Instructions to Complete
Provider Application
APPLICATIONS SUBMITTED INCOMPLETE WILL NOT BE PROCESSED OR REVIEWED; FOR ADDITIONAL INFORMATION, PLEASE REFER TO OUR DSHS WEBSITE.
http://www.dshs.state.tx.us/mhcommunity/LPND/LMHAs/harris-county.shtm

ALL QUESTIONS AND REQUIRED DOCUMENTS MUST BE COMPLETE TO BE CONSIDERED FOR CONTRACTING OPTIONS.

EACH EXHIBIT SHOULD BE CLEARLY LABELED FOR EASY IDENTIFICATION OF MATERIALS. MATERIALS NOT LABELED WITH PROPER EXHIBIT IDENTIFICATION LETTER/NUMBER WILL NOT BE REVIEWED AS PART OF SUBMISSION OF RFA.

Purpose of Application: Mental Health Mental Retardation Authority of Harris County (MHMRA) is required to ensure licensed providers for mental health, mental retardation, developmental delays and substance abuse services participate and maintain credentialing requirements to ensure client protection and compliance with billing procedures for service activities by a licensed provider.

Credentials must be assessed, verified and approved by MHMRA of Harris County's Credentialing Committee prior to delivery of service(s).

Required Items to Initiate Credentialing Process:

There are 3 types of applications that follow. Please choose the application that applies to you and complete it in its entirety. Incomplete applications will not be processed. Copies of all required documents must be received along with a completed application for review and approval by MHMRA of Harris County's Credentialing Committee. All documents are required for credentialing purposes only.

1. Provider Checklist (below) with Texas Standardized Credentialing Application (TSCA) for Licensed staff. (QMHP's sign only the QMHP section below) – Individual providers:
    - This application is for licensed practitioners to complete in full.
    - Refer to the Provider Checklist cover sheet for the documentation requirements that must be attached to be considered a complete application.

2. Facility Application with Facility Checklist– Facilities and/or group practices:
    - This application is to be completed in full by a facility or group practice.
    - Refer to the Facility Application cover sheet for the documentation requirements that must be attached to be considered a complete application.
    - Attach a TSCA for each licensed individual – MDs, Physician Assistants, APNs, LPCs, LMFTs, LCSWs and Psychologists, etc.; however, if you are a QMHP, you will follow the instructions at the bottom of the page on the Provider Checklist.
    - Facility Applications must include a Texas Standardized Application for each licensed individual to be considered complete and a Provider Checklist for each QMHP.

3. Interest Letter—To be used only by applicants who already are under contract with local Authority:
    - A current contractor since FY 10, can potentially increase their service level array if successfully have provided lesser service by audit and on-going follow-up determination. The provider would then only complete the Interest Letter and update any other information on previous applications.

A delay in the credentialing process will occur if the application is not completed and/or supporting documents are not attached.

***NOTE**: If you answered yes to any malpractice questions, please attach a letter from your attorney, a copy of the complaint and the judgment, the name of the malpractice carrier that handled the claim(s) and the firm representing the carrier.*

Please contact us if needed at (713) 970-3400, (option 4)
Via e-mail – mhnetworkdevelopment@mhmraharris.org
Fax - (713) 970-3387

MHMRA of Harris County
MH Authority Support Services
Network Management
Provider Checklist

Required documentation listed below must accompany the application for EACH licensed provider.

☐ Complete, date and sign the enclosed provider application

☐ Attach Texas Standard Application (2007 version) for Licensed individuals – MDs, Physician Assistants, APNs, LPCs, LMFTs, LCSWs and Psychologists etc. If you are a QMHP, follow instructions at the bottom of the page

- *If you had a gap of more than 6 months in employment, please attach a detailed written explanation*
- *If you answered yes to any malpractice questions, please attach a letter from your attorney, a copy of the complaint and the judgment, the name of the malpractice carrier that handled the claims and the firm representing the carrier.*

☐ Attach a copy of Curriculum VITAE

☐ Attach a copy of Current State License and/or License Registration Certificate

☐ Attach a copy of Current State Controlled Dangerous Substance (CDS/DPS) Certificate

☐ Attach a copy of Current Federal Drug Enforcement Agency (DEA) Certificate

☐ Attach a copy of Current Malpractice Insurance Face Sheet with the limits of Liability

☐ Attach a copy of the W-9 form

☐ Attach required Exhibits A-U (Note: Exhibit H and M should be complete)

☐ Attach a copy of your ECFMG certificate, if you are a foreign medical school graduate

Send the application along with the required documents by mail to:
MHMRA of Harris County
Attention: MH Authority Support Services
7011 Southwest Freeway
Houston, TX 77074
Or via e-mail to: mhnetworkdevelopment@mhmraharris.org
Fax to: (713) 970-3387

Provider Rights Notification
The practitioner has the right to appeal any alleged erroneous information by providing additional information.
Practitioners have the right to be informed of their credentialing/re-credentialing status upon request.
Practitioners have the right to review the information submitted in support of their credentialing application with exceptions below.

****For QMHPs only (Bachelor Level staff only)***

Degree: _____
Date of degree: _____

Attach a copy of transcript from an accredited college or university if degree is not in social fields: psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or a Registered Nurse.

MHMRA of Harris County
Network Management
Facility/Group Checklist

☐ Complete, date and sign the Facility Application.

☐ Attach Texas Standard Application (2007 version) for Licensed individuals – MDs, Physician Assistants, APNs, LPCs, LMFTs, LCSWs and Psychologists etc. If you are a QMHP, follow instructions below for bachelor level staff only.

- *If you had a gap of more than 6 months in employment, please attach a detailed written explanation*
- *If you answered yes to any malpractice questions, please attach a letter from your attorney, a copy of the complaint and the judgment, the name of the malpractice carrier that handled the claims and the firm representing the carrier.*

☐ Complete, date and sign the W-9 Form for each Tax Identification Number (TIN)

☐ Attach a copy of your JACHO Certification.

☐ Attach a copy of your CARF Certification.

☐ Attach a current copy of your Facility's Licenses and/or Certifications. Please include any Medicaid/Medicare Licenses and all other applicable licenses held by the facility that relate to the contracted services.

☐ Attach a copy of your Program Schedule or Program Description.

☐ Attach a copy of your Malpractice Insurance Face Sheet with the limits of liability.

☐ Attach a list of all of your facility sites with addresses.

☐ Attach a list of Psychiatrists/others with Professional Credentials with admitting privileges.

☐ Attach a copy of your Utilization Review Program.

☐ Attach a copy of Clinical Descriptions of all program tracks within the facility.

☐ Attach a copy of your Quality Assurance/Improvement Program.

☐ Attach Exhibits A-U (Note: Exhibit H and M should be complete)

☐ Attach Program brochures if available

If you have any questions, please call: 713-970-3400 (option 4)

Send the application along with the required documents by mail to:
MHMRA of Harris County
Attention: MH Authority Support Services
7011 Southwest Freeway
Houston, TX 77074
Or via e-mail to: mhnetworkdevelopment@mhmraharris.org

Fax to: (713) 970-3387

☐ ***For QMHPs only (Bachelor Level staff only)***

Degree: _____
Date of degree: _____
Attach a copy of transcript from an accredited college or university if degree is not in social fields: psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention; or a Registered Nurse.

MHMRA of Harris County
Network Management
Facility/Group Application

A. General Information:

Facility Legal Name			Does the facility have a University Association? If yes, please name	
Preferred Mailing Address Line 1			Preferred Mailing Address Line 2	
Name of Chief Executive Officer:				
City	State	Zip	County	Contact Person
Name of Chief Executive Officer				
Physical Address			Physical City, State & Zip	
Is your service address different from physical address? If yes, list it below: Address _____ City_____ State_____ Zip Code_____			Telephone Fax	
Email Address				
Are you a Medicare Provider? ___Y ___N If yes, please provide your Group or Individual Provider number.			Are you a Medicaid Provider? ___Y ___N If yes, please provide your Group or Individual Provider number.	
Your Medicare/UPIN Number			Your Medicaid Number	
Do you qualify as a Historically Underutilized Business (HUB)? ____Yes ____No If yes, Certification#			Federal Tax ID# _____ Tax Code [Example: 501© (3)] _____	
☐ Psychiatric Hospital ☐ Hospital with Psychiatric Unit ☐ Residential Facility ☐ Other Please check which is the most appropriate description:			Indicate who is your corporate owner (if applicable)	
Is this office handicapped accessible? Yes __ No __			Is this office accessible to public transportation? Yes __ No __	

Please list any certifications or accreditations, if applicable: □ JCAH □ ICF/MR □ CARF □ HCS □ HCSO □ CLASS □ ACDD □ TRC □ ECI □ TEA □ DOL □ other, please specify: _____

B. Demographic Data: The following information is requested for demographic purposes only. This data will not be part of the credentialing process. The information will only be used to supply aggregate data to the state government as part of a government contract. This information will not be used for any other purposes.

1. Could you or your business be defined as a Significant Traditional Provider as defined by the Texas Department of Health and Human Services? ☐ Yes ☐ No
   Significant Traditional Providers are defined as providers in a county that, when listed by provider type in descending order by the amount of recipient or enrollee billings provided the top 80 percent of recipient or enrollee billings for the Texas Medicaid Program.

2. Could your business be classified as a business owned by women, as defined by the Department of Minority Enterprises? ☐ Yes ☐ No
   Women Owned Business is defined as a business enterprise of which women own at least 50%or, in the case of a publicly owned business, where women own at least 51% of stock.

3. Could your business be classified as a minority owned business, as defined by the Department of Minority Enterprises? ☐ Yes ☐ No

   Minority Owned Business is defined as a business enterprise that is owned and controlled by one or more socially and/or economically disadvantaged persons. Such disadvantages may arise from cultural, racial, chronic economic circumstances or background or other similar cause.

4. If you answered yes to question 3 about minority owned businesses, which of the following categories would it fall under?

☐ Caucasian	☐ Native American or Alaskan Native	☐ Asian or Pacific Islander
☐ Black (African, Jamaican, West Indian descent)	☐ Hispanic (Mexican, Puerto Rican, South American)	☐ Other (specify)

C. Payee Information

Make checks payable to (must match tax ID owner name on file with IRS)		Type of Corporation
Billing Address Line 1	Billing Address Line 2	
City	State	Zip

D. Referral Information

Identify the percentage of your practice time dedicated to the following patient population and modality categories (must total 100%):

Population	% of Practice
Young Child (0-5)	
Child (6-12)	
Adolescent (13 – 17)	
Adult (18 – 64)	
Geriatric (65+)	

Business Lines	% of Practice
Group Health (PPO)	
Capitation (HMO)	
Medicaid	
Medicare	
Other	

E. Services

1. List Insurance: HMO's, PPO's, EAP's and employer groups for which you currently provide services.

Insurance: HMO, PPO, EAP or Employer Group

Types of Services: ___Adult ___Children ___Adult & Child ____Pharmacological ___Rehab Services ___Psychotherapy ___Day Program for Skills Training ___Site Based Habilitation ___Early Child Intervention ___In-Home & Family Support ___Telemedicine ___Residential Services ___Supported Housing ___Respite Services ___ACT Team Services ___Counseling ___Consumer Peer Support ___Supported Employment ___Other

_____

Specialty Areas:

Please check each area in which your program is qualified.

___Autism	___Elderly Services	___Mobility Impairment
___Criminal Justice	___Family Support	___Substance Abuse
___Developmental Disabilities	___Sign Language/Deaf Culture Proficiency	___HIV/AIDS Issues
___Dual Diagnosis (MR/MI)	___Homeless Services	___Other_____

2. Check all that apply and indicate # of beds and average length of stay (LOS).

ER Evaluations			Psych Services **Acute** / **Sub-Acute**						Chemical Dependency			
Psych	CD	Both	Adult	Adol	Child	Adult	Adol	Child	Detox	Rehab	Adult	Adol

3. Types of Programs (indicate average length of treatment)

Programs	Adult			Adolescent			Child		
Partial Hospital (with medical monitoring)	M/H	C/D	Both	M/H	C/D	Both	M/H	C/D	Both
Average length of Treatment									

	Day	Evening	Please indicate hours:
Intensive Outpatient			
	Day	Evening	Please indicate hours:
Outpatient			

4. Special Services (check all that apply):

Service	Notes
Involuntary Admission ☐ yes ☐ no	
Locked Units ☐ yes ☐ no	
Detox for Alcohol ☐ yes ☐ no	
Detox for Drugs ☐ yes ☐ no	

5. Other:

What ancillary services are available at your facility? _____
Do you have a rotating physician on-call operation? ☐ yes ☐ no
How often are attending physicians required to see patients? _____ visits per 7 – day week.
How often are family therapy sessions held?

6. Operations Information

Do you have a client appeals process? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Do you have an incident report process? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Do you have a confidentiality/client rights process? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Do you have an internal quality improvement process? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Do you have an internal utilization management process? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Do you have a customer/satisfaction measure? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Do you have a service outcome measure? ___Yes ___No If yes, Staff/Contact_____
Phone#_____Fax_____

Does your program have a current operating plan and budget? ___Yes ___No

Do you maintain a file on each client? ___Yes ___No

Is your program in compliance with all local city, state and federal codes and local statues as applicable to your program? Including health codes, fire/safety codes, etc? If no, please submit reasons and plan of correction on a separate sheet of paper. ____Yes ___No

If you answer yes to the following questions, please explain on a separate sheet of paper.
Have you or any of your direct care staff ever had a confirmed allegation that you/they engaged in any class of client abuse/client neglect by the Department of Family and Protective Service or any equivalent state Agency?
___Yes / ___No

F. Staffing Information

1. Check medical staffing model:

☐ Staff (Hospital Employees) ☐ Contractual ☐ Mixed Model

2. Staff Includes:

☐ Psychiatrists ☐ Psychologists ☐ Licensed Mental Health Counselors
☐ Licensed Marriage & Family Therapists ☐ Addictionologists ☐ Advanced Nurse Practitioners
☐ Licensed Social Workers ☐ Other (List)

3. Intake Process:

Do you have a 24 hour intake process? ☐ yes ☐ no	
If yes, what is the educational background of the personnel managing this operation (check all that applies)?	☐ No formal training and/or license ☐ Bachelors level ☐ Masters level (not licensed) ☐ Masters level (licensed) ☐ LPN ☐ RN ☐ Mental Health Tech. ☐ Doctorate level

4. Emergency Room Services:

Do you have emergency room services or after hours services? ☐ yes ☐ no
If yes, please explain including telephone# _____ _____ If no, which acute care hospital(s) provide emergency services for your facility? _____
Is your relationship contractual? ☐ yes ☐ no

If yes, what is the medical staffing model (check all that applies)?	☐ Staff (Hospital Employees) ☐ Contractual ☐ Mixed Model
Do you provide emergency or after hours services? ☐ yes ☐ no If yes, please explain including telephone#	

G. Treatment Teams:

Please indicate the composition of your treatment teams:

☐ Psychiatrists – Number _____	☐ Psychologists – Number _____
☐ Licensed Marriage & Family Therapists – Number _____	☐ Addictionologists – Number _____
☐ Licensed Social Workers – Number _____	☐ Advanced Nurse Practitioners – Number _____
☐ Licensed Mental Health Counselors - Number _____	☐ Other – specify

How often are treatment teams required to meet? _____ times per week.
At what point during hospitalization does discharge planning begin?
Who is involved in coordinating discharge planning?

H. Contacts - Please note who the appropriate contact person is:

Admissions Contact Name	Phone
Medical Director for Psychiatric Services	**Phone**
Medical Director for Substance Abuse Services	**Phone**
Utilization Review Director	**Phone**
Case Manager	**Phone**

I. Malpractice Insurance – Type of Liability Coverage: ☐Professional ☐ General ☐ Auto ☐ Other

List below your current malpractice insurance carrier. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage. Please note that MHMRA requires a minimum 1,000,000/3,000,000 malpractice insurance.

Current Carrier (Name and Address)	Policy Number	Dates of Coverage	Coverage Limits Per Occurrence	Coverage Limits Aggregate

If more than one type of insurance, please indicate the type of insurance and above information on a separate sheet of paper.

- Has your facility/group filed a claim under your general, professional auto or other liability insurance in the last three years? ___Yes ___No
- Are there any claims pending against your facility/organization? ___Yes ___No
- Has your program/organization's liability/malpractice coverage ever been denied, cancelled or non-renewed? ___Yes ___No
- Has your facility/organization ever had their license(s), applicable certifications of accreditations, terminated, restricted, or voluntarily relinquished? ___Yes ___No
- Has the facility/organization been sanctioned, placed on probation, placed on vender hold or lost accreditation, licensure or certification status during the last three years? ___Yes ___No

*If you answered **yes** to any of the above questions, please explain on a separate sheet of paper.*

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Carrier (Name and Address)	Policy Number	Dates of Coverage	Reason for Changing Carriers

J. Malpractice Claims History

Has your facility had any Malpractice Claims that are pending or closed during the past five (5) years? Yes ☐ No ☐

If yes, please attach the following information:

A. A letter from your attorney explaining the facts of the case.
B. A copy of the complaint and a copy of the judgment.
C. The name of the malpractice carrier that handled the claims and the firm representing the carrier.

K. Hospital Privileges

List below current hospital privileges. If privileges are restricted, please explain on an attached page. If you are not on staff at a hospital, please indicate the name of the physician who admits your patients in the space below.

Primary Admitting Facility	Address	Type of Privilege
		☐Full admitting ☐Other

Other Hospital Privileges	Address	Type of Privilege

		☐Full admitting ☐Other
		☐Full admitting ☐Other

Physician Who Admits Your Patients	Physician Phone Number	Facility Name

L. Treatment Specialties

Age Range Treated:

☐ 0-3 years old ☐ 3-5 years old ☐ 6-9 years old ☐ 10-12 years old
☐ 13-20 years old ☐ 21-64 years old ☐ 65-80 years old ☐ 80 + years old

Areas of Expertise: (Please check areas in which you have particular expertise.)

☐ ADHD	☐ Adolescent Behavior Problems	☐ Adjustment Disorder	☐ Affective Disorder
☐ Antisocial Behavior	☐ Alzheimer's	☐ Anxiety/ Panic/ Phobia	☐ Eating Disorders
☐ Behavior Disorders	☐ Behavior Therapy	☐ Bipolar Disorder	☐ Borderline Personality
☐ Child Abuse	☐ Chronic Pain Disorder	☐ Cognitive Behavioral	☐ Conduct Disorder
☐ Crisis/ Trauma Victims	☐ Dementia	☐ Depressive Disorders	☐ Developmental Disorders
☐ Dissociative Disorders	☐ EAP	☐ Eating Disorders	☐ Employee Meditation
☐ Forensics	☐ Gambling Addictions	☐ Gay/Lesbian Issues	☐ Grief Reaction
☐ Handicapped	☐ Head Trauma	☐ HIV/AIDS	☐ Impulse Control Disorders
☐ Learning Disorders	☐ Marital/ Divorce Issues	☐ Men's Issues	☐ Mood Disorders
☐ Personality Disorders	☐ Post Traumatic Stress DO	☐ Psychopharmacology	☐ Psychotic Disorders
☐ Rape Intervention/Crisis	☐ Relational Problems	☐ Religious Therapy	☐ Sexual Abuse
☐ Sexual Disorders	☐ Sleep Disorders	☐ Substance Abuse	☐ Women's Issues
☐ Workers Comp	☐ Other (specify):		

In what languages, including American Sign Language or Signed English, are staff able to provide services?_____
_____

Are you able to provide any of the following services?

☐ Services for hearing impaired
☐ Services for adults with Serious Mental Illness (SMI)
☐ Services for children who are Seriously Emotionally Disturbed (SED)
☐ Services for patients with multi-cultural issues
☐ Services for Non-English speaking patients

Please indicate any disorders or types of patients that you will not accept for treatment:

M. Program Application Required Certification Statement

I certify that the information provided in this application is correct to the best of my knowledge. I understand that any information contained in this application which subsequently is found to be false could result in denial of the application or termination from network participation.

On behalf of this facility, I consent to all MHMRA of Harris County to inspect records and documents pertinent to this application.

_____ _____

Signature of Person or Facility/Group Representative Date

_____ _____
Printed name of Person or Facility/Group Representative Title of Representative

_____
Facility or Group Name

N. General Authorization for Release of Information

General Authorization for Release of Information

I, _____(print name) hereby authorize MHMRA of Harris County to obtain any and all information required to complete a review and primary source verification of my/our credentials. Information and documents to be reviewed include, but are not limited to, licensure/certification, accreditations and claims made against licensure/certification, malpractice insurance and claims.

I hereby release from liability any and all individuals and organizations reviewing this application for their acts performed in good faith and without malice in connection with evaluating this application and the credentials and qualifications. I also release from any liability any and all individuals and organizations that provide information in good faith and without malice concerning the above release items.

A Photostat, electronic or facsimile copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to MHMRA of Harris County credentialing and /or network approval process. Such Photostat, electronic or facsimile copy shall have the same force and effect as the signed original.

Signature of Person or Facility Representative: _____Date: _____

Printed Name: _____

O. **Attestation**

Facility/Group Name_____

Are there any reasons you would be unable to perform the essential functions required with or without accommodations?

I hereby attest to the following:

☐ The information submitted in and with this application is complete and correct to the best of my knowledge. I understand that any information contained in this application which subsequently is found to be false could result in a denial of this application or termination from network participation.

NOTE: If "**YES**" is checked to any of the questions listed below, **please explain fully** on a separate sheet. Documentation is required if you have malpractice claims pending or settled in the past five (5) years (include any settlements/adjudication's, original complaint and final disposition). Your signed statement regarding the alleged incident will suffice for pending cases.

1. **Insurance Coverage:** Have you ever been denied coverage (either initial or renewal) by any professional liability insurance carrier or had an individual policy cancelled or individual surcharge placed on you based on your individual practice and or application? ☐ Yes ☐ No

2. **License:** Has any of your licensed staff's medical or professional license in any state or any applicable certifications or accreditations ever been revoked, suspended, placed on probation, conditional status, or limited? ☐ Yes ☐ No

   a. Has any of your licensed or medical staff ever voluntarily surrendered their license? ☐ Yes ☐ No

3. **Hospital Sanctions:** Has any of your licensed or medical staff surrendered their clinical privileges upon threat of censure, restriction, suspension or revocation of such privileges? ☐ Yes ☐ No

4. **Medicare/Medicaid**: Has any of your licensed or medical staff ever been fined, penalized, had an arrangement suspended, been expelled from participation or had criminal charges brought against your organization/facility by Medicare or Medicaid, CHAMPUS, or other government programs restricted, sanctioned or limited. ☐ Yes ☐ No

5. **Malpractice Action:** Has any malpractice action against any of licensed or medical staff been brought or settled in the last 5 years or has there been any unfavorable judgment(s) against them in a malpractice action ☐ Yes ☐ No

   a. To your knowledge, is any malpractice action against any of your licensed or medical staff currently pending. ☐ Yes ☐ No

6. Has any of your licensed or medical staff relinquished, withdrawn, or failed to proceed with an application for one of the following reasons described to avoid an adverse action, to preclude an investigation, or while under investigation relating to professional conduct or job performance. ☐ Yes ☐ No

7. Has any of your licensed or medical staff had any of the following ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, censure, place on probation or not renewed. ☐ Yes ☐ No

I hereby attest that the information above is true and correct.

_____ _____
Signature Date (mm/dd/yy)

Printed Name: _____

_____
Facility or Group Name

P. PARTICIPATION STATEMENT

I fully understand that if any matter stated in this application is or becomes false, MHMRA of Harris County will be entitled to terminate my provider agreement for breach. All information submitted by me in this application is warranted to be true, correct and complete.
I authorize MHMRA of Harris County to consult with the National Practitioners Data Bank, state licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Council for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character and moral and ethical qualifications, and I also authorize all of them to release such information to the client. I release MHMRA of Harris County and its employees and all those whom MHMRA of Harris County contacts from any and all liability

for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to MHMRA of Harris County of all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualification, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

_____ Date (mm/dd/yy):___/___/_____

Signature of Applicant

_____

Name (Please Print)

_____

Facility or Group Name

Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev. 01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed.

Texas Standardized Credentialing Application

(Please type or print

Section I-Individual Information

TYPE OF PROFESSIONAL

LAST NAME	FIRST	MIDDLE	(JR., SR., ETC.)

MAIDEN NAME	YEARS ASSOCIATED (YYYY-YYYY)	OTHER NAME	YEARS ASSOCIATED (YYYY-YYYY)

HOME MAILING ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

HOME PHONE NUMBER	SOCIAL SECURITY NUMBER	☐ Female ☐ Male

CORRESPONDENCE ADDRESS
7011 Southwest Freeway

CITY	STATE/COUNTRY	POSTAL CODE
Houston	TX	77074

PHONE NUMBER	FAX NUMBER	E-MAIL
713-970-3382	713-970-3386	litza.alvarenga@mhmraharris.org

DATE OF BIRTH (MM/DD/YYYY)	PLACE OF BIRTH	CITIZENSHIP

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS	ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? ☐ Yes ☐ No

U.S.MILITARY SERVICE/PUBLIC HEALTH ☐Yes ☐ No	DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY)	LAST LOCATION

BRANCH OF SERVICE	ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ☐ Yes ☐ No

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)
Issuing Institution:

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)

☐ *Please check this box and complete and submit Attachment A if you received other professional degrees.*

POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION SPECIALTY
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment

INSTITUTION

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

Education - *continued*

POST-GRADUATE EDUCATION ☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

☐ Please *check this box and complete and submit Attachment B if you received additional postgraduate training.*

OTHER GRADUATE-LEVEL EDUCATION Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	

Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.

LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
☐ DEA Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
☐ DPS Number:	ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
OTHER CDS (PLEASE SPECIFY)	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No

UPIN	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE)
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☐ Yes ☐ No Medicare Provider Number:	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☐ Yes ☐ No Medicaid Provider Number:

EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☐ N/A ☐ Yes ☐ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

PRIMARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

SECONDARY SPECIALTY	BOARD CERTIFIED? ☐ Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Professional/Specialty Information *-continued*

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

ADDITIONAL SPECIALTY	BOARD CERTIFIED? ☐Yes ☐ No Name of Certifying Board:	
INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

☐ I have taken exam, results pending for Board.

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards.

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?

HMO: ☐ Yes ☐ No PPO: ☐ Yes ☐ No POS: ☐ Yes ☐ No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History - ***Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.***

CURRENT PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
MHMRA OF HARRIS COUNTY		
ADDRESS 7011 SOUTHWEST FREEWAY		
CITY HOUSTON	STATE/COUNTRY TX	POSTAL CODE 77074
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.

Gap Dates: Explanation:

Gap Dates: Explanation:

Work History – ***continued***

Gap Dates: Explanation:

Gap Dates: Explanation:

☐ ***Please check this box and complete and submit Attachment C if you have additional work history***

Hospital Affiliations-*Please include all hospitals where you currently have or have previously had privileges.*

DO YOU HAVE HOSPITAL PRIVILEGES? ☐ Yes ☒ No	IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE? Admission to Neuropsychiatric Center or Harris County Psychiatric Center - Houston, TX	
PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?		
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

☐ ***Please check this box and complete and submit Attachment D if you have additional <u>current</u> hospital affiliations.***

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		

☐ ***Please check this box and complete and submit Attachment E if you have additional <u>previous</u> hospital affiliations.***

References-***Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities.***

1 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY	STATE/COUNTRY POSTAL CODE

References- *continued*

2 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY / STATE/COUNTRY / POSTAL CODE	
3 NAME/TITLE	PHONE NUMBER
ADDRESS	
CITY / STATE/COUNTRY / POSTAL CODE	

Professional Liability Insurance Coverage

SELF-INSURED? ☐ Yes ☐ No	NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY
ADDRESS	
CITY / STATE/COUNTRY / POSTAL CODE	

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE $0.00	AMOUNT OF COVERAGE AGGREGATE $0.00	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER

NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS

ADDRESS

CITY / STATE/COUNTRY / POSTAL CODE

PHONE NUMBER	POLICY NUMBER	EFFECTIVE DATE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)
AMOUNT OF COVERAGE PER OCCURRENCE	AMOUNT OF COVERAGE AGGREGATE $0.00	TYPE OF COVERAGE ☐ Individual ☐ Shared	LENGTH OF TIME WITH CARRIER

Call Coverage

☐ **See attached list of hospital staff within my department I utilize for call coverage**.

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES.

Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:
Name:	Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE. ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP.

Name:	Name:
Name:	Name:
Name:	Name:
Name:	Name:

Practice Location Information – ***Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.***

PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☒ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9
MHMRA OF HARRIS COUNTY	MENTAL HEALTH & MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

PRACTICE LOCATION ADDRESS
☒ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL
713-970-7000	713-970-3386	

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER
	113180703	74-1603950

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER
	MENTAL HEALTH MENTAL RETARDATION AUTHORITY OF HARRIS COUNTY

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION?	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY?
☐ Yes ☐ No		☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT
Litza Alvarenga

ADDRESS
7011 Southwest Freeway

CITY	STATE/COUNTRY	POSTAL CODE
Houston	TX	77074

PHONE NUMBER	FAX NUMBER	E-MAIL
713-970-3382	713-970-3386	litza.alvarenga@mhmraharris.org

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE
N/A	

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY?
	MHMRA OF HARRIS COUNTY	☒ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Tuesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Saturday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☐ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☒ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☒ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other: NONE

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☒ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS
SPANISH

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
SPANISH

ARE INTERPRETERS AVAILABLE?
☒ Yes ☐ No If yes, please specify languages: Available upon request through contract agency

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☒ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☒ Building ☒ Parking ☒ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☒ Text Telephony-TTY ☒ American Sign Language-ASL ☒ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☒ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☒ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☒ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☒ No

☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☒ No

☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies

☐ Other:

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☒ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ **Please *check this box and complete and submit Attachment F if you have other practice locations.***

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?

☐ Yes ☐ No

2 Have you ever received a reprimand or been fined by any state licensing board?

☐ Yes ☐ No

Hospital Privileges and Other Affiliations

3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☐ No

4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☐ No

5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☐ No

Education, Training and Board Certification

6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☐ No

7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☐ No

8 Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☐ No

9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

☐ Yes ☐ No

DEA or DPS

10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes ☐ No

Medicare, Medicaid or other Governmental Program Participation

11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

☐ Yes ☐ No

Other Sanctions or Investigations

12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes ☐ No

Section II - Disclosure Questions - ***continued***

Other Sanctions or Investigations

13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes ☐ No

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes ☐ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☐ No

Malpractice Claims History

16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?

☐ Yes ☐ No

☐ *If yes, please check this box and complete and submit Attachment G.*

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional

☐ Yes ☐ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes ☐ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☐ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☐ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☐ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes ☐ No

23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?

☐ Yes ☐ No

Please use the space on page 10 to explain yes answers to any question except #16.

Section II - Disclosure Questions-*continued*

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

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

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

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

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

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

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

APPLICANT'S INITIALS AND DATE (MM/DD/YYYY)

Section III – Standard Authorization, Attestation and Release – continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

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

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information – Please attach hard copy or scanned documents of the following:

- ☐ Copy of DEA or state DPS Controlled Substances Registration Certificate
- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
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ADDRESS		
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DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
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OTHER PROFESSIONAL DEGREE Issuing Institution:		
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OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	

OTHER POST-GRADUATE EDUCATION ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	SPECIALTY
INSTITUTION	
ADDRESS	
CITY STATE/COUNTRY POSTAL CODE	
☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)
OTHER POST-GRADUATE EDUCATION ☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment	SPECIALTY
INSTITUTION	
ADDRESS	
CITY STATE/COUNTRY POSTAL CODE	
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INSTITUTION	
ADDRESS	
CITY STATE/COUNTRY POSTAL CODE	
☐ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
PREVIOUS PRACTICE/EMPLOYER NAME		START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		
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ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
REASON FOR DISCONTINUANCE		

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	ARE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		
OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES		START DATE (MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	FAX	E-MAIL
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OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?		

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES		AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No	TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)	WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE		
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REASON FOR DISCONTINUANCE		

Practice Location Information - ***Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.***

PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY	GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS
☐ **Primary**

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BACK OFFICE PHONE NUMBER	SITE-SPECIFIC MEDICAID NUMBER	TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER	GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No	IF NO, EXPECTED START DATE? (MM/DD/YYYY)	DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT	PHONE NUMBER	FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE)	BILLING REPRESENTATIVE

ADDRESS

CITY	STATE/COUNTRY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED	CHECK PAYABLE TO	CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Tuesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Saturday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☐ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages:

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other:

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp:	Advanced Life Support in OB	☐ Staff	☐ Provider Exp:
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp:	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp:
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp:	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp:
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp:	Other (please specify)	☐ Staff	☐ Provider Exp:

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ X-ray; please list all certifications:

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories:

WHO ADMINISTERS IT?

☐ **Please *check this box and complete and submit Attachment F if you have other practice locations.***

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID **$** **$**
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
PROFESSIONAL LIABILITY CARRIER INVOLVED		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID **$** **$**
METHOD OF RESOLUTION ☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration
DESCRIPTION OF ALLEGATIONS		
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
DESCRIPTION OF ALLEGED INJURY TO THE PATIENT		
TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)? ☐ Yes ☐ No		