MID-LEVEL CREDENTIALING CHECKLIST - INITIAL

To help streamline the Credentialing process, Inland Empire Health Plan (IEHP) has developed a checklist that will identify which documents are **not applicable** to each provider type.

Should you have any questions or concerns regarding the application or checklist, please contact Credentialing at credentialing@iehp.org.

If any required information is NOT received the entire application will be RETURNED, which will delay processing.

	II. Identifying Information	III. Practice Information	IV. Medical Licensure/Registration/Certification	VI. Professional Liability	VII. Hospital & Other Institutional Affiliations	XVI. Attestation Questions	Information Release/Acknowledgments	ATTACHMENT I: STATEMENT OF AGREEMENT BY SUPERVISING PROVIDER	NOTICE TO PRACTIONERS OF CREDENTIALING RIGHTS/RESPONSIBILITIES	**ADDENDUM B** (Professional Liability Action Explanation)	**HIV/AIDS PHYSICIAN SPECIALIST FORM**	**W-9**	**MALPRACTICE INSURANCE FACE**	**DELEGATION OF SERVICES AGREEMENT BETWEEN SUPERVISING AND PHYSICIAN ASSISTANT**	**SUPERVISING PHYSICIANS' RESPONSIBILITY FOR SUPERVISION OF PHYSICIAN ASSISTANT**	**STANDARDIZED PROCEDURES**
P.A., P.A.C																
N.P.																
C.N.M.																

MID-LEVEL PRACTITIONER CREDENTIALING TIPS

To help streamline the credentialing process, we developed a tip sheet to help our providers complete the application and help identify common issues that cause delays in your application processing.

All areas of the application should be completed. For all areas that do not pertain to you, please indicate N/A under the respective area.

APPLICATION	NOTES/COMMENTS
II. Identifying information • Last Name, First Name M.I. • Other Names used • Birth Date • SSN# • Gender • Specialty • Subspecialties	Please make sure these data elements are completed to the best of your ability. These elements are used as identifying information to conduct primary source verifications on your application. If any information is missing, it will delay your application until it has been completed.
III. Practice Information • Supervising Physician Name(s) • Office Manager/Administrator (we will list this person as your main contact for obtaining Credentialing documents) • Name affiliated with TIN & TIN	This applies to all locations where IEHP patients will be treated. *If you have multiple offices with different Tax ID#'s, we will require a copy of each W-9 for your credentialing file
IV. Medical/Professional Education • School Name • Degree • Graduation Date	Please complete the following fields
V. Medical licensure/ Registration/ Certification • Licensure • DEA License • Certification Number • NPI • Medi-Cal Number If not certified, describe your intent for certification, if any, and date of eligibility for certification on a separate sheet	State Licensures, DEA Certificates, and NPI registry information must reflect California addresses. DEA's with an exempt fee is only valid at the exempting institution. If the provider is not treating IEHP patients at that facility, the provider needs to obtain a paid status DEA. The NPI registry should list the provider's practice information Any discrepancies will delay the credentialing process until the issues are addressed The acceptable board certifications are recognized by the following organizations: • National Commission of Certification of P.A. • American Association of Nurse Practitioners (AANP) • American Nurses Credentialing Center (ANCC) • National Certification Corporation for the Obstetrics Gynecology and Neonatal Nursing Specialties (NCC) • Pediatric Nursing Certification Board (PNCB) • American Association of Critical Care Nurses (AANC)
VII. Professional Liability	Professional Liability information on the application must be supported with a copy of the insurance certificate (Binders and Declarations are not acceptable) Malpractice Insurance Face sheet should indicate the covered practice location, specialty coverage, policy coverage amounts, effective and termination date and should cover all locations the provider will be treating IEHP patients. If any information is missing from the certificate, the credentialing coordinator will attempt to verify this information with your insurance carrier directly

MID-LEVEL PRACTITIONER CREDENTIALING TIPS

APPLICATION	NOTES/COMMENTS
VIII. Current Hospital and Other Institutional Affiliations	Please include all hospitals and other institutional institutions the provider has current affiliations during the past 10 years (i.e. hospitals, surgery centers)
X. Work History	Please provide your work history activities for the past five (5) years. Any gaps of six (6) months or more must be explained on a separate page. Your work history activities must also include the start date you began at your current practice
XVI. Attestation Questions If your answer is Yes to questions A through L, please provide full details on a separate sheet.	Please be sure that all questions are answered. All responses will be compared to our findings through primary source verifications. If there is a discrepancy, it will delay your application until the issue(s) are addressed
Provider Signatures and dates	Stamped and typed signatures are not accepted and applications must have a current date. Any discrepancies, you will be contacted by a coordinator regarding the non-compliant pages for your review, to re-sign and re-date

ATTACHMENT I	NOTES/COMMENTS
Statement of Agreement by Supervising Physician	Please complete this form with your Supervising Physician

PRACTITIONER RIGHTS	NOTES/COMMENTS
Notice to Practitioners of Credentialing Rights/Responsibilities	Please complete, sign and date

ADDENDUM B	NOTES/COMMENTS
Professional Liability Action Explanation	Please complete the Addendum B for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you in which you were named in the past seven (7) years.

HIV/AIDS SPECIALIST FORM	NOTES/COMMENTS
Verification of Qualifications for HIV/AIDS Specialist	If you wish to be designated as a HIV/AIDS Specialist, please check all criterion that apply to you and provide the supporting documents

W-9	NOTES/COMMENTS
Tax Identification Number and Certification	Please provide a complete, signed and dated W-9 for each TIN you will be billing with for each IEHP member

PHYSICIAN ASSISTANTS only	NOTES/COMMENTS
Delegation of Services Agreement	Please complete to its entirety
Supervising Physician Responsibility for Supervision of Physician Assistant	Please complete to its entirety

NURSE PRACTIONERS and CERTIFIED MIDWIVES only	NOTES/COMMENTS
Standardized Procedures	Please complete to its entirety

AREAS OF EXPERTISE FORM	NOTES/COMMENTS

MID-LEVEL PRACTITIONER
CREDENTIALING TIPS

AREAS OF EXPERTISE FORM	NOTES/COMMENTS
Behavioral Health Area(s) of Expertise Form	Applicable to Behavioral Health Provider's only (i.e. Practitioners who specialize in Psychiatry, Psychology, Licensed Clinical Social Workers, Marriage Family Therapists)

CREDENTIALING CONTACT INFORMATION:

To help streamline your credentialing process and avoid delays, please let us know where you would like us to send your credentialing application and correspondence to:

Contact Name: _____

Contact Title: _____

Mailing Address: _____

_____

Office Phone: _____

Cell Phone: _____

Fax _____

Email address: _____

Email cc: (optional) **Additional email(s) to include on your email communications.**

1. _____

2. _____

3. _____

P.O. Box 1800, Rancho Cucamonga, CA 91729-1800
Tel (800) 440-IEHP (4347) • TTY (800) 718-4347 • Fax (909) 890-5756 email: credentialing@iehp.org
Visit our website at: www.iehp.org

CONFIDENTIAL

Mid-Level Provider Application

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on this application, attached additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with the application:**

- State Medical License(s)
- Face Sheet of Professional Liability Policy
- Curriculum Vitae
- Job Description for Nurse Practitioner
- Supervising Guidelines for Physician Assistant

II. IDENTIFYING INFORMATION

Last Name:	First Name:	Middle:
Is there any other name under which you have been known? Name(s):		
Home Mailing Street Address:	City: State: Zip:	
Home Telephone Number: ( ) Home Fax Number: ( )	E-Mail Address: Pager Number: ( )	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card):	
Social Security #:	Gender: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity (Voluntary):	

III. PRACTICE INFORMATION

Supervising Physician Name(s):	
Practice Name (if applicable):	
Primary Office Street Address:	City: State: Zip:
Telephone Number: ( )	Fax Number: ( )
Secondary Office Street Address:	City: State: Zip
Telephone Number: ( )	Fax Number: ( )

IV. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary)

Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy):
Mailing Street Address:	City: State: Zip:	
Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy):
Mailing Street Address:	City: State: Zip:	

V. MEDICAL LICENSURE/REGISTRATION/CERTIFICATION (Remember to attach copies)

California State License/Registration/Certification #:	Issue Date:	Expiration Date:
DEA License/Registration/Certification Number:	Type:	Expiration Date:
License/Registration/Certification Number:	Type:	Expiration Date:
National Physician Identifier (**NPI):**	Medi-Cal Number:	Medicare UPIN:

VI. ALL OTHER STATE MEDICAL LICENSURE/REGISTRATION/CERTIFICATION
(List all licenses/registrations/certifications held now or previously. Remember to attach copies)

State/Number:	Type:	Expiration Date:
State/Number:	Type:	Expiration Date:
State/Number:	Type:	Expiration Date:

VII. PROFESSIONAL LIABILITY (Remember to attach copies)

Current Insurance Carrier:	Policy #:	Original effective date:
Mailing Street Address:	City: State: Zip:	
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:
Please explain any surcharges/restrictions to your professional liability coverage: (attach additional pages if needed)		

VII. PROFESSIONAL LIABILITY (continued)

Please list all of your professional liability carriers, other than the one listed above, within the past seven years.

Name of Carrier:	Policy #:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City: State: Zip:		
Telephone Number: ( )	Fax Number: ( )		
Name of Carrier:	Policy #:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City: State: Zip:		
Telephone Number: ( )	Fax Number: ( )		

VIII. HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary)

Name:	Appointment Date:
Mailing Street Address:	City: State: Zip:
Name:	Appointment Date:
Mailing Street/Address:	City: State: Zip:

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary)

Name:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City: State: Zip:	
Reason for leaving:		
Name:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City: State: Zip:	
Reason for leaving:		

IX. PEER REFERENCES

List two professional references, preferably from your specialty area, not including current relatives, current partners or associates in practice. If possible, include at least one Mid-Level Provider from the hospital/institution where you have privileges.

NOTE: References must be from individuals who are directly familiar with your clinical abilities, either through direct observation or through a close working relationship.

Name:	Specialty:	Telephone Number: ( )
Mailing Street Address:	City: State: Zip:	
Name:	Specialty:	Telephone Number: ( )
Mailing Street Address:	City: State: Zip:	

X. WORK HISTORY (Attach additional sheets if necessary)

Chronologically list all work activities for the past five years. This information must be complete. Please explain on a separate page any gaps in professional work history.

Current Practice/Employer:	Contact Name:	Telephone Number: ( ) Fax Number: ( )
Mailing Street Address	City: State: Zip:	
From (mm/yy):	To (mm/yy):	
Previous Practice/Employer	Contract Name:	Telephone Number: ( ) Fax Number: ( )
Mailing Street Address:	City: State: Zip:	
From (mm/yy):	To (mm/yy):	
Previous Practice/Employer:	Contact Name:	Telephone Number: ( ) Fax Number: ( )
Mailing Street Address:	City: State: Zip:	
From (mm/yy):	To (mm/yy):	

XVI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no". If your answer to questions A through L is "yes" or if your answer to M & N is "no", please provide full details on reverse or on a separate sheet.

A.	Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?	Yes ☐ No ☐
B.	Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?	Yes ☐ No ☐
C.	Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	Yes ☐ No ☐
D.	Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?	Yes ☐ No ☐
E.	Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program?	Yes ☐ No ☐
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?	Yes ☐ No ☐
G.	Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)?	Yes ☐ No ☐
H.	Have you ever been convicted of any crime (other than a minor traffic violation)?	Yes ☐ No ☐
I.	Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	Yes ☐ No ☐
J.	Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others? **If yes, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.**	Yes ☐ No ☐
K.	Have any judgments been entered against you or settlements been agreed to by you within the last **seven (7)** years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?	Yes ☐ No ☐
L.	Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged) or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?	Yes ☐ No ☐
M.	Is your professional liability insurance valid and current?	Yes ☐ No ☐
N.	Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?	Yes ☐ No ☐

I hereby affirm that the information submitted in this Section XVI, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Mid-Level Provider's Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

INFORMATION RELEASE/ACKNOWLEDGMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between this Healthcare Organization and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and business and individuals acting as their agents) for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state[1] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq. if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action taken or pending against me by any licensing, certification or registering agency, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my clinical license, certification or registration; or (ii) any adverse action taken against me by any Healthcare Organization which has resulted in the filing of an action report with any licensing, certifying or registering agency or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non- renewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or participation agreement with the Healthcare Organization. A photocopy of this document shall be as effective as the original.

Print Name Here _____

Mid-Level Provider's Signature _____ Date _____

(Stamped Signature Is Not Acceptable)

[1] *The intent of this release is to apply, at a minimum, protections comparable to those available to any regardless of where such action is brought.*

MID-LEVEL PROVIDER APPLICATION

ATTACHMENT I: STATEMENT OF AGREEMENT BY SUPERVISING PROVIDER

Name: _____ **Employed as:** _____
Mid-Level Provider

Name: _____
Supervising Provider

I, _____, M.D./D.O. supervising Provider for the above named Mid-Level Provider, do hereby make the following statements of agreement in accordance with the policies/procedures regulating the Mid-Level Provider program:

1. I hereby accept full legal and ethical responsibility for the performance of all duties and acts performed by the above named Mid-Level Provider whom I have employed.

2. I hereby request approval to allow above named Mid-Level Provider to perform, outside my immediate supervision, the specific activities and duties, as outlined in the ***attached supervising guidelines and/or job description of the Mid-Level Provider***.

3. I agree to immediately notify IPA/Medical, in writing, in the event my approval to supervise an Mid-Level Provider is removed, limited or otherwise altered by action of the Medical Board of California, or in the event of any notification of investigation of my supervision by the Board, or if there is a change in employment status of the Mid-Level Provider hereby applying.

4. I agree to inform all patients that said Mid-Level Provider will participate in the total care of the patient and agree to ensure that the Mid-Level Provider will be clearly identified by badge.

5. I agree to comply with all regulations and policies of the Medical Board of California and/or other regulating agencies and IPA/Medical with respect to the supervision of the Mid-Level Provider, specifically including such regulations and policies which have been or may, from time to time, be adopted by said Board and/or other regulating agencies and IPA/Medical with respect to:

   a. Billing for the services of the Mid-Level Provider;

   b. Requirements for supervision of the Mid-Level Provider with respect to the type and scope of services approved by the Medical Board of California for the Mid-Level Provider to perform; and

   c. Requirement for identification of the Mid-Level Provider while rendering services.

   It is understood that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by IPA/Medical of the performance of services by the Mid-Level Provider for the health plan.

6. I understand the right of the Mid-Level Provider to render medical services under my contract shall be contingent upon my continued membership and contract with IPA/Medical. If I terminate my membership or contract, or if my membership or contract is suspended, revoked or terminated, the Mid-Level Provider's clinical activities shall automatically be changed accordingly. Similarly, if my membership or contract is restricted, the Mid-Level Provider's activities shall be restricted accordingly.

7. If applicable, a certificate issued to me by the Medical Board of California indicating my approval to supervise an Mid-Level Provider in the type and scope of practice for which this application has been made is attached.

8. I understand that the above named Mid-Level Provider shall have only such authority as is necessary to perform the duties and tasks indicated in this application. Questions of authority shall be referred to me for case by case resolution.

_____ _____
Provider's Signature Date

California Participating Physician Application
Notice to Practitioners of Credentialing Rights/Responsibilities

I. Right of Review

As an applicant for credentialing/recredentialing, you have a right to review non-privileged information obtained for the purpose of evaluating your application. This includes information obtained from outside sources such as liability insurance carriers, Medical Boards, National Practitioner Data Bank. It does not include review of information that is privileged, such as references or recommendations which are protected by law from disclosure. You have a right to be informed, upon request, of the status of your credentialing application; and the right to correct erroneous information submitted by another party, provided the information is not peer-review protected.

You may request to review such information at any time by sending a written request via fax or letter to Credentialing Department at: P.O. Box 1800, Rancho Cucamonga, CA 91729-1800, fax number (909) 890-5756. Following receipt of your request, you will be contacted by the Credentialing Department, within five (5) working days in order to arrange a date and time for review of the information in the Credentialing Department.

II. Notification of Discrepancy

You will be notified in writing, by fax or letter, when information obtained by primary sources varies significantly from information provided on your application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

III. Correction of Erroneous Information

If you believe that erroneous information has been supplied to Inland Empire Health Plan by primary sources, you may correct such information by submitting written notification to the Credentialing Department at the above cited address/fax number. Your notification, via letter or fax, must include a detailed explanation of the discrepancy and must be returned to the address above within fifteen (15) days of notification of discrepancy.

Upon receipt of your notification, Inland Empire Health Plan will re-verify the primary source information under consideration. If the primary source information has changed, an immediate correction will be made to your credentials file. You will be notified of this action. If the primary source information remains inconsistent with your notification, you will be advised of same through letter or fax. You will be requested to provide proof of correction by the primary source to the Credentialing Department via letter or fax as cited above within ten (10) days. Subsequently, a second reverification of primary source information will be performed by Inland Empire Health Plan. If, after ten (10) working days, primary source information remains inconsistent and in dispute, you will be subject to adverse action up to administrative termination from Inland Empire Health Plan.

Print Name Here: _____

Physician Signature _____ Date _____

(Stamped signature is Not Acceptable)

California Participating Physician Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to: _____, herein, this Healthcare Organization[1]

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Patient's Last Name	First	Middle:
Street Address:	City:	
	State:	ZIP:

II. CASE INFORMATION

City, County and State where lawsuit filed:	Court case number, if known:		
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suite Filed:	Sex of Patient:	Age of Patient

Location of Incident:

☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center

☐ Other (please specify) _____

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consultant, etc):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization:

_____
_____
_____
_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CHECK ONE)

- ☐ Lawsuit/arbitration still ongoing, unresolved.
- ☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
- ☐ Judgment rendered and I was found not liable.
- ☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
- ☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. Please print.

SUMMARY

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I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare Organization", its representatives, and any individuals, or entities providing information to this Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the California Participating Physician Application. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

Print Name Here: _____

Mid-level Signature: _____ Date: _____
(Stamped signature is Not Acceptable)

Verification of Qualifications *for*
HIV/AIDS PHYSICIAN SPECIALIST

Health plans and healthcare organizations must implement regulations related to AB2168 (Ch. 426, 2000). This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently definite an HIV/AIDS specialist under Regulation LS-34-01.

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

Please check <u>ANY and ALL</u> of the criteria listed below that apply to you.

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

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

☐ I am credentialed as a "HIV Specialist" by the American Academy of HIV Medicine (attached AAHIVM Certification);

OR

☐ I am Board Certified in Infectious Disease **AND** in the preceding **twelve (12)** months have clinically managed a minimum of **twenty-five (25)** HIV patients **and** have successfully completed **fifteen (15)** hours of category 1 continuing medical education (CME) in HIV medicine, **five (5)** hours of which was related to antiretroviral therapy;

OR

☐ In the past **twenty-four (24)** months, I have provided clinical management of **twenty (20)** patients; **and** in the past **twelve (12)** months completed board certification in Infectious Disease

OR

☐ In the past **twenty-four (24)** months I have provided clinical management to **twenty (20)** HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV Medicine;

OR

☐ In the past **twenty-four (24)** months I have clinically managed at least 20 HIV patients and in the past **twelve (12)** months have completed 15 hours of category of 1 CME in HIV Medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (attach copies of the CME credits and Exam verification)

I attest that, to the best of my knowledge, the above information can be supported by documentation, if required.

Name of Practitioner (Please print): _____ Date: _____

Practitioner's Signature: _____ License No: _____

Office Telephone _____ Office Fax: _____

Form **W-9**
(Rev. January 2011)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name/disregarded entity name, if different from above

Check appropriate box for federal tax classification (required): ☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶

☐ Other (see instructions) ▶

☐ Exempt payee

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

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on the "Name" line to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

			–		–				

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

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

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

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

Inland Empire Health Plan

Behavioral Health
Areas of Expertise Form

Provider Name: _____

Last First M.I.

☐ **Degree:**		☐ **License Number:**		
☐ PhD/PsyD	☐ LMFT	☐ LCSW	☐ BCBA	☐ Psychiatric NP
☐ Psychiatrist: Board Certification in (select all that apply) :				
☐ General ☐ Child and Adolescents ☐ Psychosomatic Medicine ☐ Addiction Medicine ☐ Geriatric ☐ N/A				

Individual Therapy- Select All That Apply Below:

☐ 12 Step Recovery	☐ Gender Dysphoria (to be reviewed by Credentialing)
☐ Non- 12 Step Recovery	☐ Grief/ Loss
☐ Addiction: Chemical	☐ HIV/ AIDS Issues
☐ Addiction: Non-Chemical	☐ Life Transitions Issues
☐ Adjustment Disorder	☐ Maternal Mental Health
☐ Adoption Issues	☐ Men's Issues
☐ Adult Children of Alcoholics	☐ Military related PTSD
☐ Anger Management	☐ Obsessive Compulsive Disorder
☐ Anxiety Disorder	☐ Pain Management
☐ Attention Deficit Disorder	☐ Parenting Issues
☐ Autism Spectrum Disorder	☐ Perinatal Mood Disorder
☐ Behavioral/ Conduct Disorder	☐ Personality Disorder
☐ Bi-Polar Disorder	☐ Post-Traumatic Stress Disorder
☐ Cancer Survivor	☐ Psychotic/ Schizophrenic Mood Disorder
☐ Christian Counseling	☐ Reactive Attachment Disorder
☐ Chronic Illness	☐ Sexual Dysfunction
☐ Clinical Hypnosis	☐ Sexual/ Physical Abuse Perpetrators
☐ Codependency	☐ Sleep/ Wake Disorder
☐ Disability Related Mental Health Issues	☐ Somatoform Disorder
☐ Disruptive, Impulse Control & Conduct Disorder	☐ Stress Management
☐ Eating Disorder Spectrum	☐ Women's Issues
☐ Factitious Disorder	☐ Trauma
☐ Family Counseling	

Group Therapy- Select All That Apply Below:

☐ 12 Step Recovery	☐ Mood Disorders
☐ Non- 12 Step Recovery	☐ Men's Issue
☐ Addiction: Non-Chemical	☐ Parenting
☐ Anger Management	☐ Sexual/ Physical Abuse
☐ Anxiety Disorder	☐ Social Skills
☐ CBT	☐ Trauma
☐ Depression	☐ Women's Issues
☐ Grief/ Loss	☐ Other (specify):
☐ Medication Education Group	

Select All That Apply Below:

EMDR - Certified	☐ No	☐ Yes	Date Certified:
Trauma/ Stress Disorder	☐ DBT	☐ CPT	
Dissociative Disorder	☐ DBT	☐ MBT	☐ TFP
Substance/ Addictive Disorder	☐ Vivitrol	☐ Suboxone	☐ Naltrexone
Psychological Testing	☐ Intellectual	☐ Projective	☐ Personality

Patient Population- Fill In All That Apply Below:

Children age range:	**Adolescents** age range:	**Adults** age range:	**Geriatric Adults** age range:

Accepting New Patients: ☐ Yes ☐ No	**Print Full Name:**
Date:	**Provider's Signature:**

QUESTIONNAIRE FOR:
PROVIDERS FOR TRANSGENDER MEMBERS

IEHP is interested in identifying Providers who have experience and interest in providing high quality care to Transgender Members. Please complete the following survey.

NPI: _____

LAST NAME: _____ **FIRST NAME:** _____

SPECIALTY: _____ **EMAIL:** _____

PHONE: _____ **FAX:** _____

1. Are you willing to be listed in our Provider Directory as a provider available to our Transgender Members?

☐ Yes ☐ No, (You may stop survey)

2. Please assess your ability in providing high quality care to Transgender Members:

☐ Advanced ☐ Moderate ☐ Minimal ☐ No experience (Move to Question 6)

3. What services do you provide to Transgender patients? (Select all that apply)

☐ Hormone Treatment ☐ Mental Health Services ☐ Integrated mental and physical health service model

☐ Procedures (surgical, office-based) and what type: _____

☐ Other _____

4. Approximately how many Transgender patients have you serviced in the past twelve (12) months?

☐ None ☐ 1 – 2 ☐ 3 – 9 ☐ 10 – 25 ☐ Over 25

5. How long have you been providing care to Transgender patients?

☐ Under 1 year ☐ 1 – 5 years ☐ 5 – 9 years ☐ Over 10 years

6. What training, if any, have you received to treat Transgender patients? (Select all that apply)

☐ CME events. Please list organization that provided CME: _____

_____

☐ Member of World Professional Association for Transgender Health (WPATH)?

☐ Transgender certifications through WPATH?

☐ None ☐ Other: _____

7. What clinical practices guidelines/resources do you use in proving transgender care? (Select all that apply)

☐ WPATH Standards of Care

☐ UCSF Center of Excellence for Transgender Health – Guidelines for the Primary and Gender – Affirming Care of Transgender and Non-Binary People

☐ Endocrine Society Clinical Practice Guidelines ☐ None

☐ Other, please list: _____

8. What steps have you taken to make your practice trans-friendly? (Select all that apply)

- ☐ Staff Trainings? When was the last training? _____
- ☐ Office policies/procedures?
- ☐ Bathroom policies
- ☐ Unique gender identification/name/pronoun capture in EMR?
- ☐ None

9. Have you ever written a letter to support the acquisition of gender affirming surgery?

☐ Yes ☐ No

10. Are you willing to write letters to support the acquisition of gender affirming surgery?

☐ Yes ☐ No

11. How many of these letters have you written in the past twelve (12) months?

☐ None ☐ 1 – 3 ☐ 3 – 10 ☐ Over 10

12. What resources would you recommend IEHP offer to support you in your efforts at providing high quality transgender care? Any other comments: