



NETWORKS

CREDENTIALING APPLICATION

EASY AS 1, 2, 3!!!

1. Complete the simple application, including consent form: sign and date.
(DDN does NOT accept STAMPED signatures)
2. Make copies of the supporting documents listed below:
 - ✓ Dental License (provide copies for EVERY state in which you are licensed)
 - ✓ DEA Registration for **EVERY STATE** the DDS is practicing in (or documentation DEA is pending)
 - ✓ Board/Specialty Certificate (if applicable)
 - ✓ Professional Liability Insurance Declaration Page - to include name of each provider covered, effective and expiration dates, insurance carrier, coverage limits of no less than \$1million/\$3 million.
-If expiration date is within weeks of this application, updated documentation must be submitted.
 - ✓ W-9 Form or Taxpayer Identification Number Request
3. Mail the application along with a signed DeCare Dental Networks, LLC Contracting Dentist Agreement to:

DeCare Dental Networks, LLC
Attn: National Credentialing
P.O. Box 1175
Minneapolis, MN 55440-1175

OR, *TO EXPEDITE*, APPLICATION CAN BE FAXED TO:

FAX: (866) 286-8840
QUESTIONS? Call (866)232-8658



NETWORKS

Request for Taxpayer Identification Number and Certification (SUBSTITUTE FORM W-9)

Instructions: Please type or print clearly. Sign, date and return to requester in the enclosed envelope. Do not send to the IRS

Business Entity: Name of the entity that provides dental services per IRS. (As used to apply for your Tax Identification Number (TIN). This appears on Form SS-4, on your Quarterly Withholding Form 941, or on your annual IRS Tax Return.)

Business Name: (Name used to advertise for business, if different from above name.)

Business Address:

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

City, State and ZIP code

Taxpayer Identification Number (TIN)

Enter your TIN, which corresponds to the business entity listed above. This may be an Employer Identification Number (EIN) or your Social Security Number (SSN) dependent upon how you file your tax returns with the IRS. This is the Tax Identification Number you use when you submit claims.

TIN

Grid for entering TIN digits

Check one: This is my EIN or SSN

Please check appropriate box: Individual/Sole Proprietor Corporation Partnership Other _____

If you use a different Tax Identification Number at another office location, please copy this form and complete the copied form with the additional Tax Identification Number and office location information.

Qualifying Exemption Exempt from tax under 501(a)

Reason, if any (check) The United States or any of its agencies or instrumentalities

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

Certification: (1) I certify under penalty of perjury that the Taxpayer Identification Number I have provided is correct.
(2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
(3) I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you failed to report all interest and dividends on your tax return.

Signature: _____

Office Phone: () _____

Print signer's name & title: _____

Date: _____

DeCare Dental Networks, LLC
ATTN: National Network
P.O. Box 1175 • Minneapolis, MN 55440-1175
FAX: 1-866-286-8840

See back of form for additional information.

Purpose of Form

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

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

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

If you are a foreign person, use the appropriate Form W-8. See Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Corporations.

What is backup withholding?

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

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

1. You do not furnish your TIN to the requester, or
2. You do not certify your TIN when required (see the Part III instructions on page 2 for details), or
3. The IRS tells the requester that you furnished an incorrect TIN, or
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Penalties

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

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

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

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

For Credentialing Staff Use Only

Specialty _____

Date Application Received _____

Date Application Signature _____

Attach a recent 2" x 2"
passport size photograph for
the master file and each
facility marked on this
application

PERSONAL DATA

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

1. Name _____

2. Other Name(s) Previously Used _____ Effective _____

3. Social Security Number _____ 4. UPIN# _____ 5. Medicaid _____

6. Medicare# _____ 7. NPI (National Provider Identifier) _____

8. Tax ID# _____ Name Affiliated with Tax ID# _____

8A. Other Tax ID's (Attach separate sheet if applicable)

9. Place of Birth _____ Date of Birth _____

10. Gender _____ 10. Citizenship _____

11. If Not US Citizen: Visa # _____ Status _____ Expiration Date _____

12. Name of Spouse/Significant Other

13. Local Residence

Complete Address

Telephone Number _____ E-Mail Address _____

14. Date of Relocation to NV (If Applicable) _____ Date Expected to Begin Practice _____

Specialty _____ Staff Status Requested _____

Current Address (if different from above)

15. Alternate Care of Hospitalized Patients: If you do not apply for admitting privileges, list the name/names of physicians or groups with whom you have established a current hospital admission coverage agreement:

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

OFFICE INFORMATION

16. Local Primary Practice/Group Name _____

Complete Office Address _____

Office Phone _____ FAX Number _____ E-Mail _____

Preferred Method of Contact _____ Phone _____ FAX _____ E-Mail _____

16A. Other Practice Locations (Please attach a separate sheet)

17. Office/Credentialing Contact Name & Address _____

Title _____ Phone Number _____ FAX Number _____ E-Mail Address _____

18. Secondary/Billing Office Address _____

Office Phone _____ FAX Number _____ E-Mail _____

19. Practitioner's Beeper/Cell Number _____ Answering Service Number _____

20. Practitioner Call Coverage _____

21. Are you currently accepting new patients into your practice? _____ YES _____ NO
(If NO, your name may not appear in the Managed Care directory)

22. Office Hours _____ Monday _____ Tuesday _____ Wednesday
_____ Thursday _____ Friday _____ Saturday _____ Sunday

23. Describe after-hours patient care operation. _____

24. Any practice restrictions? (Specify) _____

25. Office accessible to disabled pursuant to ADA guidelines? _____ YES _____ NO

26. Languages (other than English) Spoken in Your Office

A. By Provider _____

B. By Staff _____

27. Do you wish to have these languages listed in a Provider Directory? _____ YES _____ NO

28. Do you accept Medicare assignment? _____ YES _____ NO

29. Is your office within twenty (20) minutes of the facilities at which you have privileges? _____ YES _____ NO

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

- 30. Office Laboratory services provided? _____
- 31. Office Radiology services provided? _____
- 32. Additional office testing available? _____
- 33. Surgical facilities/services provided at the office? _____
- 34. Do you wish to be listed (for Managed Care) as _____ PCP _____ Specialist _____ Both

PROFESSIONAL LICENSES

Attach copies of license(s)

35. Nevada Medical/Dental/AHP license # _____ Date Issued _____ Date Expires _____

Other State Licenses:

State	Number	Issue Date	Expiration Date
-------	--------	------------	-----------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DEA AND NEVADA STATE PHARMACY REGISTRATION

Attach copies of certificates

36. Federal DEA Registration # _____ Date Expires _____

Nevada State Pharmacy # _____ Date Expires _____

Other State Pharmacy Licenses:

State	Number	Issue Date	Expiration Date
-------	--------	------------	-----------------

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

37. Examinations Taken – Attach Copies

ECFMG No _____	Date of Certification _____
FLEX Exam _____	Date Taken _____
USMLE No. _____	Date Taken _____
National Board of Medical Examiners _____	Date Taken _____

38. Other Training or Certification (Check and complete all that apply, attach copies for hospitals only)

TYPE	Date of Certification	Expiration Date
CPR	_____	_____
ACLS	_____	_____
ATLS	_____	_____
BLS	_____	_____
NALS	_____	_____
PALS	_____	_____
OTHER	_____	_____

EDUCATION/TRAINING

39. Pre-Medical/Dental/AHP Education

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Degree Earned

40. Medical/Dental/AHP Education

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Degree Earned

41. **Internship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

42. **Internship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

43. **Residency** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

44. **Other Residency** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

Phone

FAX

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

45. **Fellowship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

46. **Fellowship** (if applicable) Type _____ (Specialty)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

47. **Fifth Pathway** (Required to be completed by Non-USA Grads in lieu of ECFMG Certification)
(if applicable)

Facility Name

Mailing Address

Phone

FAX

FROM: Mo/Yr

TO: Mo/Yr

Program Director

OTHER POST GRADUATE EDUCATION
List in chronological order and include copies of certificates

48. _____
Facility Name Specialty & Degree Awarded

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

49. _____
Facility Name

Mailing Address

Phone FAX

FROM: Mo/Yr TO: Mo/Yr Program Director

BOARD CERTIFICATIONS

Attach copy of certificate(s)

This section pertains to specialty boards that are organized and recognized by the American Board of Medical Specialties or American Osteopathic Association. (AHPs List Board certification as applicable)

50. _____

Name of Specialty Board

Mailing Address

Date of Certification _____ Expiration Date _____

If **not** certified, indicate current status _____

If **not** certified, are you scheduled to take the exam? If so, when? _____

51. _____

Name of Specialty Board

Mailing Address

Date of Certification _____ Expiration Date _____

If you have ever failed a board examination, please indicate Board and date _____

52. _____

Name of Specialty Board

Mailing Address

Date of Certification _____ Expiration Date _____

If you have ever failed a board examination, please indicate Board and date _____

53. Other Board Certification _____

MILITARY SERVICE

Attach copy of discharge papers.

54. Have you ever served or are you currently serving in the United States Military? _____ YES _____ NO

If YES, Branch of Service _____

FROM _____ / _____ TO _____ / _____ Type of Discharge _____

DD214 (provide copy with application)

NOTE: SHADED PORTIONS N/A TO ALLIED HEALTH PROFESSIONALS

EMPLOYED FACULTY POSITIONS AND ACADEMIC AFFILIATIONS

List in chronological order. Do not include hospital staff memberships or surgical center affiliations.

55.

Facility Name	FROM: Mo/Yr	TO: Mo/Yr
Mailing Address		
Phone Number	FAX Number	
Position	Department	
Reason for Leaving		

56.

Facility Name	FROM: Mo/Yr	TO: Mo/Yr
Mailing Address		
Phone Number	FAX Number	
Position	Department	
Reason for Leaving		

57.

Facility Name	FROM: Mo/Yr	TO: Mo/Yr
Mailing Address		
Phone Number	FAX Number	
Position	Department	
Reason for Leaving		

PRIVATE PRACTICE AND OTHER

List any private practice affiliations or other employment since completion of medical/dental/AHP school. For any time period not covered by an affiliation or training, please provide a written explanation.

58. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

59. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

60. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

61. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

62. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

63. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

64. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

65. _____
Affiliated With FROM: Mo/Yr TO: Mo/Yr

Person to Contact for Verification

Mailing Address

Phone Number

FAX Number

HOSPITAL AND OTHER HEALTH CARE ENTITY MEMBERSHIPS

List ALL hospitals and surgical centers where you currently have or have had affiliation, membership and/or have been granted privileges. If you have withdrawn an application or you are no longer affiliated with a hospital or surgical center, provide an explanation on a separate page. If an explanation is attached, make sure the original entry is denoted. For any time period not covered by an affiliation or training, please provide a written explanation.

66. Hospital/Surgical Center

Affiliated With	FROM: Mo/Yr	TO: Mo/Yr
------------------------	--------------------	------------------

Person to Contact for Verification

Mailing Address

Phone Number	FAX Number
--------------	------------

Staff Category _____ () Check here if explanation is attached

67. Hospital/Surgical Center

Affiliated With	FROM: Mo/Yr	TO: Mo/Yr
------------------------	--------------------	------------------

Person to Contact for Verification

Mailing Address

Phone Number	FAX Number
--------------	------------

Staff Category _____ () Check here if explanation is attached

68. Hospital/Surgical Center

Affiliated With	FROM: Mo/Yr	TO: Mo/Yr
------------------------	--------------------	------------------

Person to Contact for Verification

Mailing Address

Phone Number	FAX Number
--------------	------------

Staff Category _____ () Check here if explanation is attached

69. Hospital/Surgical Center

Affiliated With	FROM: Mo/Yr	TO: Mo/Yr
------------------------	-------------	-----------

Person to Contact for Verification

Mailing Address

Phone Number	FAX Number
--------------	------------

Staff Category _____ () Check here if explanation is attached

70. Hospital/Surgical Center

Affiliated With	FROM: Mo/Yr	TO: Mo/Yr
------------------------	-------------	-----------

Person to Contact for Verification

Mailing Address

Phone Number	FAX Number
--------------	------------

Staff Category _____ () Check here if explanation is attached

71. Hospital/Surgical Center

Affiliated With	FROM: Mo/Yr	TO: Mo/Yr
------------------------	-------------	-----------

Person to Contact for Verification

Mailing Address

Phone Number	FAX Number
--------------	------------

Staff Category _____ () Check here if explanation is attached

PROFESSIONAL LIABILITY (MALPRACTICE) INSURANCE

Attach copy of present policy face sheet and list **ALL** insurance carriers for the past 10 years. Attach additional sheets if necessary.

72. Present Carrier for Nevada Practice _____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

73. Previous Carrier _____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

74. Previous Carrier _____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

75. Previous Carrier _____

Mailing Address

Phone Number FAX Number

Policy # Effective Date Expiration Date

Amounts of Coverage: Occurrence/Claim \$ _____ Aggregate \$ _____

CONTINUING MEDICAL EDUCATION/CEU

76. Attach documentation of continuing medical education/CEU courses attended during the previous two (2) years, if applicable. Indicate which is specialty specific. Approved documentation includes a copy of CME/CEU Certificates or a list from a recognized professional organization such as AOA, AAFP, AMA, AAOS, etc.

PEER REFERENCES

MD/DO, DDS/DMD, etc.: List the names and complete information of three (3) peer references, other than associates, relatives, prospective associates or training directors with equivalent licensure (MD/DO, DDS/DMD, etc.) who have, within the past three (3) years, personal knowledge of your current clinical abilities, ethical character and ability to work with others. At least two of the references should be of your same specialty.

AHPs: List three physicians who are familiar with your clinical abilities and recent practice. Note: references will be evaluated primarily by the extent of direct clinical observation and other work with the applicant. If you are applying for CRNFA privileges, some Entities require each physician to complete a Statement of Physician Sponsorship form (contact Entity for form).

77. _____

Peer Reference	Specialty
_____ Complete Mailing Address	
_____ Phone Number	_____ FAX Number

78. _____

Peer Reference	Specialty
_____ Complete Mailing Address	
_____ Phone Number	_____ FAX Number

79. _____

Peer Reference	Specialty
_____ Complete Mailing Address	
_____ Phone Number	_____ FAX Number

PRACTITIONER QUESTIONNAIRE

80. If answers to any of the following questions is YES, please provide full details on a separate sheet, to include date of occurrence, description of events and current status.

- A. Has your license to practice medicine in any jurisdiction **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, otherwise limited or restricted, or been made subject to a program of probation, or have you **ever** been issued a citation or letter of reprimand by the licensing agency, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO
- B. Has your medical staff membership or medical staff status at any hospital or comparable acute or long term care facility or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends ever been commenced? YES NO
- C. Have your admitting or clinical privilege(s) at any other hospital, or at any comparable acute or long term care facility, or ambulatory surgery center or comparable facility, **ever** been denied, revoked, voluntarily or involuntarily terminated, relinquished, suspended, or restricted or limited, based on patient care or professional conduct reasons, or have formal or informal proceedings, or investigations, toward any of those ends **ever** been commenced? YES NO
- D. Have you **ever** voluntarily or involuntarily relinquished medical staff membership or status, admitting or clinical privileges, withdrawn an application for membership or privileges at any hospital or comparable acute or long term care facility, or ambulatory surgery center or comparable facility, after notification of the actual or imminent commencement of a formal or informal review, or investigation of your practice, credentials or professional conduct? YES NO
- E. Has your membership, participation, privileges, contractual affiliation or other status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, restricted or limited based upon patient care or professional conduct grounds, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO

- F. Have you **ever** voluntarily or involuntarily relinquished membership, participation, privileges, a contractual affiliation or other comparable status with any health maintenance organization, medical group, ambulatory or outpatient care center, clinic, independent practice association, preferred provider organization, or any other comparable health care entity after notification of the actual or imminent commencement of a formal or informal review or investigation, of your practice or professional conduct? YES NO
- G. Has your membership or status in any state or local professional society or other comparable medical organization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended or restricted based upon patient care or professional conduct concerns, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- H. Has your status as a participating provider in the Medicare, Medicaid, or Tricare (formerly Champus) programs **ever** been sanctioned, denied, suspended, voluntarily or involuntarily terminated, limited or revoked, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- I. Has a letter of concern or reprimand **ever** been issued to you? YES NO
- J. Have you **ever** been denied professional liability insurance or has your policy **ever** been canceled? YES NO
- K. (1) Have you **ever** been named in a complaint based on allegations of professional negligence or professional misconduct or have you **ever** received notice of an intent to commence litigation of that type? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** YES NO
- (2) With regard to any suit, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending? **Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.** YES NO
- L. Does your professional liability (malpractice) coverage exclude you from performing any specific procedures(s) or practicing portions of your specialty for which you are requesting privileges? YES NO
- M. Has your specialty board certification or eligibility **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO
- N. Has your Drug Enforcement Agency or other controlled substances authorization **ever** been denied, revoked, voluntarily or involuntarily terminated, suspended, or restricted or have formal or informal proceedings, or investigations toward any of those ends **ever** been commenced? YES NO

- O. Have you **ever** been convicted of a criminal offense other than a minor traffic violation? YES NO
- P. Are you now or have you **ever** been addicted to a controlled substance or alcohol? **If the answer to this question is yes, please provide the name, address and a full description of any rehabilitation program in which you are now participating or in which you have participated as well as the name and title of the individual who can describe your care and participation in that program. An organization may require that you complete a Health Status Form which provides the name and title of the individual/organization (counselor/diversion program/treating provider) who can advocate on behalf of your sobriety status.** YES NO
- Q. Do you currently use illegal drugs? YES NO
- R. Do you have any mental or physical condition that may significantly affect your ability to practice medicine or to exercise the particular privileges that you have requested? If so, do you believe that, with reasonable accommodation, you will be able to provide care meeting the standards controlling the award of privileges and status that you seek? YES NO
- S. Would you require an accommodation in order for you to exercise medical staff duties or the privileges requested safely and completely? YES NO

**Standard Authorization, Attestation and Release for Health Plans, Health Insurers and
Health Care Organizations**

(Not for Use for Employment Purposes)

Purpose of Form

This form has been developed for use by Nevada health plans and health insurers, and may be used by hospitals and other healthcare organizations. Its purpose is to provide a single consolidated form for use by applicants for participation as a provider (hereinafter, "Participation") with health plans or health insurers and may be used for hospital and other healthcare organization medical staff membership and clinical privileges (hereinafter, sometimes, "Membership"). This form, once properly completed will be accepted by all Nevada health plans and health insurers and may be accepted by hospitals and other healthcare organizations (hereinafter, collectively referred to as "Entities").

Acknowledgements and Agreements with respect to Health Plans and Health Insurers

I understand and agree that, as part of the credentialing application process for Participation at or with each health plan or health insurer and any of their affiliated Entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by them for determining initial and ongoing eligibility for Participation.

Acknowledgements and Agreements with respect to Healthcare Organizations

By filing this application, I agree to be bound by the bylaws, rules and regulations, policies, and code of conduct of each and every medical center, medical staff and other healthcare organizations to which I am applying in Nevada. I understand that I have an opportunity to review those bylaws, rules and regulations and policies.

I understand that it is my responsibility to assure that a copy of this application is sent to each and every healthcare organization to which I wish to apply.

I understand that my misrepresentation or significant omission in this application constitutes cause for denial or for subsequent revocation of membership and privileges. I also understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application.

I recognize that as the applicant I bear the burden of demonstrating that I am qualified and remain qualified for the award of membership and privileges in accord with the criteria and standards described in the applicable bylaws and comparable documents, and I recognize that I have the burden of resolving any reasonable doubts about my qualifications for membership and privileges.

In order to facilitate the evaluation of this application and the assessment of any subsequent exercise of privileges, I agree to meet and cooperate with the various officers, representatives and committees charged with responsibility for credentialing and peer review activities.

I understand that the evaluation of credentials shall be accomplished in a professional manner, and that I will be afforded an appropriate review in the event that action on this application is adverse in accordance with the bylaws or rules pertaining to each organization.

As part of this application, I pledge that if I am granted the requested membership and privileges, I will maintain an ethical practice in accord with applicable bylaws, and specifically that I will:

- a) Refrain from fee splitting or other inducements relating to patient referral;
- b) Provide for the continuous care and supervision of my patients;
- c) Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical practitioner who is not qualified to undertake this responsibility and who is not adequately supervised;
- d) Seek consultations whenever necessary or requested by the patient or family;
- e) Abide by all applicable and generally recognized ethical principles applicable to my profession and to each and every healthcare entity to which I am applying; and
- f) Maintain the confidentiality of patient information received by both paper and electronic means.

Furthermore, should I be granted the requested membership and privileges, I will accept appropriate committee assignments and otherwise assist, as requested, in the discharge of medical staff responsibilities.

Acknowledgements and Agreements with Respect to all Entities

Independent Action, No Employment

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me Membership or Participation. I understand that my application for Membership or Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Membership or Participation

I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated Entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Membership or Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Membership or Participation

I authorize any third party, including, but not limited to, individuals, agencies, medical groups, Entities responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter

reasonably having a bearing on my qualifications for Membership or Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any Entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information

I hereby further authorize any third party at which I currently have Membership or Participation or had Membership or Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Membership or Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: a) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Membership or Participation or impose a corrective action plan; b) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or c) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I had knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Authorization of Release Among Entities

Moreover, I consent to the communication and release of information and documents (including medical staff records and patient care records) among the Entities to which I apply and the release of the same by and to any and all other hospitals, medical staffs, medical schools, training programs, medical societies, professional associations, professional liability insurers, licensing authorities, specialty boards, health maintenance organizations, health plans, health insurers, medical groups, ambulatory or outpatient care center, clinics, independent practice associations and any and all other sources that may be available for the purpose of evaluating my professional education, training, experience, character, conduct and judgment. In this regard, care shall be taken to safeguard the privacy of medical information and the confidentiality of medical staff information and medical records.

I specifically authorize the transmission of this application and all supporting documentation, and all information collected during the credentialing process, to each and every component of the Entities in which I have sought Membership or Participation, and I further fully authorize the release of that documentation or information to any health plan, health insurer, hospital, medical staff, medical group or other health care entity that may seek it as part of an authorized credentialing or peer review process.

Required HIPAA Privacy Rule, Nevada Law Provisions

I understand and agree that some of the information to be disclosed pursuant to this Authorization may include information that is "protected health information" under 45 CFR parts 160 and 164, and may also include information protected under Nevada or other federal law ("other confidential medical information"); including blood, breath or urine test results, communicable disease information, information about sexually transmitted disease, (including HIV and AIDS), information about mental health treatment I have sought and/or received, and/or information about drug and/or alcohol abuse treatment I have sought and/or received.

This authorization will expire upon my retirement from medical practice. I acknowledge: a) that I have the right to revoke the authorization as it relates to protected health information and/or

other confidential medical information at any time, and b) that I understand that once protected information is disclosed, it may no longer be protected by federal privacy law. I may revoke this authorization in this regard only in a writing sent by certified mail to the organization to which I originally furnished this Statement. The revocation will be effective only upon receipt.

Release from Liability

I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit any other applicable immunities provided by law for peer review and credentialing activities.

I fully release from liability any person or entity, including any and all representatives of the Entities and any representative, agent or component thereof, that requests or provides information in connection with the evaluation of my application, credentials and practice, to the fullest extent allowed by applicable statutes, regulations and judicial decisions. Moreover, I fully release from liability the participating Entities to which I am applying and any Agent or component thereof, and all other persons or Entities participating in the evaluation of my credentials and practice from any and all liability for their actions and decisions, to the fullest extent allowed by applicable statutes, regulations and judicial decisions.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. Except with respect to its application to protected health information or other confidential medical information, I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Membership or Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. With respect to protected health information or other confidential medical information, this Authorization may be revoked and provided above. However, I understand that my revocation of this Authorization with respect to protected health information or other confidential medical information or my failure to promptly provide another consent with respect to any other information may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Membership or Participation at or with the Entity and will result in the cessation of any action on my application for Membership or Participation. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or

authorized to be released pursuant to the credentialing process. Further, I specifically agree to notify the Entities to which I am applying immediately upon notification upon any significant change or any formally recommended change in licensure status, or any actual or formally recommended denial, suspension or revocation of privileges or membership or status by another healthcare entity, or cancellation or interruption of my professional liability insurance coverage. I understand that corrections to the application are permitted at any time prior to a determination of Membership or Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission, as determined solely by the Entity, in my application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Membership or Participation; and/or immediate suspension or termination of Membership or Participation and will result in the cessation of any action on my application for Membership or Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name: _____

Signature _____

Date _____

MALPRACTICE CLAIM INFORMATION WORKSHEET

Please duplicate this form and complete for EACH case. Also, for each case that has been settled or dismissed, supply court documentation.

Practitioner Name _____

1. Patient Name _____

2. Diagnosis _____

3. Your involvement in the case (attending, consulting, etc.) _____

4. Allegation(s) _____

5. Clinical Case Summary (Include additional pages or inserts if necessary)

6. Patient Outcome _____

7. Other Pertinent Details _____

8. Date of Incident _____ Date Filed _____ Date Closed _____

9. Resolution of Case (dismissed, settled out of court, litigated, other)

NOTE: All cases litigated must include legal documentation.

10. Settlement amount paid on your behalf, if any

11. Professional liability insurer involved:

A. Name of Insurer _____ B. Policy # _____

B. Address of Insurer

Name: _____

Signature _____ **Date** _____

No claims to report

Regardless of whether you have had any claims, this form must be signed and dated.