MPCH
Massachusetts Partnership for Correctional Healthcare

CREDENTIALING APPLICATION PACKET INSTRUCTIONS

1) If you ARE registered with CAQH, **complete the "Provider Data Form" enclosed. You DO NOT need to complete the "Integrated Massachusetts Application for Initial Credentialing/Appointment"**

2) If you ARE NOT registered with CAQH, **complete the "Integrated Massachusetts Application for Initial Credentialing/Appointment" enclosed. You will also need to include the items listed on the "Credentialing Application Checklist" You DO NOT need to complete the "Provider Data Form."**

3) **Please mail or fax to the following: Massachusetts Partnership for Correctional Healthcare, c/o Centene PDM/Credentialing, 7711 Carondelet Ave., St. Louis, MO 63105. Fax Number: 866-524-7048**

Provider Data Form
For Credentialing Purposes

DATE:	Are you registered with CAQH? Yes No	
If Yes, CAQH Provider ID:	Social Security:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Birth Place:	Race/ Ethnicity:
Home Phone:	Email:	
Practice Name:	Department Name (If Hospital Based):	
Primary Office Street Address:	Suite #:	
Primary Office City:	State: County:	Zip:
Primary Telephone:	Primary Fax:	
Provider Type (MD, DO, PhD, LCSW, LPC, etc) :	Tax ID:	
Please list any certifications or accreditations obtained at this location:		
Answering Service Contact Information:		
Billing Contact Information:		
Does this office use Practice Management software? Yes	What type of anesthesia do you provide in your group/office (Please circle all that apply)? Local Regional Conscious Sedation General None Other (please specify):	
Specialty:	Applying As (circle): Specialist Allied Health Professional Primary Care Physician Group Practice	
Are you board certified? Yes No	If Yes, board name:	Exp. Date:
Board Certification Number:	DEA Certificate Number:	
Medicaid ID #:	State License Number:	Licensing State:
UPIN: NPI:	NPI Group:	
Other Insurance Network Participation:		
Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.:		
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 if you have one.		
Do you have a CLIA Certificate? Yes No	Do you have a CLIA waiver? Yes No	Type of Service Provided:
Certificate Number: Certificate Expiration Date:	Billing Name: Tax ID #:	

Note: If you have already completed your application with CAQH, please ensure that you have authorized Massachusetts Partnership for Correctional Healthcare to access your data. This can be done by calling CAQH at (888) 599-1771. Using the CAQH Universal Credentialing Data-Source does not grant participation or constitute applying for participation with this product line.

Credentialing Application Checklist

The original application with attachments should be returned to
Massachusetts Partnership for Correctional Healthcare
c/o Centene PDM/Credentialing
7711 Carondelet Ave.
St. Louis, MO 63105

Please type or print in black ink when completing this form. If you need more space or have more than three locations, attach additional sheets and reference the question being answered. Please do not write "see CV" or "refer to CV" in place of completing the required information. To assist in the timely processing of your application, we have provided the following checklist of documents necessary to complete your application packet for review.

Copies of:

- Valid, current State of Massachusetts medical license
- Current Drug Enforcement Agency (DEA) or Controlled Dangerous Substance (CDS) certification
- Current malpractice coverage or bond that complies with the physician's relevant practice act in the Massachusetts Statutes
- If you do not have current hospital admitting privileges, please have your covering physician complete the *Covering Physician Letter (see page 13 of application)*
- Curriculum Vitae / Work history for the past 5 years
- Current board certification or actively in the process of obtaining board certification
- Education Certificate for Foreign Medical Graduates (ECFMG) – if applicable
- A completed and signed application and attestation forms
- Copy of a Driver's License
- Completed W-9 Form

If there is information missing, a Provider Representative will notify the applicant within thirty (30) days of receipt, of missing or incomplete application elements.

Physician has thirty (30) days from the date of signed application to provide all missing elements to Massachusetts Partnership for Correctional Healthcare. If all elements have not been submitted within the 30-day timeframe, the application will be returned to the applicant.

Once your credentials have been verified, the Massachusetts Partnership for Correctional Healthcare Credentialing Committee will review your application and you will be notified of our decision in writing.The Credentialing Committee meets monthly to review completed files and determine provider participation status.

Massachusetts Physician Credentialing
Fact Sheet

New Credentialing Process

The Massachusetts Physician Credentialing Initiative, which went into effect April 1, 2004, establishes a standardized process for physician credentialing by health plans and hospitals. This effort streamlines and simplifies the credentialing process, featuring a uniform application for physicians to complete, copy and submit to each health plan and hospital with which they seek affiliation. Participating health plans will process 95% of complete initial applications within 30 days, and communicate regularly with physicians on application status.

Industry Collaboration

This initiative is sponsored by the Massachusetts Association of Health Plans, Blue Cross Blue Shield of Massachusetts, the Massachusetts Hospital Association and the Massachusetts Medical Society, while initial participants include Harvard Pilgrim Health Care, Fallon Community Health Plan, Health New England, Tufts Health Plan, Neighborhood Health Plan, Network Health, Harvard Vanguard Medical Associates, Massachusetts General Hospital, Massachusetts General Physician's Organization, NEMSO-Beverly Hospital, Brigham & Women's Hospital, and Brigham & Women's Physician Organization. A complete list of participants is available through the Massachusetts Medical Society Web site at *www.massmed.org*. For any questions, please contact your health plan.

New Process Highlights

- Uniform initial credentialing application (excluding psychiatrists) at participating health plans and hospitals
- Uniform recredentialing application, along with plan/hospital-specific profile forms to be used by all physicians (excluding psychiatrists), at participating health plans and hospitals
- Standard criteria for hospital-based physicians
- Turnaround time for 95% completed initial applications within 30 days
- Standard reporting of application status

Meeting the 30-day turnaround standard for initial applications will require that providers submit complete applications; incomplete applications will be returned with a cover letter identifying the missing or incomplete information. A complete application shall include:

- An application that is signed and appropriately dated by the physician applicant
- Complete and legible information
- Explanations that are satisfactory to the health plan, to any affirmative answer
- A current CV with appropriate required dates in months and years
- A signed, currently dated Applicant's Authorization to Release Information form
- Copies of current licenses in all states in which the physician practices
- Copies of current Massachusetts controlled substances registration and federal DEA controlled substance certificate, or if not available, a letter describing prescribing arrangements
- Hospital letter or verification of hospital credentialing (or alternative pathways)
- A copy of current malpractice face sheet coverage statement indicating name of insurer, amounts and dates of coverage
- Documentation of Board certification (or alternative pathways)
- Documentation of training (if not Board-certified)
- No affirmative responses on questions related to quality or clinical competence
- No modifications to Applicant's Authorization to Release Information form
- No discrepancies between physician-provided information and information received from other sources
- Appropriate Health Plan participation agreement(s), if applicable

Integrated Massachusetts Application for Initial Credentialing/Appointment

Section I – Personal Information

Personal Data:

Last Name: _____ First Name: _____ Middle Name: _____

Suffix (Jr., II, etc.): _____ Prof. Title (M.D., Ph.D., etc.): _____

Other Name(s) Used (include maiden name): _____

Current Home Address: **(Please include Apt #, Street Address, City, State, Zip)**	**Local Area Home Address** (if different from current)**:** **(Please include Apt #, Street Address, City, State, Zip)**
Phone Number: ( )	Phone Number: ( )
Fax Number: ( )	Fax Number: ( )

Email Address: _____

Alternate Email Address: _____ Languages Spoken: _____

Specialty: _____(% of practice:___) Sub-specialty:_____(% of practice:___)

Social Security #: ___ __ __ - __ __ - __ __ __ __ Date of Birth: __ __ / __ __ / __ __ Gender: ☐ Male ☐ Female

Place of Birth City: _____ State: _____ Country: _____

Citizenship (Country): _____

If not an American citizen, what kind of visa will you hold while you are here?

Type: _____ Sponsor: _____ Expiration Date: _____

Do you hold permanent immigrant status in the United States? Yes* ☐ No ☐

*If yes, please attach a copy of green card or approval letter.

National Identification Number: _____

Country of Issue: _____

International Medical Graduate:

If you are a graduate of an international medical school (except Canada) and seeking clinical privileges, you are required to be certified by the Educational Commission for Foreign Medical Graduates (ECFMG). Please complete the section below and include a copy of your ECFMG certificate.

Certificate Number: _____ Date Passed: _____

Date passed USMLE: Step 1: _____ Step 2: _____ Step 3: _____

FLEX: Yes ☐ No ☐ Date Passed: _____

Are you currently in the United States on a Temporary Visa (i.e., J-1, H-1, F-1)? Yes* ☐ No ☐

If yes, attach copy of current IAP-66 (if applicable). If not currently in the United States, have you been in the United States on a temporary visa within the past five years? Yes ☐ No ☐ *If yes, complete below

Dates (Mo/Yr)		Type of Visa	Visa Sponsor
From:	To:		
From:	To:		

Office Information: Please list **all** office addresses. Indicate which office is your primary office (only one office can be noted as your Primary Office), and which should be your mailing address. Also, please indicate if this particular address is your administrative, clinical or research office.

Office/Practice Name: ______ Practice Manager Name: ______ Street Address: ______ Street Address: ______ City: ______ State: ______ Zip: ______ If not currently at this site, expected start date: ______ OFFICE PHONE #: ______ OFFICE FAX #: ______	**Office Type:** ☐ **Primary Practice Address** ☐ **Administrative Address** ☐ **Other Clinical Practice Office** ☐ **Research Office**	**Mailing Address** **YES** ☐ **NO** ☐

Office/Practice Name: ______ Practice Manager Name: ______ Street Address: ______ Street Address: ______ City: ______ State: ______ Zip: ______ If not currently at this site, expected start date: ______ OFFICE PHONE #: ______ OFFICE FAX #: ______	**Office Type:** ☐ **Primary Practice Address** ☐ **Administrative Address** ☐ **Other Clinical Practice Office** ☐ **Research Office**	**Mailing Address** **YES** ☐ **NO** ☐

Office/Practice Name: ______ Practice Manager Name: ______ Street Address: ______ Street Address: ______ City: ______ State: ______ Zip: ______ If not currently at this site, expected start date: ______ OFFICE PHONE #: ______ OFFICE FAX #: ______	**Office Type:** ☐ **Primary Practice Address** ☐ **Administrative Address** ☐ **Other Clinical Practice Office** ☐ **Research Office**	**Mailing Address** **YES** ☐ **NO** ☐

Board Certification: (Please list both specialty and sub-specialty board certification)

Board Name: ______________________________

Specialty: ______________________________

Date of Initial Certification: __________ Valid Through: __________ Date Re-certified: __________

Board Name: ______________________________

Specialty: ______________________________

Date of Initial Certification: __________ Valid Through: __________ Date Re-certified: __________

Board Name: ______________________________

Specialty: _____

Date of Initial Certification: _____ Valid Through: _____ Date Re-certified: _____

If you are not Board Certified, are you eligible for Board admission? Yes ☐ No ☐ If you are not Board Certified, please indicate the date that you plan to sit for the Board exam or confirm that you received your medical training prior to when the Board was offered.

_____. If you are Board Eligible and do not plan to sit for the Boards please explain why: _____

_____

Education: In chronological order, list **all** schools you have attended beyond high school. Attach additional sheet if necessary. Please provide **complete** mailing addresses.

College/University: _____

Street: _____ City: _____ State: _____ Zip: _____

Country: _____ Degree: _____ From: __ __/__ __/ __ __ __ __ To: __ __/__ __/ __ __ __ _

College/University: _____

Street: _____ City: _____ State: _____ Zip: _____

Country: _____ Degree: _____ From: __ __/__ __/ __ __ __ __ To: __ __/__ __/ __ __ __ _

College/University: _____

Street: _____ City: _____ State: _____ Zip: _____

Country: _____ Degree: _____ From: __ __/__ __/ __ __ __ __ To: __ __/__ __/ __ __ __ _

Internship: **Include only primary hospital (do not include rotations)**. Attach additional sheet if necessary:

Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____

Supervisor/Chief/Contact Person: _____ Phone Number: _____

Residencies: **Include only primary hospital (do not include rotations)**. Attach additional sheet if necessary.

Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____

Supervisor/Chief/Contact Person: _____ Phone Number: _____

Hospital/Facility: _____

Street: _____ City: _____ State: _____ Zip: _____

Department/Specialty: _____ Dates (Mo/Yr) From: _____ To: _____

Supervisor/Chief/Contact Person: _____ Phone Number: _____

Fellowships: **Include only primary hospital (do not include rotations)**. Attach additional sheet if necessary.

Hospital/Facility: ____

Street: ____________________ City: ______________ State: _________ Zip: ______

Department/Specialty: _______________ Dates (Mo/Yr) From: _________ To: __________

Supervisor/Chief/Contact Person: ______________________Phone Number:______________

Hospital/Facility: ____

Street: ____________________ City: ______________ State: _________ Zip: ______

Department/Specialty: _______________ Dates (Mo/Yr) From: _________ To: __________

Supervisor/Chief/Contact Person: ______________________Phone Number:______________

Hospital/Facility: ____

Street: ____________________ City: ______________ State: _________ Zip: ______

Department/Specialty: _______________ Dates (Mo/Yr) From: _________ To: __________

Supervisor/Chief/Contact Person: ______________________Phone Number:______________

Professional Affiliations/ Work History: List **all** healthcare facilities, both current and prior, (i.e., hospitals, health centers, medical groups, clinics, military facilities, etc.) with which you have been affiliated for the purpose of providing patient care. **Do not list internships, residences or fellowships that you noted on previous pages - please include any moonlighting**. Please use additional sheets if necessary. List most recent affiliations first. Please indicate your primary Hospital.

Primary Hospital ☐

Hospital/Facility: ______________________Reason for Discontinuance: ___________________

Street: ____________________ City: ______________ State:__________ Zip: __________

Department/Specialty: ____________________ Staff Category: __________________________

Supervisor/Chief: ____________ Dates (Mo/Yr) From ______To _______ Admitting Privileges: Yes ☐ No ☐

Primary Hospital ☐

Hospital/Facility: ______________________Reason for Discontinuance: ___________________

Street: ____________________ City: ______________ State:__________ Zip: __________

Department/Specialty: ____________________ Staff Category: __________________________

Supervisor/Chief: ____________ Dates (Mo/Yr) From ______To _______ Admitting Privileges: Yes ☐ No ☐

Primary Hospital ☐

Hospital/Facility: ______________________Reason for Discontinuance: ___________________

Street: ____________________ City: ______________ State:__________ Zip: __________

Department/Specialty: ____________________ Staff Category: __________________________

Supervisor/Chief: ____________ Dates (Mo/Yr) From ______To _______ Admitting Privileges: Yes ☐ No ☐

►►►Please provide an explanation of any gaps in your professional career. ◄◄◄

Continue on an attached sheet if you have more affiliations than space allows.

Statement of Continuing Medical Education Credits: (please list the courses taken in the last 24 months. Your education activities should relate, at least in part, to your privileges.)

Course Taken:	Where:	When:	# of CME hours:

Military Commitment:

Branch of Service:	
Duty Status:	
Rank:	
Present Duty Assignments:	
☐ **I have no military obligations**	

Licensure: Please list all professional licenses that you currently hold or have held in any jurisdiction.

Current Licenses:

Number	State	Expiration Date	Type (full, limited, temporary)

Previous Licenses:

Number	State	Expiration Date	Type (full, limited, temporary)

Life Support Certifications: As applicable please list any life support certificates you may have

	Number, if applicable	State, if applicable	Expiration Date	Type
Basic Life Support (BLS)				
CPR				
Adv Cardiac Life Support (ACLS)				
Pediatric Adv Life Support (PALS)				
Neonatal Adv Life Support (NALS)				
Adv Trauma-Life Support (ATLS)				

Massachusetts Controlled Substance Registration Certificate - Registration Number: _____ Issue Date: _____

Federal Drug Enforcement Administration (DEA) Certificate Registration Number: _____ Exp. Date:_____

National Practitioner Identification Number (NPI): _____

If you have Medicare, Medicaid and UPIN numbers please list them below:

MA. Medicare ID #: _____ MA. Medicaid ID #:_____ UPIN #: _____

Do you participate in and meet the conditions of participation in Medicare? Yes ☐ No ☐

CONTROLLED SUBSTANCES PRESCRIBING/DISPENSING WAIVER

As requirement by State and Federal regulations, you must either possess individual valid **state and federal** controlled substances certificates or you must sign a statement waiving your right to prescribe/dispense controlled substances. If you will be prescribing/dispensing Schedule VI controlled substances only, you need not have a federal controlled substances certificate, but must have a state controlled substances certificate.

STATEMENT

This certifies that I will not prescribe/dispense controlled substances. This statement will become null and void when I present to the Department Credentials Administrator of each Hospital and Health Plan to which I applied, a valid federal and state controlled substances certificates.

Signature: _____ Date: _____ Print Name: _____

This certifies that I will prescribe/dispense Schedule VI controlled substances only (requires state certificate).

Signature: _____ Date: _____ Print Name: _____

Professional References: Please check with the individual Hospital/Health Plan to which you are applying for specific instructions regarding the submission of Professional References.

Contact Name: _____ Contact Title: _____

Hospital/Facility:_____ Department: _____ Phone Number: (___)_____

Street: _____ City: _____ State: _____ Zip: _____Country: _____

Contact Name: _____ Contact Title: _____

Hospital/Facility:_____ Department: _____ Phone Number: (___)_____

Street: _____ City: _____ State: _____ Zip: _____Country: _____

Contact Name: _____ Contact Title: _____

Hospital/Facility:_____ Department: _____ Phone Number: (___)_____

Street: _____ City: _____ State: _____ Zip: _____Country: _____

Professional Liability Insurance: List names, complete addresses, policy numbers, dates of coverage and limits of liability for **all liability insurance carriers** including self-insured institutions and including internship and residency programs for the past 10 years. Please attach additional sheets, if necessary. List most recent carriers first.

Name of Company: _____

Street: _____ City: _____ State:_____ Zip: _____

Policy Number: _____ Dates of Coverage (Mo/Yr) From: _____ To: _____

Underwriter:_____ Institution Affiliation: _____

Amount of Coverage per Occurrence:_____ Amount of Coverage Aggregate:_____

Name of Company: _____

Street: _____ City: _____ State:_____ Zip: _____

Policy Number: _____ Dates of Coverage (Mo/Yr) From: _____ To: _____

Underwriter:_____ Institution Affiliation: _____

Amount of Coverage per Occurrence:_____ Amount of Coverage Aggregate:_____

Name of Company: _____

Street: _____ City: _____ State:_____ Zip: _____

Policy Number: _____ Dates of Coverage (Mo/Yr) From: _____ To:_____

Underwriter:_____ Institution Affiliation: _____

Amount of Coverage per Occurrence:_____ Amount of Coverage Aggregate:_____

Questions regarding licensure and prescriptive privileges:

1.	Have any disciplinary actions** been threatened, initiated or are any pending against you by a state licensure board?	Yes* ☐ No ☐
2.	Has your license to practice in any state ever been denied, limited, suspended or revoked, diminished, not renewed, relinquished (whether voluntarily or involuntarily) or are any proceedings currently pending which may result in any such action?	Yes* ☐ No ☐
3.	Have your privileges to possess, dispense or prescribe controlled substances ever been suspended, revoked, denied, restricted, not renewed, surrendered (voluntarily or involuntarily) or have you been called before or warned with regard to these privileges by this state or any jurisdiction or federal agency at any time? Is any such action currently pending?	Yes* ☐ No ☐
4.	Have any formal or written complaints been filed against you with any state professional licensing board?	Yes* ☐ No ☐
5.	Do you hold a narcotic registration for any other state?	Yes* ☐ No ☐

Questions regarding healthcare facility employment and/or privileges:

6.	Has your professional employment ever been suspended, diminished, revoked or terminated at any hospital or healthcare facility or are any proceedings that may result in any such action currently pending?	Yes* ☐ No ☐
7.	Has your medical staff appointment/privileges ever been limited, suspended, diminished, revoked, refused/denied, terminated, restricted, not renewed, relinquished (whether voluntarily or involuntarily) at any hospital or healthcare facility or are proceedings currently pending which may result in any such action?	Yes* ☐ No ☐
8.	Have you ever withdrawn (or voluntarily relinquished) your application for appointment, re-appointment or privileges or resigned from the medical staff because disciplinary action** or loss or restriction of clinical privileges was threatened or before a decision about your appointment and/or privileges was rendered by a hospital's or healthcare organization's governing board?	Yes* ☐ No ☐
9.	Have you ever been the subject of disciplinary action** or proceedings at any healthcare facility?	Yes* ☐ No ☐
10.	Have you ever been investigated for scientific misconduct?	Yes* ☐ No ☐
11.	Have you ever been suspended, sanctioned or restricted from participating in any private, federal or state health program (e.g., Medicare or Medicaid or Blue Cross/Blue Shield)?	Yes* ☐ No ☐
12	Do you have any financial interest (directly or through family or business partners) in any nursing home, laboratory, pharmacy, medical equipment or supply house or other business to which patients from this facility might be referred or recommended?	Yes* ☐ No ☐
13.	Have you had an application for membership as a participating provider rejected by any HMO/PPO or other prepaid health care plan or your contract as a participating provider terminated by any HMP/PPO or other prepaid plan?	Yes* ☐ No ☐

Questions regarding liability insurance coverage and claims:

14.	Has your professional liability insurance coverage ever been terminated by action of an insurance company?	Yes* ☐ No ☐
15.	Have you ever been denied professional liability insurance coverage?	Yes* ☐ No ☐
16.	Has your present professional liability insurance carrier excluded any specific procedures from your coverage?	Yes* ☐ No ☐
17.	Have there been any suits or claims against you alleging malpractice, negligence, failure to diagnose, etc. which have been pending, opened, or closed during the past ten (10) years?	Yes* ☐ No ☐

Please Note: Liability claims, suits or settlements should include: names, addresses, ages of claimants or plaintiffs; nature and substance of claim; date and place at which claim arose; amounts paid, if any; date and manner of disposition, judgment, settlement or otherwise; date and reason for final disposition; if no judgment or settlement, patient's condition at point of your involvement; patient's condition at end of treatment; and the nature and extent of your involvement with the patient.

Miscellaneous Questions:

18.	Are you unable to perform the essential functions of the position for which you have applied or of the privileges you have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to patients or staff?	Yes* ☐ No ☐
19.	Are you currently engaged in the illegal use of drugs?	Yes* ☐ No ☐
20.	Have you engaged in the illegal use of drugs within the past ten (10) years?	Yes* ☐ No ☐
21.	Have you ever been convicted in a criminal action? (Do not include a first conviction for simple assault, speeding, minor traffic violations, affray, disturbance of the peace or any conviction of a misdemeanor more than 5 years prior to this application if there has been no criminal conviction of any offense within 5 years of this application.)	Yes* ☐ No ☐
22.	Has your membership in any local, state or national medical society ever been suspended or terminated?	Yes* ☐ No ☐
23.	Have you ever been the subject of an inquiry or disciplinary action** by any governmental or other regulatory agency? Is any such action pending? (Include all documentation relating to all inquiries whether action taken, dismissed or pending. Copy of complaint(s), response(s) to complaint(s) and any/all BORM/APPROPRIATE BOARD letters.)	Yes* ☐ No ☐
24.	Have you failed to complete any CME requirements in the state in which you've been practicing?	Yes* ☐ No ☐

*** Please use Page 11 if you answered "Yes" to any of these questions.** **** Please see Page 12 for definition of "Disciplinary Action"**

Section II – Additional Information

Section III -- Applicant's Authorization and Release

I hereby apply for:

1. Medical/professional staff appointment and clinical privileges as requested herein at each hospital to which I submit this application (Hospital); and
2. Participation as a network or health plan provider with each provider network or health plan to which I submit this application (Health Plan).

I am willing to make myself available for interviews in regard to this application. I also agree to provide each Hospital and Health Plan with updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital(s), Health Plan(s) or their respective authorized representatives. I understand that failure to provide all information requested will prevent evaluation of and/or action on my application.

I hereby attest that the information in or attached to this application is true and complete and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges requested. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, may constitute sufficient cause for rejection of this application resulting in denial of Hospital appointment and clinical privileges or Health Plan network participation. In the event that Hospital appointment or privileges, or Health Plan network participation, has/have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in termination of such appointment or privileges, or network participation.

I understand that with the exception of information determined by the Hospital or Health Plan to be peer review protected, I have the right to request in writing and subsequently review any information obtained by the Hospital or Health Plan to support its evaluation of my application and to correct any erroneous information.

I agree that if I am granted Hospital clinical privileges or Health Plan network participation, I will maintain during the term of my appointment or participation malpractice insurance coverage in an amount equal to or greater than the minimum required by the Hospital or Health Plan respectively and with a carrier acceptable to the Hospital or Health Plan respectively.

I hereby authorize the Hospital and the Health Plan to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records which shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting, as well as to my moral and ethical qualifications.

I hereby authorize any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualification to provide and/or release information (both written and oral) to representatives of the Hospital and its medical/professional staff and to the Health Plan bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications. Such information includes but is not limited to information regarding any and all malpractice actions, pending or final disciplinary actions and alterations in privileges, and any information with respect to whether I am able to perform the essential functions of the position for which I have applied or the privileges I have requested with or without a reasonable accommodation, according to accepted standards of professional practice and without posing a direct threat to patients or staff (including without limitation information regarding any impairment due to the use of drugs or alcohol).

I authorize and request my medical malpractice liability insurance carrier to release information to the Hospital and Health Plan regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition.

If requested, I agree to undergo a mental or physical examination, prior to or during the term of my appointment to determine whether I am able to perform the essential functions of the position for which I have applied or for the privileges which I have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a threat to patients or staff.

I agree to notify the Hospital and Health Plan as soon as I become aware that any health care organization, Hospital or any licensing, certifying or regulatory authority has initiated or taken disciplinary action of any kind against me, or has initiated an investigation as a result of a complaint or allegation against me.

I hereby release from liability any and all individuals and organizations that, in good faith and without malice, provide information to the Hospital and Health Plan or to their respective medical/professional staff for the purpose of evaluating this application. I also hereby release from liability the Hospital and Health Plan, their respective medical/professional staffs and their respective agents and representatives for their

Applicant's Authorization and Release (cont'd)

acts performed in good faith and without malice in connection with the evaluation of my professional skills, competence, character, credentials and qualifications and the exchange of information with respect to my professional skills, competence, character, credentials and qualifications.

I agree that a photocopy of this Authorization and Release will be as valid as the original, and that this Authorization and Release will remain valid as to each Hospital and Health Plan unless revoked by me in writing, or the date on which the Hospital or Health Plan next conducts re-credentialing of my status with the Hospital or Health Plan.

This Section Applies to Applications for Hospital Appointments and Privileges:

I acknowledge that (1) a medical/professional staff appointment and clinical privileges at the Hospital is not a right of every licensed professional who makes application for the same; (2) my request will be evaluated in accordance with prescribed procedures defined in the Hospital(s) and Medical/Professional Staff Bylaws, policies and procedures, and rules and regulations; (3) all recommendations relative to my application are subject to the ultimate action of the Hospital Board, whose decision shall be final; (4) if appointed, my initial appointment and clinical privileges shall be provisional for the time period determined by the Board; (5) I have the responsibility to keep this application current by informing the Hospital of any change in my professional liability insurance coverage, the filing of a lawsuit against me and any change in my medical/professional staff status at any other hospital, or with any other health care organization or professional organization; and (6) reappointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the Hospital, as evidenced by appropriate treatment and continuous care of patients for whom I have responsibility, and acceptable performance of all duties related thereto as well as the other factors deemed relevant by the Hospital. Reappointment and continued clinical privileges shall be granted only on formal application, according to Hospital and Medical/Professional Staff Bylaws, polices and procedures and upon final approval of the Hospital Board.

I have received and had an opportunity to read the Bylaws of the Medical/Professional Staff. I specifically agree to abide by all such bylaws and any policies and procedures that are applicable to appointees to the Medical/Professional Staff.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patients to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised: (3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services; (4) seek consultation whenever necessary or required; (5) abide by generally recognized ethical principles applicable to my profession; (6) abide by standards of clinical practice that may be in effect from time to time; (7) provide continuous care and supervision as needed to all patients in the hospital for whom I have responsibility; and (8) as required by my appointment to the Hospital(s), accept committee assignments and such other duties and responsibilities as shall be assigned to me by the Hospital(s) Board and medical/professional staff.

This Section Applies to Applications for Participation in Provider Networks:

I acknowledge that (1) participation in the provider network or networks operated or contracted by the Health Plan is not a right of every licensed professional who makes application for the same; (2) acceptance of this application does not constitute approval or acceptance of participation until such time as a provider contract is executed by me and the Health Plan to which I have applied; (3) my request will be evaluated in accordance with prescribed procedures defined in the Health Plan's policies and procedures; (4) all recommendations relative to my application are subject to the ultimate action of the Health Plan's credentialing committee, or other governing body designated by the Health Plan, whose decision shall be final; (5) I have the responsibility to keep this application current by informing the Health Plan of any change in my professional liability insurance coverage, the filing of a lawsuit against me, and any change in my medical/professional staff status, including but not limited to a disciplinary action, at any hospital, or with any other health care organization or professional organization; (6) my continued participation in the provider network remains contingent upon my continued demonstration of professional competence, continued compliance with the Health Plan's credentialing criteria, compliance with the Health Plan's policies and procedures for re-credentialing, and compliance with my contract with the Health Plan; and (7) my complete name and title, specialty or specialties, hospital affiliations, practice addresses, telephone number, languages spoken and handicap accessibility at my practice locations may be included in a physician directory prepared for enrollees of each Health Plan with whom I sign contract.

Further, I authorize the Health Plan(s) to provide my credentialing status to my affiliated provider organization's leaders and notwithstanding anything to the contrary contained in any agreement, I authorize the Health Plan(s) to release my name, address, telephone number, tax identification number and other identifying information to individuals and entities for legitimate business purposes related to the administration of Health Plan products and services.

SIGNATURE: _____ DATE SIGNED: _____

PRINT NAME: _____

If you have answered "yes" to any of the questions on the Application, please supply the information requested below. Use a separate copy of this form for **each** question and indicate the number of the question to which you are responding.

Question #_____

PLEASE PRINT OR TYPE RESPONSES

Provider's Name: _____

Medical License Number: _____

Date of Action/Occurrence: _____

Date Claim/Complaint/Criminal Case was filed: _____

Facility Where Incident Occurred: _____

Status of Claim/Complaint/Criminal Care (open, closed including date closed, etc): _____

Duration of Occurrence: _____

Professional Liability Carrier Involved: _____

Amount of Settlement: _____

Method of Resolution:

- ☐ Dismissed
- ☐ Judgment for Plaintiff(s)
- ☐ Settled with Prejudice
- ☐ Settled without Prejudice
- ☐ Judgment for Defendant(s)
- ☐ Mediation or Arbitration
- ☐ Letter of advice, consent agreement, letter of concern, warning letter, PHS agreement, other (please include a copy)

Date of Settlement/Action Taken: _____

Were you the primary defendant or co-defendant? YES ☐ NO ☐

Detailed Description:

MASSACHUSETTS BOARD OF REGISTRATION IN MEDICINE
Definition of "Disciplinary Action" (243 CMR 3.02)

(1) An action of any entity, including, but not limited to, a governmental authority, a health care facility, an employer, or a professional medical association (international, national, state or local).

(2) An action that is:
- (a) formal or informal, or
- (b) oral or written (except an oral reprimand or admonition is not a "disciplinary action.")

(3) Any of the following actions on their substantial equivalents, whether voluntary or involuntary:

- (a) Revocation of a right or privilege
- (b) Suspension of a right or privilege
- (c) Censure
- (d) Written reprimand or admonition
- (e) Restriction of a right or privilege
- (f) Non-renewal of a right or privilege
- (g) Fine
- (h) Required performance of public service
- (i) A course of education, training, counseling, or monitoring, only is such course arose out of the filing of a complaint or the filing of any other formal charges reflecting upon the licensee's competence to practice medicine
- (j) Denial of a right or privilege
- (k) Resignation
- (l) Leave of absence
- (m) Withdrawal of an application
- (n) Termination or non-renewal of a contract with a license

(4) Divisions (e), (f) and (j) through (n) above are "disciplinary actions" only if they relate, directly or indirectly, to:

- (a) the licensee's competence to practice medicine, or
- (b) a complaint or allegation regarding any violation of law or regulation (including, but not limited to, the regulations of the Board) or bylaws of a health care facility, medical staff, group practice, or professional medical association, whether or not the complaint or allegation specifically cites violation of a specific law, regulation or by-law.

(5) If based only upon a failure to complete medical records in a timely fashion and/or failure to perform minor administrative functions, the action adversely affecting the licensee is not a "disciplinary action" for the purposes of mandatory reporting to the Board, provided that the adverse action does not relate directly or indirectly to:

- (a) the licensee's competence to practice medicine, or a complaint or allegation regarding any violation of law or a Board regulation, whether or not the complaint or allegation specifically cites violation of a specific law or regulation.

Section IV – Payor Enrollment Information

Practice Information and Demographics

Do you wish to be listed as ☐ Primary Care Physician ☐ Specialist ☐ Both

If you are in Internal Medicine, Family Practice, or Pediatrics, but do not maintain a panel of patients, indicate the services you are providing:

☐ Hospitalist ☐ Covering ☐ Moonlighting ☐ Urgent Care ☐ Locum Tenens: From: _____

To:_____

Do you practice exclusively within an inpatient setting? Yes ☐ No ☐

Do you practice in a private office and submit claims for those services under a separate TID #? Yes ☐ No ☐

If you are a specialist in emergency medicine, radiology, anesthesiology or pathology, do you: (a) provide services exclusiv hospital setting and only incident to hospital services; and (b) provide services as a result of patients being directed to the h (c) willing to be not separately identified as available to Members in any Health Plan literature, such as Health Plan directo Yes ☐ No ☐

Are you currently accepting new patients into your practice? Yes ☐ No ☐

Please list all Insurers for which you are currently a provider and your Provider #, if any

Insurer:	Provider #, if any
Blue Cross & Blue Shield of Massachusetts (Indemnity)	
Blue Cross & Blue Shield of Massachusetts (HMO)	
Tufts Health Plan	
Harvard Pilgrim Healthcare	
Neighborhood Health Plan	
Fallon Community Health Plan	
Health New England	
Network Health	
Medicare	
Medicaid	
Other: _____	
Other: _____	

Professional Practice

☐ Solo		Facility Name:
☐ Partnership	Name of Partner(s):	Facility Name:
☐ Single Specialty Group	Name of Group/Specialty:	Facility Name:
☐ Multi Specialty Group	Name of Group/Specialty:	Facility Name:
☐ Other	Specify:	Facility Name:

Please list conditions that you treat. Please provide up to five particular clinical interests.

Under what specialty(s) do you want to be listed in the Insurer's Provider Directory(s)? _____

_____

Which age groups do you treat? ☐ All ages ☐ 0-11 yrs ☐ 12-18 yrs ☐ 19-25 ☐ 26-65 yrs ☐ 65+ yrs

List any restrictions on your practice: _____

Length of time it takes for a new patient visit: 1/2 hr. ____ 1 hr. ____ 1 1/2 hrs. ____ 2 hrs. ____ 2 ½+ hrs. ____

What is the average waiting time for a patient to schedule an appointment:

Type of Visit	Waiting Time
Initial visit to establish a relationship with a physician	
Preventative health care visit (routine physical)	
Urgent visit	

What are the average number of visits scheduled per hour? _____

Do you perform laboratory tests in your office? Yes ☐ No ☐

If yes, are you CLIA (Clinical Laboratory Improvement Amendment) certified? Yes ☐ No ☐

Will you be billing for diagnostic interpretations (i.e. interpretation of x-rays)? Yes ☐ No ☐

Please check which of the following diagnostic modalities/facilities are present in your office and list any additional procedures and any special diagnostic testing (e.g., surgical procedures, etc.) you perform in your office, including any special equipment used.

☐ X-ray ☐ Diagnostic Ultrasound ☐ Endoscopy ☐ Routine EKG

☐ Other Cardiac Testing, including _____ ☐ Other _____

Accept Walk-ins? Yes ☐ No ☐

Name of Practice Appointment Secretary: _____

Name of Practice/Office Manager and Email address: _____

_____

Which Credit Cards Do You Accept? Mastercard ☐ Visa ☐ AMEX ☐ Other(s) _____

Do you request payment at the time of Service? Yes ☐ No ☐

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.) _____

_____

_____

What should a patient bring to the appointment? _____

_____

_____

What questions should we ask a patient, to help determine the appropriateness of the referral?_____

_____

_____

Other comments: _____

_____

Billing Information:

Practice Locations (from page 2 of this application)

Name of Primary Practice:	Name of Secondary Practice:
Phone Number: ( )	Phone Number: ( )

Practice Type: ☐ Solo ☐ Group ☐ Clinic ☐ Other Group/Corporate Name as it appears on your W-9: _____ Language fluency in the office: _____ Resources for translation: _____ Does the office have handicapped access? Yes ☐ No ☐	Practice Type: ☐ Solo ☐ Group ☐ Clinic ☐ Other Group/Corporate Name as it appears on your W-9: _____ Language fluency in the office: _____ Resources for translation: _____ Does the office have handicapped access? Yes ☐ No ☐

List Name, Specialty and Phone number of physicians covering your practice in your absence. Your practice must provide 24 hour coverage. (Please attach additional sheet, if necessary)

Name	Specialty	Provider Type	Phone Number

Office/Practice Name:
_____
Street Address:
_____
Street Address:
_____
City: _____ State: _____ Zip:
_____
If not currently at this site, expected start date:_____
OFFICE PHONE #: _____
OFFICE FAX #: _____

Office Type:

Mailing Address

☐ **Primary Address**

☐ **Administrative Address** **YES** ☐
☐ **Clinical Practice Office** **NO** ☐
☐ **Research Office**

Payment information: Make checks payable to: _____
_____
Payment Address (please provide complete mailing address): _____
_____
Billing entity phone #: _____ IRS Tax ID#: _____
Applies to: ☐ Primary Practice ☐ Secondary Practice

Office/Practice Name:
_____
Street Address:
_____
Street Address:
_____
City: _____ State: _____ Zip:
_____
If not currently at this site, expected start date:_____

Office Type:

Mailing Address

☐ **Primary Address**

☐ **Administrative Address** **YES** ☐

OFFICE PHONE #: _____
OFFICE FAX #: _____

☐ **Clinical Practice Office** **NO** ☐
☐ **Research Office**

Payment information: Make checks payable to: _____

Payment Address (please provide complete mailing address): _____

Billing entity phone #: _____ IRS Tax ID#: _____

Applies to: ☐ Primary Practice ☐ Secondary Practice

PLEASE COPY THIS PAGE FOR ADDITIONAL OFFICE LOCATIONS

In the event that the Hospital or Health Plan has any questions about this application, please provide contact information below. **Unanswered or missing information will delay processing of this application and/or may result in the application being returned as incomplete.** It is essential to have appropriate contact information in order to avoid delays.

Is the mailing address on Page 2 the address to which you want your re-credentialing application sent? YES ☐ NO ☐
(If no, please provide address to which you want your re-credentialing application sent at the bottom of this page.)

Practitioner/Practice Name: _____

Credentialing Contact Name: _____

Contact Title: _____

Contact Telephone: _____ Fax: _____

Contact E-Mail: _____

Contact Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact hours of availability: _____

Office Hours for: _____
Practitioner/Practice Name

	Start Time	End Time
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		