Instructions to Help Eliminate the Need for Returns or Delays

Application

IMPORTANT: *There are several sections throughout the application that have check boxes indicating that nothing has changed. If you check this box, you do not need to fill out the section.*

- 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 your license
  - ✓ Current copy of DEA (if applicable)
  - ✓ Current copy of malpractice insurance policy
  - ✓ Current copy of your CV
  - ✓ Copy of Diploma/Certificates form completed postgraduate training (if applicable)
- In every section that is not applicable, you must write **"N/A"** otherwise the packet will be returned.
- Please make sure to sign and date pages that require you to do so. Digital or stamped signatures are not accepted.

Addendum B

- If you **have not** had any malpractice issues you must check of the **"N/A"** box at the top of the page and then you must **sign and date page (2) two.**
- If you have had malpractice action(s) in the proceeding (7) seven years you must complete the addendum for the action(s).
- Most physicians create the summary on a separate piece of paper but you are welcome to use page (2) two. **Please remember to sign and date page (2) two.**

Office Verification Form

- Please complete this form in its entirety.

CONFIDENTIAL/PROPRIETARY

Participating Provider Re-Credentialing Application
Physical Therapy/Occupational Therapy/Speech/Language Therapist

I. INSTRUCTIONS

Please type or legibly print in black or blue ink. **ALL** questions must be answered. Incomplete applications will be returned. If more space is needed, attach additional sheets and reference the question being answered. Do not use abbreviations when completing the application. Current copies of the following documents must be submitted with this application:

❑ Copy of License	❑ Curriculum Vitae / Resume
❑ Professional Liability Certificate of Insurance	❑ Alien Registration Card (if not US Citizen)

II. BUSINESS INFORMATION

Business Name:		
Office Hours:	Type of Organization:	
Office Street Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Tax ID # under which you bill:	Office Manager:	
Are you currently Medicare Certified as an: ☐ Independent PT/OT ☐ Rehab Office ☐ CORF	Date Certified:	
If not currently certified, or only as a CORF, please explain.	Business Lic#	
Please Indicate what services you provide:		
What foreign languages are spoken?		

III. Professional Liability Information

Name of Company:	Policy End Date:	Policy #:
Amount per incident $	In Aggregate $	

IV. Ownership

Please list any person, including sole owners, along with their professional designation and social security number, who have an ownership interest in the practice

Name:	Social Security #:	Professional Designation:
Name:	Social Security #	Professional Designation:
Name:	Social Security #	Professional Designation:

V. Participating Therapist Information

1) Name:	License #:	Expiration Date:	Hours Worked Per Week:	National Physician Identifier (NPI):
Social Security #:	Date of Birth:	College:		Year Graduated:
Post Graduate College:	Post Graduate Degree:	Other Names Under Which You've Been Known:		Gender: ☐ M ☐ F
Home Address:		Citizenship:		Place of Birth:

VI. Staff Information

Please list the names, titles and number of hours worked per week in patient-related duties by each support person at the facility

Name:	Hours:
Name:	Hours:
Name:	Hours:
Name:	Hours:
Name:	Hours:
Name:	Hours:

VII. WORK HISTORY (Include history for the past 3 years to current; if nothing has changed, please check the box and include a copy of your CV) ☐

Company / Group:	From:	To:
Address:		
City:	State:	Zip:

Company / Group:	From:	To:
Address:		
City:	State:	Zip:
Company / Group:	From:	To:
Address:		
City:	State:	Zip:

RELEASE AND CERTIFICATION STATEMENT

I hereby authorize Exclusive Care – County of Riverside or its representatives, to contact individuals, reporting entities, agencies and healthcare facilities for membership or request for certification or information. I hereby release from any liability Exclusive Care and all persons and entities engaged in quality assessment, peer review and credentialing on behalf of Exclusive Care. Further, I hereby release from any liability all persons and entities providing information to Exclusive Care in good faith without malice concerning my professional training, experience, ethics, character and other qualifications for serving as a member provider. I hereby consent to the release of such information. I certify that the information provided in request for appointment or certification to Exclusive Care is true and correct to the best of my knowledge and belief.

Further, I hereby affirm that the information submitted in this application, including any attachments hereto, are true, current, correct, and complete to the best of my knowledge and belief and are furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application.

Print or Type Name	Signature	Date

VIII. ATTESTATION

If you answer "YES" to questions 1 thru 11, or "NO" to question 12, please provide full details on a separate sheet.		YES	NO
1.	Has your license to practice therapy in any jurisdiction, 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?	☐	☐
2.	Have you ever been charged, suspended, fined disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program; or is any such action pending?	☐	☐
3.	Have your membership, contractual participation or employment by any medical organization (e.g., 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 such action pending?	☐	☐
4.	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?	☐	☐
5.	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 such action pending?	☐	☐
6.	Have you been denied certification/recertification by a therapy board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	☐	☐
7.	Have you ever been convicted of any crime (other than a minor traffic violation)?	☐	☐
8.	Do you presently use any drugs illegally?	☐	☐
9.	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?	☐	☐
10.	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?	☐	☐
11.	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?	☐	☐

I hereby affirm that the information submitted in this Section VII, Attestation, 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 provider participation agreement.

Print or Type Name _____ Signature _____ Date _____

California Participating Physician Application
Addendum B
Professional Liability Action Explanation

This Addendum is submitted to: **Exclusive Care** herein, this Healthcare Organization [1]. **N/A** ☐

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 **Check here if N/A** ☐

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)

Office Verification Form

PLEASE COMPLETE & 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: _____