California Participating Physician Application

This application is submitted to: ______________________________, herein, this Healthcare Organization. [1]

I. INSTRUCTIONS:

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach 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 this application:**

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

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name (s):		
Home Mailing 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 copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (If Hospital Based):	
Primary Office Street Address:	City:	
	State:	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/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

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

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:	
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	Zip:

V. 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:

POSTGRADUATE TRAINING AND EXPERIENCE

V.I 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)

Physician Name: ______________________

VII RESIDENCIES/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 and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (eg. Residency, ect.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? Yes No (If "No," please explain on separate sheet)			

Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (eg. Residency, ect.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? Yes No (If "No," please explain on separate sheet)			

Institution:		Program Director:	
Mailing Address:		City:	
		State:	Zip:
Type of Training (eg. Residency, ect.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? Yes No (If "No," please explain on separate sheet)			

VIII RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title)

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 equivalent requirements approved by the Medical Board of California
- board or association with an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Recertified:	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 eligibility for certification on separate sheet

Physician Name: ______________________

IX 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:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

California State License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Medicare UPIN/National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:	

XI. 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:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:	
Mailing Address:		City:	
		State:	Zip:
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.

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

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

Physician Name: ____________________

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

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation{s} first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes 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 on Addendum A.

B. PREVIOUS AFFILIATIONS During 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:		

Physician Name: ______________________

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:		

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including 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.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

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:

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

Chronologically list all work history activities since completion of postgraduate training (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)		

Physician Name: ______________________

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

Physician Name: ______________________

VI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through K is "yes," or if your answer to L is "no," please provide full details on 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. Do you presently use any drugs illegally?

Yes No

J. 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

K. 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

L. 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 XI, 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 agreement.

Print Name Here: ______________________________

Physician Signature ______________________________ Date: ______________
(Stamped Signature Is Not Acceptable)

Physician Name: ______________________

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 businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), 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[3] 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 against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section *805* report with the Medical Board of California, or 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 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 physician participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on pages 8 and 9.

Print Name Here: ______________________________

Physician Signature ______________________________ Date: ______________
(Stamped Signature Is Not Acceptable)

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

Addenda Submitting (Please check the following):	*This Application and Addenda A and B were created and are endorsed by:*
Addendum A - Health Plan and IPA/Medical Group Addendum B - Professional Liability Action Explanation	• American Medical Group Association - (310/430-1191 x223) • California Association of Health Plans - *(916/552-2910)* • California Healthcare Association - *(916/552-7574)* • California Medical Association - (415/882-5166) • The Medical Quality Commission - (310/936-1100 x230)

Individual healthcare organizations may request additional information or attach supplements to this form. They are not part of the California Participation Physician Reapplication nor have they been endorsed by the above organizations. Any questions about supplements should be addressed to the health care organization from which it was provided.

California Participating Physician Application

Addendum A

Health Plans and PPG's/Medical Groups

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

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Medical Group(s)/IPA(s) Affiliation:		

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s) ____________

Please check all that apply:

☐ Solo Practice ☐ Single Specialty

☐ Group Practice ☐ Multi Specialty

II. BILLING INFORMATION

Billing Company:		
Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

Name:	Type of Provider:	License Number:

If you are a Physician Assistant Supervisor, please indicate State License Number: ____________

Do you personally employ any physicians (do not include physicians that are employed by the medical group)? ☐ Yes ☐ No

If so, please list:

Name:	Type of Provider:	License 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.

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? ☐ Yes ☐ No
If yes, specify limitations: ______

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ 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 accreditations, certifications, or licensures?
- ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ California Department of Health Services Licensure
- ☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
- ☐ Medicare Certification
- ☐ The Medical Quality Commission (TMQC)
- ☐ Other ______

IV. OFFICE HOURS – Please indicate the hours your office is open:

OFFICE	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holiday
Primary								
Secondary								
Third								

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

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

Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )
Covering Physician's Name:	Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

______

______

______

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VII. 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? ☐ Yes ☐ No

Do you have a CLIA waiver? ☐ Yes ☐ No

Certificate Number:	Certification Expiration Date:

VIII. ADDITIONAL LICENSURES/CERTIFICATES

Are you currently accepting Medi-Cal patients? ☐Yes ☐No If yes, please indicate Medi-Cal #: ____________________

Are you CHDP (Child Health and Disability Prevention Program) certified? ☐Yes ☐No If yes, please indicate certificate #: ____________

Are you CPSP (Comprehensive Perinatal Services Program) certified? ☐Yes ☐No If yes, please indicate certificate #: ____________

Are you CCS (California Children Services) certified? ☐Yes ☐No If yes, please indicate certificate #: ____________________

Are you a certified Workers' Compensation provider? ☐Yes ☐No If yes, please indicate certificate #: ____________________

IX. PROFESSIONAL ORGANIZATIONS

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

Organization Name	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name: ____

Physician Signature: ____
(Stamped Signature Is Not Acceptable)

Date: ______________________________

Physician Name:

CONFIDENTIAL/PROPRIETARY

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 n 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

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 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, 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 section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum 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

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 abut 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: ______________________________

Physician Signature: ______________________________ Date: __________

(Stamped Signature Is Not Acceptable)

Addendum C
to the
California Participating Physician Application

Internet access? YES NO	If yes, e-mail address:
How many ______________________ Health Plan patients do you see each month?	

I. Healthy Families	
Number of days open per week:	Total office operating hours per week:
Participation on the Healthy Family Program requires a minimum of 5 days and 36 office hours per week.	
II. Military Reserve Status	
Are you currently on active duty and/or military reserve? YES NO	

III. Right of Review

A practitioner has the right to review information obtained by L.A. Care Health Plan for the purpose of evaluating that practitioner's credentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank), but does not extend to review of information, references or recommendations protected by law from disclosure.

A practitioner may request to review such information at any time by sending a written request via letter or fax to the Manager of Credentialing, L.A. Care Health Plan, 1055 W. Seventh Street, 8th Floor, Los Angeles, CA 90017, fax number (213) 623-8987. The Manager of Credentialing will notify the practitioner within 72 hours of the date and time when such information will be available for review at the L.A. Care Health Plan Credentialing Department, located in Los Angeles, CA.

IV. Notification of Discrepancy

Practitioners will be notified in writing, via letter or fax, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license or certificate, suspension or termination of hospital privileges, or board certification expiration, when one or more of these examples have not been self-reported by the practitioner on his/her application form. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

V. Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to L.A. Care Health Plan by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice (via letter or fax) along with a detailed explanation to the Manager of Credentialing, L.A. Care Health Plan, 1055 W. Seventh Street, 8th Floor, Los Angeles, CA 90017, fax number (213) 623-8987. Notification to L.A. Care Health Plan must occur within 48 hours of L.A. Care Health Plan's notification to the practitioner of a discrepancy as provided in Section IV or within 24 hours of a practitioner's review of his/her credentials file as provided in Section III.

VI. Physician Signature:

____ Date:_______________________

Stamped signature is not acceptable

For L.A. Care Use Only	
Provider ID #	

Addendum E

This Addendum is submitted to:____

Primary Care/Specialist Experience Attestation

Please indicate below the age of the patients for whom you have provided primary care services / specialist services in the last 5 years or wish to treat. In order for a category to apply, it must represent at least 20% of your average practice and you must be familiar with routine standard preventive services. **Please check all those that apply:**

☐ Children (0 to 16 years of age) **Must be Pediatrician or CHDP certified.**
☐ Adults (16 years of age and older)
☐ If you desire age limitations different from above, please specify:

____

Behavior Health Experience Attestation

Please indicate below the age of the patients for whom you have provided specialist services in the last 5 years. Please check all those that apply:

☐ Children (0 to 16 years of age) **Must submit proof of training or be CHDP certified.**
☐ Adults (16 years of age and older)
☐ If you desire age limitations different from above, please specify:

____

Primary Care Experience Attestation – School Based Clinics

Providers of school based clinics will see members as indicated below.

☐ Children (0 to 16 years of age) **Must be Pediatrician or CHDP certified.**
☐ Adults (16 years of age and older)
☐ If you desire age limitations different from above, please specify:

____

Special Services

Please indicate if you are in the following:

☐ California Children's Services **(CCS)** Paneled
☐ Child Health and Disability Prevention Program **(CHDP)** Health Assessor

Please submit proof of your **CCS** or **CHDP** status.

I attest to the fact that all of the information submitted by me in this document is true and correct to the best of my knowledge and belief. I fully understand that any significant misstatement or omission from this attestation may constitute cause for denial of participation or dismissal from participation with L.A. Care Health Plan.

Practitioner's Signature: ______________________________ Date:______________
(Stamped signature is not acceptable.)

ADDENDUM TO 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 may request to review such information at any time by sending a written request via fax or letter to the Manager of Credentialing, 1680 Hill Street, Signal Hill, CA 90755, fax number 562-427-4634. Following receipt of your request, you will be contacted by the Manager or his/her designee, within three (3) 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 Universal Care / Brand New Day 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, Universal Care / Brand New Day 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, fax, or phone. 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 re-verification of primary source information will be performed by the Credentialing Department.

Print Name: ______________________________

______________________________ ______________

Signature (Stamped signature is Not Acceptable) (Date)

California Participating Physician Application

Addendum E

HIV/AIDS Specialist Designation

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

Health plans and health care organizations must implement regulations related to AB 2168 (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 defined 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.

We will use your information for internal referral procedures and for publication listing in the Cal-Optima Specialist Intranet Provider Directory.

As always, if information about your practice changes, please notify us promptly.

☐ 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:**

- **If Yes: Are you willing to take CalOptima member referrals?** ☐ **Yes** ☐ **No**

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine.

OR

I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV medicine by a member board of the American Board of Medical Specialties;

OR

☐ I am board certified in Infectious Disease and in the past 12 months have clinically managed at least 25 HIV patients and completed 15 hours of category 1 CME in HIV medicine, five hours of which was related to antiretroviral therapy;

OR

☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed board certification in Infectious Disease;

OR

☐ In the past 24 months I have provided clinical management to 20 HIV patients and in the past 12 months have completed 30 hours of category 1 CME in HIV medicine;

OR

☐ In the past 24 months I have clinically managed at least 20 HIV patients and in the past 12 months have completed 15 hours of category 1 CME in HIV medicine and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

* Reimbursement rates are available on the CalOptima website.

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

Physician's Name (Print) ______________________________________ Date ____/____/____

Signature ____________________________ License # ______________ Telephone # (____)______-______

Name and Title of Person Submitting Form ____

[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.

Form **W-9**
(Rev. October 2007)
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, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=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 Line 1 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

or

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.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,