:**		**Date of Graduation: (mm/yy)**
Mailing Address:	**City:** **Columbus**	**State:**	**ZIP:**
Medical/Professional School:	**Degree Received:**		**Date of Graduation: (mm/yy)**
Mailing Address:	**City:**	**City:** **County:**	**ZIP:**

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:	**Program Director:**	
Mailing Address:		
City:	**State:** **Country:**	**ZIP:**
Type of Internship:		
Specialty:	**From:** **(mm/yy)**	**To:** **(mm/yy)**

Physician Name: _____

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city and ZIP code, and dates. Include all programs you attended, whether or not completed.

Institution:		**Program Director:**	
Mailing Address:	**City:**	**State:** **County:**	**ZIP:**
Type of Training (e.g. residency, etc.):	**Specialty:**	**From:** **(mm/yy)**	**To:** **(mm/yy)**
Did you successfully complete the program? D **Yes** D **No** **(If "No", please explain on a separate sheet.)**			
Institution:		**Program Director**	
Mailing Address:	**City:**	**State:** **County:**	**ZIP:**
Type of Training:	**Specialty:**	**From:** **(mm/yy)**	**To:** **(mm/yy)**
Did you successfully complete the program? D **Yes** D **No** **(If "No", please explain on a separate sheet.)**			
Institution:		**Program Director:**	
Mailing Address:	**City:**	**State:** **County:**	**ZIP:**
Type of Training:	**Specialty:**	**From:** **(mm/yy)**	**To:** **(mm/yy)**
Did you successfully complete the program? D **Yes** D **No** **(If "No", please explain on a separate sheet.)**			

VIII. MEDICAL LICENSE/REGISTRATION (Remember to attach copies of documents)

California State Medical License Number:	**Issue Date:**	**Expiration Date:**
Drug Enforcement Administration (DEA) Registration Number:		**Expiration Date:**
Controlled Dangerous Substances Certificates (CDS) (if applicable):		**Expiration Date:**
ECFMG Number (applicable to foreign graduates):		**Date Issued:** **Valid Through:**
Medicare UPIN/National Physician Identifier (NPI):	**MediCal/Medicaid Number:**	

Physician Name: _____

IX. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	**Policy Number:**	**Original Effective Date:**	
Mailing Address:	**City:**	**State:**	**ZIP:**
Per Claim Amount:	**Aggregate Amount:**	**Expiration Date:**	

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.

Please list all of your professional liability carriers within the past seven years, other than the one listed above:

Name of Carrier:	**Policy :**	**From: (mm/yy)**	**To: (mm/yy)**
Mailing Address:	**City:**	**State:**	**ZIP:**
Name of Carrier:	**Policy :**	**From: (mm/yy)**	**To: (mm/yy)**
Mailing Address:	**City:**	**State:**	**ZIP:**

X. ALL OTHER STATE MEDICAL LICENSES. List All Medical License Now or Previously Held.

(Attach additional sheets if necessary. Reference This Section Number and Title)

State:	**License Number:**	**Expiration Date:**
State:	**License Number:**	**Expiration Date:**
State:	**License Number:**	**Expiration Date:**

XI. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

- **a member board of the American Board of Medical Specialties**
- **a member board of the American Osteopathic Association**
- **a board or association with equivalent requirements approved by the Medical Board of California**
- **a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty**

Name of Issuing Board:	**Specialty:**	**Date Certified/Recertified:**	**Expiration Date (if any):**

Physician Name: _____

Have you applied for board certification other than those indicated above? D **Yes** D **No**				
If so, list board(s) and date(s):				
If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.				

XII. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)
(Attach additional sheets if necessary. Reference This Section Number and Title)

Type:	**Number:**	**Expiration Date:**
Type:	**Number:**	**Number:**

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Primary Admitting Hospital:	**City:**	**State:**	**ZIP:**
Department/Status (active, provisional, courtesy, etc.):	**Appointment Date:**		
Name and Mailing Address of other Hospital/Institution:	**City:**	**State:**	**ZIP:**
Department/Status (active, provisional, courtesy, etc.):	**Appointment Date:**		
Name and Mailing Address of other Hospital/Institution:	**City:**	**State:**	**ZIP:**
Department/Status (active, provisional, courtesy, etc.):	**Appointment Date:**		

If you do not have hospital privileges, please explain on Addendum A.

B. **PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)**

Name and Mailing Address of Hospital/Institution:		**City:** **State:**	**ZIP:**
From: **(mm/yy):**	**To:** **(mm/yy):**	**Reason for Leaving:**	
Name and Mailing Address of Hospital/Institution:		**City:** **State:**	**ZIP:**
From: **(mm/yy):**	**To:** **(mm/yy):**	**Reason for Leaving:**	
Name and Mailing Address of Hospital/Institution:		**City:** **State:**	**ZIP:**
From: **(mm/yy):**	**To:** **(mm/yy):**	**Reason for Leaving:**	
Name and Mailing Address of Hospital/Institution:		**City:** **State:**	**ZIP:**
From: **(mm/yy):**	**To:** **(mm/yy):**	**Reason for Leaving:**	

Physician Name: ______________________________

XIV. PEER REFERENCES

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

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	**Specialty:**	**Telephone Number:** **Fax Number:**
Mailing Address:	**City:**	**State:** **ZIP:**
Name of Reference:	**Specialty:**	**Telephone Number:** **Fax Number:**
Mailing Address:	**City:**	**State:** **ZIP:**
Name of Reference:	**Specialty:**	**Telephone Number:** **Fax Number:**
Mailing Address:	**City:**	**State:** **ZIP:**

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in work history on a separate page.

Current Practice:	**Contact Name:**		**Telephone Number: ( )** **Fax Number: ( )**		
Mailing Address:	**City:**	**State:**	**ZIP:**	**From: (mm/yy)**	**To: (mm/yy)**
Name of Practice/Employer:	**Contact Name:**		**Telephone Number: ( )** **Fax Number: ( )**		
Mailing Address:	**City:**	**State:**	**ZIP:**	**From: (mm/yy)**	**To: (mm/yy)**
Name of Practice/Employer:	**Contact Name:**		**Telephone Number: ( )** **Fax Number: ( )**		
Mailing Address:	**City:**	**State:**	**ZIP:**	**From: (mm/yy)**	**To: (mm/yy)**

Physician Name: _____

XVI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to question A through K is "yes," or if your answer to L is "no," please provide full details on a separate sheet.

A.	**Has your license to practice medicine in any jurisdiction, your Drug enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?**	
	Yes D	**No** D
B.	**Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?**	
	Yes D	**No** D
C.	**Have you ever been denied, for possible incompetence or improper professional conduct, or breach of contract, clinical privileges, membership, contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) or have your clinical privileges, membership, contractual participation or employment at any such organization ever been suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending?**	
	Yes D	**No** D
D.	**Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach or contract, or in return for such an investigation not being conducted, or is any such action pending?**	
	Yes D	**No** D
E.	**Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?**	
	Yes D	**No** D
F.	**Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subject to probationary conditions, or not renewed, or is any such action pending?**	
	Yes D	**No** D
G.	**Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?**	
	Yes D	**No** D
H.	**Have you ever been convicted of any crime (other than a minor traffic violation)?**	
	Yes D	**No** D
I.	**Do you presently use any drugs illegally?**	
	Yes D	**No** D
J.	**Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?**	
	Yes D	**No** D
K.	**Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?**	
	Yes D	**No** D
L.	**. Are you able to perform all the services required by your agreement with, or the professional staff bylaws, or the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?**	
	Yes D	**No** D

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

Print Name Here:

Physician Signature_____**Date**

_____**(Stamped Signature Is Not Acceptable)**

Physician Name:_____.

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and 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 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 claim history}, licensing authorities, and businesses and individuals acting as their agents collectively "Healthcare Organizations,") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[3] 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 Professional Code Section 809 et seq, if applicable.

I the undersigned 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 against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension reduction, limitation, nonrenewal or voluntary relinquishment by registration 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, ant filed and served malpractice suite or arbitration action; or (vi) my conviction of any criminal law (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 application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 7 and 8.

Print Name Here:_____

Signature_____**Date**_____

(Stamped Signature Is Not Acceptable)

3
The intent of this release is to apply at a minimum, protection comparable to those available in California to any action, regardless of where such action is brought.

Physician Name: _____

This Application and Addenda A and B were created and are endorsed by:

- American Medical Group Association - (310/430-1191x223)
- California Association of Health Plans - (916/552-2910)
- California Healthcare Association - (916/552-7574)
- California Medical Association - (415/882-3368)

Addenda Submitting (Please check the following):

D **Addendum A - Health Plan and IPA/Medical Group**
D **Addendum B - Professional Liability Action Explanatio**

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Application nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the healthcare organization from which it was provided.

Physician Name:_____.

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to:_____herein, this Healthcare Organization. [1]

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:

Medical Group (s) /IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No
Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s))

Please check all that apply:
☐ Solo Practice ☐ Single Specialty
☐ Group Practice ☐ Multi specialty

II. BILLING INFORMATION

Billing Company:

Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐Yes ☐No
If so, please list:

Name: Type of Provider: License Number:

_____
_____
_____
_____
_____

If you are a Physician Assistant Supervisor, please include State License Number:_____
Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐Yes ☐No
If so, please list:

Name: California Medical License Number:

_____ _____
_____ _____

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

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

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

1
The term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

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

Do you participate in EDI (electronic data interchange)? ☐Yes ☐No

If so, which Network? _____

Do you use a practice management system/software: ☐Yes ☐No

If so, which one? _____

What type of anesthesia do you provide in your group/office?
☐ Local ☐Regional ☐Conscious Sedation ☐General ☐None ☐Other (please specify) _____

Has your office received any of the following accreditations, certifications or licensures?
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ California Department of Health Services Licensure
☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other _

IV. OFFICE HOURS - Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holidays

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number: ( )	Fax Number: ( )

Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	

If you do not have hospital privileges, please provide written plan for continuity of care:

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VII. LABORATORY SERVICES

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

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

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

Organization Name	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name Here: _____

Physician Signature:_____Date: _____
(Stamped Signature Is Not Acceptable)

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to_____herein, this Healthcare Organization [1].

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

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where lawsuit filed: _____	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient: _____

Location of Incident:
☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center
☐ Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc.):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐Yes ☐No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.

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

Name_____Phone Number ( )

Name_____Phone Number ( )

1 As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: $
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: $
- ☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

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

Print Name Here: _____

Physician Signature_____Date:_____

(Stamped Signature Is Not Acceptable)

California Participating Physician Application
Addendum C

Section A	CONFIDENTIAL QUESTIONS -- HEALTH HISTORY		
1.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.**	YES	NO
2.	Are your a certified Worker's Compensation provider? **If yes, please attach a copy of your certificate.**	YES	NO
3.	Are you a reservist? If yes, what branch of the military? _____ Anticipated date of separation from reserve duty? _____/_____/_____	YES	NO
4.	Medicaid/Medi-Cal #:		

I attest to the fact all of the information submitted by me in this document are true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from the application may constitute cause for denial of participation or cause for summary dismissal.

_____ _____

Provider Name **Date**

_____

Signature

NATIONAL MEDICAL ASSOCIATION
CREDENTIALING APPLICATION

- *Please type or print legibly using black or blue ink*
- *Complete application in its entirety*
- *Write NIA if not applicable*
- *Use an additional sheet if more space is needed*
- *Fax to: (310) 532-6043 * Questions: Call (800) 684-3211 or (310) 532-6614*

DEMOGRAPHIC DATA

Last Name	*First Name*	*Middle Initial*	*Title*
Office Address	*City*	*State*	*Zip*
Social Security No.	*Date of Birth*		*Gender*
Telephone Number ( ) -	*Fax Number* ( ) -		*E-Mail Address*
Board Certification	*Specialty*		*Expiration Date*

EDUCATION AND TRAINING

Medical School (Name)	*Address*			*Graduation Year*
	City	*State*	*Zip*	*Degree*
Internship (Institution Name)	*Address*			*From:*
Specialty	*City*	*State*	*Zip*	*To:*
Residency (Institution Name)	*Address*			*From:*
Specialty	*City*	*State*	*Zip*	*To:*
Fellowship (Institution Name)	*Address*			*From:*
Specialty	*City*	*State*	*Zip*	*To:*

LICENSURE

License Number		*State of Licensure*		*Expiration Date*	
Other State License#	*State*	*Other State License #*	*State*	*Other State License#*	*State*
DEA Number		*Expiration Date*			
Malpractice Insurance Carrier:		*Policy #*		*Expiration Date*	
Mailing Address		*City*	*State*	*Zip*	

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and performance ("credentialing information") by and between the "National Medical Association" and other Healthcare organizations (e.g. hospital, medical staffs, medical groups, independent practice associations (IPA's) health maintenance organizations (HMO's) preferred provider organizations (PPO's) 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 for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgments 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 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 laws.

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

Print Name:

Physician Signature: *Date:*

(Stamped Signature is not acceptable)

Addendum E

This Addendum is submitted to:_____

Primary Care/Specialist Experience Attestation

Please indicate below the age of the patients for whom you have provided primary care services / specialist services in the last 5 years or wish to treat. In order for a category to apply, it must represent at least 20% of your average practice and you must be familiar with routine standard preventive services. **Please check all those that apply:**

- ☐ Children (0 to 16 years of age) **Must be Pediatrician or CHDP certified.**
- ☐ Adults (16 years of age and older)
- ☐ If you desire age limitations different from above, please specify:

_____

Behavior Health Experience Attestation

Please indicate below the age of the patients for whom you have provided specialist services in the last 5 years. Please check all those that apply:

- ☐ Children (0 to 16 years of age) **Must submit proof of training or be CHDP certified.**
- ☐ Adults (16 years of age and older)
- ☐ If you desire age limitations different from above, please specify:

_____

Primary Care Experience Attestation – School Based Clinics

Providers of school based clinics will see members as indicated below.

- ☐ Children (0 to 16 years of age) **Must be Pediatrician or CHDP certified.**
- ☐ Adults (16 years of age and older)
- ☐ If you desire age limitations different from above, please specify:

_____

Special Services

Please indicate if you are in the following:

- ☐ California Children's Services **(CCS)** Paneled
- ☐ Child Health and Disability Prevention Program **(CHDP)** Health Assessor

Please submit proof of your **CCS** or **CHDP** status.

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with L.A. Care Health Plan.

Practitioner's Signature: _____ Date:_____
(Stamped signature is not acceptable.)

Letter to Practitioner
Screening for Identification of Qualified HIV/AIDS Practitioners

Date: _____

Dear Provider

California Health & Safety Code (CA H&SC) 1374.16 requires the establishment of a process for standing referrals to a specialist, to include a process to refer a member with a condition or disease that requires specialist medical care over a prolonged period of time or is life-threatening, degenerative or disabling to a specialist or specialty care center that has expertise in treating the condition or disease.

California code 28 CCR1300.74.16 (e) establishes the required qualifications of an HIV/AIDS specialist to whom a member is being referred on an extended or standing basis, under the conditions of CA H&SC 1374.16.

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

- Your preference to be listed as a qualifying HIV/AIDS specialist for the purpose of receiving standing referrals for members whose condition requires ongoing treatment by a practitioner with the specified expertise in treating their condition.
- If you state you wish to be listed for purposes of standing referrals, then please indicate the criterion or criteria, as defined by state regulation, under which you qualify. You must meet at least one of these criteria as written in order to qualify.

We will use your information for internal referral procedures.

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

Thank you for your cooperation. We appreciate your continued dedication to our patients.

Please contact Brand New Day's Credentialing Department if you have questions regarding the process of participating as an HIV/AID specialist.

HIV/AIDS Specialist Fax-Back Form

Fax To: Credentialing Department **Fax Number: 657-400-1216**

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

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

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

☐ I am board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; **OR**

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

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

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

☐ Meet the following qualifications:
In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patientes who are infected with HIV; **AND**
Completed any of the following:

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

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

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

I attest that, to the best of my knowledge, the above information can be supported by documentation (if required).

Physician's Name (Print): _____ Date: _____

Physician's Signature: _____ License #_____

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

Request for Taxpayer Identification Number and Certification

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

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

Print or type. See **Specific Instructions** on page 3.

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

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

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

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

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

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

☐ Other (see instructions) ▶

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

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

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

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

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

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

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

Social security number

			–		–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

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

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

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

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

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

Purpose of Form

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

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

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

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