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.

California Participating Physician Reapplication

This application is submitted to: **Exclusive Care EPO**, herein, this Healthcare Organization[1]

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. Please do not use abbreviations when completing the reapplication. **Current copies of the following documents must be submitted with this reapplication:**

- State Medical License(s)
- Board Certification (if applicable) within last three years
- DEA Certificate
- Face Sheet of Professional Liability Certification

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: Home Fax Number:	E-Mail Address:	
Date of Birth: Gender ☐Female ☐Male	Social Security Number:	
Citizenship (If not a United States citizen, please include copy of Alien Registration Card):		
Specialty:		
Subspecialties:		

III. PRACTICE INFORMATION - WITHIN LAST THREE YEARS. If nothing has changed, please check here ☐

Practice Name (if applicable):	Department Name (If hospital based):	
Primary Office Street Address:	City:	
	State:	ZIP:
Phone Number:	Fax Number:	
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Secondary Office Street Address:	City:	
	State:	ZIP:

[1] As used in the Information Release/Acknowledgments Section of this reapplication, the term "this Healthcare Organization" shall refer to the entity to which this reapplication is submitted as identified above.

Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary 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. RESIDENCIES/FELLOWSHIPS - WITHIN LAST THREE YEARS. If nothing has changed, please check here ☐

(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 completed within the last two years in chronological order, giving name, address, city and ZIP code, and dates. Include **all** programs you have attended, whether or not completed.

Institution:	Program Director:		
Mailing Address:	City:		
	State:	ZIP:	
Type of Training (e.g. residency, etc.):	Specialty:	From:	To:

Did you successfully complete the program? ☐Yes ☐No (If "No," please explain on separate sheet.)

V. BOARD CERTIFICATION - WITHIN LAST THREE YEARS. If nothing has changed, please check here ☐

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):

Have you applied for board certification other than those indicated above? ☐Yes ☐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.

VI. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.) - WITHIN LAST THREE YEARS. If nothing has changed, please check here ☐		
Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

VII. MEDICAL LICENSURE/REGISTRATION (Remember to attach copies of documents)	
California State Medical License Number:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):	Expiration Date:
Medicare UPIN/National Physician Identifier (NPI):	MediCal/Medicare Number:

VIII. ALL OTHER STATE MEDICAL LICENSES		
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

IX. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet.)			
Current Insurance Carrier:	Policy #:	Original Effective Date:	
Mailing Address:		City:	
		State:	ZIP:
Per claim amount: $	Aggregate amount: $	Expiration Date:	
Please list all of your professional liability carriers within the past two years other than the one listed above:			
Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From:	To:
Mailing Address:		City:	
		State:	ZIP:

X. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past two years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If you do not have hospital privileges, please explain on Addendum A.

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, temporary, etc.):	Appointment Date:	
Name and Mailing Address of Other **Hospital/Institution:**	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	
Name and Mailing Address of **Other Hospital/Institution:**	City:	
	State:	ZIP:
Department/Status:	Appointment Date:	

B. PREVIOUS HOSPITAL AND OTHER INSTITUTION AFFILIATIONS - WITHIN LAST THREE YEARS

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

XI. WORK HISTORY - WITHIN LAST THREE YEARS. If nothing has changed, please check here ☐

Chronologically list all work history activities within the last three years (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 professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Practice /Employer:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:

XII. 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 three (3) 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 reapplication 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 credentialing reapplication and any credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

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

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

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

During such time as this reapplication is being processed, I agree to update the reapplication 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 no renewal of my license to practice medicine in California; (ii) any suspension, revocation or no renewal of my DEA or other controlled substances registration; or (iii) any cancellation or no renewal 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, no renewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this reapplication and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my reapplication or termination of my privileges, employment or physician participation agreement. A photocopy of this document shall be as effective as the original, however, current dates are required on pages 5 and 6.

Print Name Here: _____

Physician Signature_____Date: _____

(Stamped Signature Is Not Acceptable)

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

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)

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: _____