

REQUIRED ATTACHMENTS

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 9.
- ✓ Current Employer Identification Number (EIN) **and** W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009 (A) (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

X

Name *(Please Print)*

Signature

Original Attestation Date

Second Attestation Date

Third Attestation Date

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.