

California Participating Physician Application

Addendum D

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)