Tips to help eliminate the need for returns or delays

Application

- If an erroneous entry is made on any part of the application, please draw a single line through the error, write in the correction, and initial and date the change. White out and other similar materials are not acceptable.
- Please make sure copies of all documents required in Section I of the application are attached. The following is a document check list:
  - _ Current copy of medical license
  - _ Current copy of DEA and/or CDS, if applicable
  - _ Current copy of malpractice insurance policy
  - _ ECFMG certificate, if applicable
  - _ Current Curriculum Vitae (CV)
- In every section that is not applicable, you must write **"N/A"** otherwise the packet will be returned.
- On page 1, Section II, please remember to include your "SSN and Date of Birth".
- On page 1, Section III, please remember to include your "Tax ID Number"
- On pages 2. Sections IV through VII, please fill out all sections instead of writing "See CV." If a section does not apply, please write in N/A.
- On pages 4 Section XII, a complete chronology of your work history is required. There should be no unexplained gaps of more than (6) six months in sequence and you must list a minimum of (3) three years of work history. This will eliminate the need to request additional information
- Page 5, Section XIII is your "attestation". This is one of the most carefully scrutinized areas of the application. I encourage every doctor to read each statement carefully and answer each question him/herself. The Medical Board of California (MBOC) considers any omission of information in this section as an act of fraud. If you answer "Yes" to any statement for A through K you must provide full details on a separate sheet. Please read statement L carefully before providing an answer. Exclusive Care cannot accept this application unless the physician has signed and dated pages 5 and 6 (of 6). A stamped signature or date is not acceptable per NCQA guidelines.

Addendum A

This attachment to the application is fairly self-explanatory, however please remember the following:

- In Section I, please indicate your choice to be a PCP, Specialist, or in some cases both.
- In Section III, please stipulate whether you employ any allied health professionals (e.g. nurse practitioners, physician assistants, certified nurse midwives).
- Section IV requests your office hours, Section V requests the name(s) of doctors who provide coverage when you are unavailable. The covering physician must be agreeable to providing all of the services that would be available to your members in your absence.

Addendum B

- If you **have not** had any malpractice issues you must write **"N/A"** in Section 1 where it states "last name" and then you must **sign and date page (2) two.**
- If you have had malpractice action in the proceeding (7) seven years you must complete the following:
  1. Section I, please indicate plaintiff's name **(not the physician name).**
  2. Section II, please complete all questions.
  3. Section III, provide a clear legible summary that includes:
     a) The plaintiff's allegation
     b) The date of the alleged incident
     c) Your diagnosis and treatment
     d) The results of your treatment
     e) Any other information that will help the physician members of the Credentials Committee understand the situation
     f) If amounts have been paid on your behalf, please indicate total
- Most physicians create the summary on a separate piece of paper but you are welcome to use the bottom of page (2) two. **Please remember to sign and date page (2) two.**
- If you have had more than one malpractice action, have your office make extra copies of both pages 1 and 2 and fill out a set for each case in which you have been involved.

Addendum C

- This addendum restates some of the attestation questions listed on page 8 of the application; however, the wording has been revised to be more specific. Please read each question carefully. You must complete this section **in addition** to the attestation questions on page 8. If not applicable please state "N/A". **Please remember the physician must sign and date.** A stamped signature or date is not acceptable per NCQA guidelines.

Addendum D

- Entire form must be completed. Please do not reference any other section of the application.

Allied Health Professional Application

I. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Fill in all blanks and answer all questions. Please provide all addresses including zip codes. Mark "N/A" if no applicable. Please do not use abbreviations when completing the application.
Current copies of the following documents must be submitted with this application:

☐California State Medical License, Registration or Certificate
☐DEA Certificate (if applicable)
☐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:	
Home Telephone Number:	State:	ZIP:
Home Fax Number:	E-Mail Address:	
Birth Date:	Birth Place (City/State/Country)	
Citizenship (If not US, please include copy of Alien Registration Card):		
Social Security #:	Gender[1]: ☐ Male ☐ Female	
AHP Specialty:		

III. PRACTICE INFORMATION

Practice Name (if applicable):			
Supervising Physician (if applicable):			
Primary Office:			
Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Tax ID Number:			
Office Manager/Administrator:	Phone Number:		
E-mail Address:	Fax Number:		

[1] This information will be used for consumer information purposes only.

Secondary Office:			
Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		
Tax ID Number:			

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

College or University Name:			
Address:	City:	State:	Zip:
Degree:	Date of Graduation:		

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

College or University Name:	Degree Received:	Date of Graduation:	
Address:	City:	State:	Zip:
Degree:	Date of Graduation:		

VI. OTHER TRAINING (Internships, Fellowships, Preceptorships, Postgraduate Education)

Institution:	Degree:	Date Completed:	
Address:	City:	State:	Zip:
Institution:	Degree:	Date Completed:	
Address:	City:	State:	Zip:

VII. LICENSES/CERTIFICATIONS/REGISTRATIONS (Remember to attach copies of documents)

California State Medical License Number:	Issue Date:	Expiration Date:
Other State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
ECFMG (Applies to Foreign Medical Graduates):		Date Issued:
Medicare UPIN/National Physician Identifier (NPI):		

VIII. PROFESSIONAL LIABILITY INSURANCE (Remember to attach copy of professional liability policy or certification face sheet.) (Attach additional sheets if necessary. Reference this Section # and Title)

Current Insurance Carrier:	Policy Number:	Original effective date:

Address:	City:	State:	Zip:

Per Claim Amount $	Aggregate Amount:$	Expiration Date:

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

Previous Carrier:	Policy #:	From:	To:
Address:	City:	State:	Zip:
Previous Carrier:	Policy #:	From:	To:
Address:	City:	State:	Zip:

IX. MEMBERSHIP IN PROFESSIONAL SOCIETIES (Attach additional sheets if necessary. Reference this section number and Title)

Are you a member of a professional society? ☐Yes ☐ No	Do you have a membership pending? ☐Yes ☐ No
Do you intend to apply for membership? ☐Yes ☐ No	

If a member past or present, or an applicant to any other County, State or National Medical Society, give name:

X. HOSPITAL/INSTITUTION AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and Title)

Institution Name:	From:	To:	
Address:	City:	State:	Zip:
Institution Name:	From:	To:	
Address:	City:	State:	Zip:
Institution Name:	From:	To:	
Address:	City:	State:	Zip:

XI. PEER REFERENCES

List three (3) professional references, preferably from you 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. **DO NOT PROVIDE PHYSICIAN CELL PHONE NUMBERS. ONLY OFFICE TELEPHONE#.**

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

Name of Reference:	Title:	Phone #:	
Address:	City:	State:	Zip:

Name of Reference:	Title:	Phone #:	
Address:	City:	State:	Zip:
Name of Reference:	Title:	Phone #:	
Address:	City:	State:	Zip:

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

Chronologically list all work history activities since completion of postgraduate training. 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 professional history on a separate page.

Current Practice	From:	To:	
Address:	City:	State:	Zip:
Contact Name and Title:	Phone #:	Fax #:	
Previous Practice:	From:	To:	
Address:	City:	State:	Zip:
Contact Name and Title:	Phone#:	Fax #:	
Previous Practice:	From:	To:	
Address:	City:	State:	Zip:
Contact Name and Title:	Phone#:	Fax #:	
Previous Practice:	From:	To:	
Address:	City:	State:	Zip:
Contact Name and Title:	Phone#:	Fax #:	

XIII. ATTESTATION QUESTIONS

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

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 ☐ No ☐

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes ☐ No ☐

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 of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes ☐ No ☐

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 ☐ No ☐

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed , or is any such action pending?

Yes ☐ No ☐

G. Have you 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 No

H. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes No

I. Do you presently use any drugs illegally?

Yes No

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 ☐ No ☐

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 ☐ No ☐

L. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, 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 ☐ No ☐

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto 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.

Print Name Here:_____

Physician Signature_____Date_____

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

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

I am informed and acknowledge that federal and state[2] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action 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 resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this 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 5 and 6.

Print Name Here _____

Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

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

California Participating Physician Application

Addendum A

Health Plans and IPA's/Medical Groups

This Addendum is submitted to: **Exclusive Care** 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(ies)):

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:

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

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

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: _____

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

California Participating Physician Application
Addendum B
Professional Liability Action Explanation

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

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 you 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

The Exclusive Provider Health
Plan of the County of Riverside

Exclusive Care California Participating Provider Application

Addendum D

REMITTANCE INFORMATION

IDENTIFYING INFORMATION OF THE PROVIDER:

Last Name: _____

First Name: _____

Tax ID Number: _____

Legal Name of the company that should appear on your check that matches your business license and W9

_____

PLEASE SEND MY CHECKS TO THE FOLLOWING ADDRESS:
(do not reference any other section of the application, this area must be completed and signed by the provider)

_____

_____

_____

_____
Attach your w-9 tax information form to this addendum

_____ _____

Provider Signature **Date**

Office Verification Form

PLEASE COMPLETE and RETURN WITH APPLICATION

In order for Exclusive Care to maintain the most accurate and up to date information it is VERY IMPORTANT that the following information is provided.

Provider(s) full name(s) at location:

_____,_____,

_____,_____,

_____,_____,

_____,_____,

_____,_____

Location(s)_____

_____

_____

Office Hours:_____

Phone number:_____ **Fax number:**_____

Back office number:_____ **(Not for public use)**

Other clinical staff: (PA, NP, MFT, LCSW)

_____

_____

_____

Signature: _____ **Printed Name:** _____

Date: _____