blue california

blue california
Promise Health Plan

Credentialing Application Information Checklist

The credentialing checklist below indicates the documents required by the Blue Shield of California ("Blue Shield") and Blue Sheild of California Promise Health Plan ("Blue Shield Promise") Credentialing Department.

Email the completed and signed application, signed addendums, and completed checklist to Blue Shield's Credentialing Department at BSCInitialApp@blueshieldca.com.

If you have questions or wish to discontinue the credentialing process at any time, please send a written request to the credentialing department at the email address above.

Please complete and submit all of the requested information. **Missing or omitted information will delay or stop the credentialing application process.** Add a checkmark next to each item below to confirm it has been included in your submission. If an item does not apply to your provider type or specialty, please enter N/A. The Blue Shield Credentialing department may reach out to you if it is determined that additional information is required.

☐	**Credentialing Application** A completed, signed and dated California Participating Practitioner Application (CPPA) is required for initial credentialing, as well as for re-credentialing. When re-credentialing, check the "Check if there are any changes and update below" box in each section to indicate changes to existing information. **All sections of the attached application must be completed, including the attestation questionnaire and addendums A and B.**
☐	**Curriculum Vitae** Copy of the current Curriculum Vitae (CV) resume. Include work history for the previous **five years**, listing beginning and ending months and years of each employment. If there are any work gaps of six months or more, please provide a written explanation.
☐	**Medical License** Copy of a current valid and unrestricted California medical license issued by the appropriate licensing board.
☐	**Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate:** Copy of DEA Controlled Substance Registration Certificate with California address, if applicable.
☐	**Professional Malpractice Liability Insurance Certificate** Copy of current Professional Liability Insurance Certificate which includes the following information: • Name of policy holder • Name of policy carrier • Limits of liability ($1M/$3M; $1M/$1M for allied health and non-physician behavioral health practitioners) • Expiration date
☐	**Board Certification** Copy of current Board Certification, if applicable
☐	**Educational Commision for Foreign Medical Graduate (ECFMG) Certificate** Copy of ECFMG Certificate, if applicable
☐	**Physician Supervisory Agreement** (For midlevel only)
☐	**National Provider Indentifier (NPI):**
☐	**Medi-Cal Acceptance Letter or number:**
☐	**Medicare Certification Letter or number:**
☐	**Specialty requested:**
☐	**Credentialing mailing address:**
☐	**Phone number:**
☐	**Email address:**
☐	**Contact name:**

Please note: This credentialing process is being conducted under the provisions of California Evidence Code Section 1157 and Health and Safety Code Section 1370. All information submitted or obtained during this process will be used and maintained in accordance with these provisions.

Note: The standardized form below is provided in collaboration with the Health Industry Collaboration Effort (HICE). All organizations participating in this collaboration are using this same form. More information on HICE is available at https://www.iceforhealth.org/home.asp

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided in the original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

Check if there are any changes and update below

Last Name:	First Name:	Middle:	
Is there any other name under which you have been known? Name(s):			
Home Mailing Address:			
City:	State:	ZIP Code:	
Telephone Number:	Fax Number:	Cell Number:	Pager Number:
Practitioner Email:	Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):		
Birth Date:	Birthplace:		
Race (optional):	Ethnicity (optional):	Language(s) (optional):	

The credentialing entity will not discriminate or base credentialing decisions on the applicant's race, ethnicity or language and providing this information is optional.

Driver's License State/Number:	Social Security Number:	Gender: ☐ Male ☐ Female
Your intent is to serve as a(n): ☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based		
Specialty:		
Subspecialties:		

III. Practice Information

Check if there are any changes and update below

Practice Name (if applicable):		Department Name (if hospital based):	
Primary Office Address:			
City:		State:	ZIP Code:
Telephone Number:	Fax Number:	Website (if applicable):	Pager Number:
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None			

III. Practice Information, cont'd.

Check if there are any changes and update below

Type of practice (check all that apply):

- ☐ Solo Practice
- ☐ Group Practice
- ☐ Single Specialty Group
- ☐ Multi-Specialty Group
- ☐ Urgent Care

Primary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Secondary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):	
Secondary Office Address:			
City:		State:	ZIP Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	

Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None

Type of practice (check all that apply):

- ☐ Solo Practice
- ☐ Group Practice
- ☐ Single Specialty Group
- ☐ Multi-Specialty Group
- ☐ Urgent Care

Secondary Office Hours of Operation:	Languages spoken by Staff:
	Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Tertiary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):	
Tertiary Office Address:			
City:		State:	ZIP Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	

Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None		
Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Single Specialty Group ☐ Multi-Specialty Group ☐ Urgent Care		
Tertiary Office Hours of Operation:	Languages spoken by Staff:	
	Languages spoken by Provider:	
Group Medicare PTAN/UPIN #:	Group NPI #:	
Mailing Address		
Which of your practices is your primary mailing address? ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other		
If your mailing address is different from your practice address, please provide it:		

IV. Billing Information

Check if there are any changes and update below

Which of your practices handles your billing? ☐ Primary ☐ Secondary ☐ Tertiary ☐ if none, please provide billing info:		
Billing Company:		
Billing Company Mailing Address:		
City:	State:	ZIP Code:
Contact Person:	Telephone Number:	
Federal Tax ID Number:	Name Associated with Tax ID:	

V. Practice Description

Check if there are any changes and update below

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No
If yes, please list:

Name	Type of Provider	License Number
Physician Assistant Supervisor Name:		License Number:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ☐ Yes ☐ No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary
		☐ Primary ☐ Secondary ☐ Tertiary

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

Please list any clinical services you do **not** perform that are typically associated with your specialty:

Which offices does this apply to:	☐ Primary ☐ Secondary ☐ Tertiary
Is your practice limited to certain ages?	☐ Yes ☐ No If yes, specify limitation:
Which offices does this apply to:	☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company:			
Answering Service Company Address:			
City:	State:	ZIP Code:	Email:

Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training, and Experience

Check if there are any changes and update below

Medical/Professional Education

Medical School/Professional:		Degree Received:	Graduation Date:
Mailing Address:		Website (if applicable):	
City:	State:	ZIP Code:	Registrar's Phone Number:

Internship/PGY-1

Institution:	Program Director:		
Address:	City:	State:	ZIP Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Type of Internship:	From (mm/yyyy):	To (mm/yyyy):	
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)			

Residencies/Fellowships Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution:	Program Director:		
Address:	City:	State:	ZIP code:
Telephone Number:	Fax Number:	Website(if applicable):	
Type of Training:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)			

Institution:	Program Director:		
Address:	City:	State:	Zip code:
Telephone Number:	Fax Number:	Website (if applicable):	
Type of Training:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)			

Institution:	Program Director:		
Address:	City:	State:	Zip code:
Telephone Number:	Fax Number:	Website (if applicable):	
Type of Training:	Specialty:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐ Yes ☐ No (if No, please explain on a separate sheet.)			

VII. Medical Licensure & Certifications

Check if there are any changes and update below

California State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Agency (DEA) Registration Number:	Schedules:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Issue Date:
Individual National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:	Individual Medicare PTAN Number:

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

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 or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

Have you applied for board certification other than those indicated on the prior page (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 below or in a separate sheet.

Specialty:	Describe here:
Board Name:	
Exam Date:	

VIII. Current Hospital and Other Institutional Affiliations

Check if there are any changes and update below

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). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:		State:	ZIP Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:		State:	ZIP Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:		State:	ZIP Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:		State:	ZIP Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):
If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):			

B. Previous Hospital and Other Institutional Affiliations

Name and Address of Affiliation:	Department:
	From (mm/yy):
	To (mm/yy):
Reason for leaving:	
Name and Address of Affiliation:	Department:
	From (mm/yy):
	To (mm/yy):
Reason for leaving:	

Name and Address of Affiliation:	Department:
	From (mm/yy):
	To (mm/yy):
Reason for leaving:	
Name and Address of Affiliation:	Department:
	From (mm/yy):
	To (mm/yy):
Reason for leaving:	
Name and Address of Affiliation:	Department:
	From (mm/yy):
	To (mm/yy):
Reason for leaving:	

IX. Peer References

Check if there are any changes and update below

List three professional references, preferably from your 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 where you currently hold privileges.

Note: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, an MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference:		Specialty:	
Address:	City:	State:	ZIP Code:
Telephone Number:	Fax Number:	Email Address:	
Name of Reference:		Specialty:	
Address:	City:	State:	ZIP Code:
Telephone Number:	Fax Number:	Email Address:	
Name of Reference:		Specialty:	
Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Email Address:	

X. Work History

Check if there are any changes and update below

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is not sufficient. Please explain any gaps on a separate page.

Current Practice:		Contact Name:	
Address:	City:	State:	ZIP Code:
Telephone Number:	Fax Number:	From (mm/yyyy):	To (mm/yyyy):

Current Practice:		Contact Name:	
Address:	City:	State:	ZIP Code:
Telephone Number:	Fax Number:	From (mm/yyyy):	To (mm/yyyy):

Current Practice:		Contact Name:	
Address:	City:	State:	ZIP Code:
Telephone Number:	Fax Number:	From (mm/yyyy):	To (mm/yyyy):

XI. Professional Liability

Check if there are any changes and update below

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier:		Policy Number:	
Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Email Address:	Tail Coverage: ☐ Yes ☐ No	Per Claim Amount:	
Original Effective Date:	Expiration Date:	Aggregate Amount:	

Name of Carrier:		Policy Number:	
Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Email Address:	Tail Coverage: ☐ Yes ☐ No	Per Claim Amount:	
Original Effective Date:	Expiration Date:	Aggregate Amount:	

Name of Carrier:		Policy Number:	
Address:	City:	State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Email Address:	Tail Coverage: ☐ Yes ☐ No	Per Claim Amount:	
Original Effective Date:	Expiration Date:	Aggregate Amount:	

XII. Professional and Practice Services

Check if there are any changes and update below

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

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other (please specify):

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.

Federal Tax ID:	Type of Service Provided:	Do you have a CLIA certificate? ☐ Yes ☐ No
Billing Name:		Do you have a waiver? ☐ Yes ☐ No
CLIA Certificate Number:		CLIA Certificate Expiration Date:

Have you or your office received any of the following accreditations, certificates, or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)

☐ Medicare Certification ☐ The Medical Quality Commission (TMQC)

☐ Child Health and Disability Prevention Program (CHDP) ☐ Comprehensive Perinatal Services Program (CPSP)

☐ California Children Services (CCS) ☐ Family Planning

☐ Other:

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant.

Organization Name	Membership Status	
	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Do you participate in electronic data interchange (EDI)? ☐ Yes ☐ No If so, which Network?

Do you use a practice management system/software? ☐ Yes ☐ No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine, OR

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties, OR

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; AND
2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; OR

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV, AND

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; OR
2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; OR
3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, Drug Enforcement Administration (DEA) registration or an 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
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 federal program or is any such action pending?	☐ Yes ☐ No
3. 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) federal programs, 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
4. 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), 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
5. 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
6. Have you ever been denied certification/recertification by a specialty board?	☐ Yes ☐ No
7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?	☐ Yes ☐ No
8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense?	☐ Yes ☐ No
8. b.Are any such actions pending?	☐ Yes ☐ No
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? If YES, please complete Addendum B.	☐ Yes ☐ No
10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If YES, please complete Addendum B.	☐ Yes ☐ No
11. 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
12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.	☐ Yes ☐ No

Continue to the Next Page for Additional Attestation Questions

ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)?	☐ Yes ☐ No ☐ Yes ☐ No
14. Are you currenly engaged in the illegal use of drugs, or have a chemical or substance abuse dependency?	☐ Yes ☐ No
15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs?	☐ Yes ☐ No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and 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.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:**

PRINTED NAME: **DATE:**

Continue to the Next Page for Information Release/Acknowledgements

INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and 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 care service 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 recredentialing 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 peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state 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, within fourteen (14) 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 (or any subsections) with the Medical Board of California, appropriate licensing board 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 any 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 pledge to provide continuous care for my patients.

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.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:**

PRINTED NAME: **DATE:**

Addenda Submitting: Addendum B; Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

The CPPA has been completed. Please be sure you have signed the last two pages before submission.

California Participating Practitioner Application

Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g. malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices will notify the practitioner with 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email, or fax to the Credentialing Department of the Healthcare Organization's offices. The provider will be notified in writing by fax, email, or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email, or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges, or board certification expiration, when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction of the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below withing 10 working days. The Credential Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address:	City:	State:	Zip:

APPLICANT SIGNATURE (Stamp is Not Acceptable):

PRINTED NAME:

DATE:

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to: herein, this Healthcare Organization

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 an 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.

Please check here if there are no pending/settled claims to report and sign below to attest.

I: Practitioner Identifying Information			
Last Name:	First Name:		Middle:
II: Case Information			
Patients Name:	Patients Gender: ☐ Male ☐ Female		Patients DOB:
City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:
Location of incident: ☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery center ☐ Other (specify):			
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, 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:	Telephone Number:	Fax Number	

III: Status of Lawsuit/Arbitration (check one)	
☐	Lawsuit/arbitration still ongoing, unresolved.
☐	Judgement rendered and payment was made on my behalf. Amount paid on my behalf:
☐	Judgement rendered and I was found not liable.
☐	Lawsuit/arbitration settled, and payment made on my behalf. Amount paid on my behalf:
☐	Lawsuit/arbitration settled/dismissed, no judgement 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 sheets.

Please include:

1. Condition and diagnosis at the time of incident.
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

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 evaluation or verification contained in this document, which is part of the California Participating Practitioner Application. In order for the 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 about 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 attorney(s) listed on Page 1 to discuss any information regarding this case with “this Healthcare Organization.”

APPLICANT SIGNATURE (Stamp is not acceptable):

PRINTED NAME:

DATE: