



CREREDENTIALING APPLICATION PACKET INSTRUCTIONS

- 1) **If you would like to register with CAQH**, please see the CAQH brochure enclosed (entitled: "Introducing Universal Credentialing Data Source") for more information on how to register online or call Magnolia Health Plan at (866) 912-6285.

- 2) **If you ARE registered with CAQH**, complete the "CAQH Provider Data Form" enclosed. You DO NOT need to complete the "Mississippi Uniform Credentialing Application."

- 3) **If you ARE NOT registered with CAQH**, complete the "Mississippi Uniform Credentialing Application" enclosed. You will also need to include the items listed on the "Credentialing Application Checklist" You DO NOT need to complete the "CAQH Provider Data Form."

CAQH Provider Data Form
For Credentialing Purposes

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

Note: If you have already completed your application with CAQH, please ensure that you have authorized Magnolia Health Plan to access your data. This can be done by calling CAQH at (888) 599-1771. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Magnolia Health Plan.

Credentialing Application Checklist

YOU MUST INCLUDE THE FOLLOWING WITH THE COMPLETED

MISSISSIPPI UNIFORM CREDENTIALING APPLICATION

(Please use this checklist as a guide)

- Signed and Dated Copy of Practitioner Application, Attestation and Authorization Sheet
- Any gaps of time six (6) months or greater from professional school/training to the present date must be documented.
- Physician Supervisor Form or Summary Letter must be submitted for Physician Assistant, Nurse Practitioner and Nurse Midwife
- Copy of State License(s)
- Copy of DEA Registration
- Copy of State Controlled Dangerous Substance Certificate
- Copy of Declaration Page of Professional Liability Policy
- Copy of Board Certification Certificate (if applicable)
- Copy of Certificate or Letter Certifying Formal Post-Graduate Training
- Copy of Curriculum Vita/Resume
Chronological order with month/year
(Not accepted as a substitute for completion of application.)
- Copy of ECFMG Certificate (if applicable)
- Copy of Certificates for Conducting X-ray and/or Laboratory Services (if applicable)

Mississippi Uniform Credentialing Application

Please check one:

- Original Application
- Reappointment

This application is submitted to: , herein, this Managed Care Entity¹.

SECTION A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided.

Current copies of the following documents must be submitted with this application.

- State Medical License(s)
- Face Sheet of Professional Liability Policy or Certification
- DEA Certificate
- Curriculum Vitae
- Board Certification (if applicable)
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City:	
	State:	ZIP:
Home Telephone Number: Home Fax Number:	E-Mail Address: Pager Number:	
Birthday Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).	
Social Security #:	Gender 2 : <input type="checkbox"/> Male <input type="checkbox"/> Female	
Specialty:	Race/Ethnicity 2 (voluntary):	
Subspecialties: Internal Medicine		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if Hospital based):
Primary Office Street Address:	Primary Office Mailing Address if different from Street Address:
City: State: County: Zip:	City: State: County: Zip:
Telephone Number:	FAX Number:
Office Manager/Administrator:	Telephone Number:
	Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

¹ As used in the information Release/Acknowledgements Section of this application, the term “this Managed Care Entity” shall refer to the entity to which the application is submitted as identified above.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	FAX Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ()	
	FAX Number: ()	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Handicap Access: <input type="checkbox"/> Yes <input type="checkbox"/> No	24 Hour Coverage: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Will you accept new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No	Back office Telephone Number: ()	
Please identify other networks in which you participate:		
Please identify other networks from which you have been denied admission or de-selected:		
Name of Network	Address	Reason for Denial or Deselection
Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotripsy, mobile testing, MRI, etc? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If Yes, please list:		
Medical Group(s) / IPA(s) Affiliation:		
Do you intend to serve as a primary care provider? <input type="checkbox"/> Yes <input type="checkbox"/> No	Please check all that apply:	
Do you intend to serve as a specialist? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Solo Practice <input type="checkbox"/> Single Specialty	
If Yes, please list specialty(s):	<input type="checkbox"/> Group Practice <input type="checkbox"/> Multi Specialty	
Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If so, please list:		
Name:	Type of Provider:	License Number:
Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name:	Mississippi Medical License Number:	

² This information will be used for consumer information purposes only.

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

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

Is your practice limited to certain ages? If Yes, specify limitations: Yes No

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

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

What type of anesthesia do you provide in your group/office?
 Local Regional Conscious Sedation General None Other (please specify): _____

Has your office received any of the following accreditation's, certifications, or licensures?
 American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) Medicare Certification
 Mississippi Department of Health Licensure Other:

IV. BILLING INFORMATION

Billing Company:

Street Address:	City:	
	State:	ZIP:

Contact:	Telephone Number:
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Name Affiliated with Tax ID Number:	Federal Tax ID Number:
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V. OFFICE HOURS – Please indicate the hours your office is open:

Monday 24 HOUR COVERAGE	Tuesday 24 HOUR COVERAGE	Wednesday 24 HOUR COVERAGE	Thursday 24 HOUR COVERAGE	Friday 24 HOUR COVERAGE	Saturday 24 HOUR COVERAGE	Sunday 24 HOUR COVERAGE	Holidays 24 HOUR COVERAGE

VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title)

Answering Service Company:	Telephone Number: ()	Fax Number: ()
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Mailing Address:	City:	
	State:	ZIP:

Covering Physician's Name:	Telephone Number: ()
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Covering Physician's Name:	Telephone Number: ()
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Covering Physician's Name:	Telephone Number: ()
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Covering Physician's Name:	Telephone Number: ()
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If you do not have hospital privileges, please provide written plan for continuity of care:

VII. FOREIGN LANGUAGES SPOKEN			
Fluently by Physician:		Fluently by Staff:	
VIII. LABORATORY SERVICES			
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.			
Tax ID #:	Billing Name:		Type of Service Provided:
Do you have a CLIA Certificate? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a CLIA waiver? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Certificate Number:		Certificate Expiration Date:	
IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)			
Medical School:	Degree Received:	Date of Graduation (mm/yy)	
Mailing Address:	City:		
	State & Country:	ZIP:	
Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy)	
Mailing Address:	City:		
	State & Country	ZIP:	
X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)			
Institution:	Program Director:		
Mailing Address:	City:		
	State & Country:	ZIP:	
Type of Internship:			
Specialty:		From: (mm/yy)	To: (mm/yy)
XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)			
Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.			
Institution:	Program Director:		
Mailing Address:	City:		
	State & Country:	ZIP:	
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:		City:	
		State & Country:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)			

XII. BOARD CERTIFICATION (Attach copies of documents.)

Include certifications by board(s) which are duly organized and recognized by: ☼ a member board of the American Board of Medical Specialties ☼ a member board of the American Osteopathic Association ☼ a board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	Specialty:	Certification Number:	Date Certified/ Rectified:	Expiration Date (if any):

Have you applied for board certification other than those indicated above? Yes No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? If Yes, Provide details. Yes No

XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
Drug Enforcement Administration (DEA) Registration Number: Unlimited? <input type="checkbox"/> Yes <input type="checkbox"/> No If "No", please explain on separate sheet		Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):		Date Issued:	Valid Through:
Visa Number:		Date Issued:	Valid Through:
Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:	

XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical licenses now or Previously Held. (Attach additional sheets if necessary. Reference this section number and title.)

State	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No
State:	License Number:	Expiration Date:	Active: <input type="checkbox"/> Yes <input type="checkbox"/> No

XVI. PROFESSIONAL ORGANIZATIONS

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

ORGANIZATION NAME	Applicant	Member
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="checkbox"/>	<input type="checkbox"/>

Are you an Officer or Director of any of the professional organizations listed above? If Yes, please list: Yes No

XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number: ()	Fax Number: ()	
Per Claim Amount: \$	Aggregate Amount: \$	Expiration Date:

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country::	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	ZIP:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and title.)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc)	Appointment Date:	

If you do not have hospital privileges, please explain.

B. PREVIOUS AFFILIATIONS (Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:
Name and Mailing Address of other Hospital/institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number: ()	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice/Employer:	Contact Name:	Telephone Number: ()
		Fax Number: ()
Mailing Address:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	

Section B.

Professional Liability Action Explanation

Please complete this section 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 five (5) 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 Section B prior to completing, and complete a separate form for each lawsuit.

I. 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 Suit 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, Consulting, etc.):

Allegation:

Is/was there any 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 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 to serve as your authorization:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE 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.**

SECTION D.
Attestation Questions

1. 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
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? Yes No
3. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public 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
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), 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
5. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? Yes No
6. 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
7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)? Yes No
8. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes No
9. Are you currently engaged in the illegal use of drugs? (“Illegal use of drugs” means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. “Currently” does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one’s ability to practice.) Yes No
10. Have any judgments or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration’s against you pending? Yes No
11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? Yes No
12. 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
13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity 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, yourself, or others? (A “YES” ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.) Yes No
14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services? Yes No

I hereby affirm that the information submitted in this Section D 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 intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

**Section E. Information
Release/Acknowledgements**

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 Managed Care Entity” 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 businesses and individuals acting as their agents (collectively. “Healthcare Organizations”), for the purpose of evaluating this applications 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 (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity 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 Managed Care Entity as may be required by state and federal law and regulation.

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 Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity 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 against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or 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 understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11, and 12 of this application.

Print Name Here: _____

Physician Signature: _____ Date _____
(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

- This Application is endorsed by:**
- **Mississippi Association of Health Plans**
 - **Mississippi State Medical Association**
 - **Mississippi Hospital Association**

³ The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.