ISHN
INTEGRATED SOLUTIONS HEALTH NETWORK
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PRACTITIONER INITIAL CREDENTIALING APPLICATION

The information listed below is required information and documentation for Credentialing. If the answer does not apply to you or your specialty, please complete the blank with NA. Thank you!

Practitioner Name:

3290

PLEASE COMPLETE/SIGN THE FOLLOWING:

☐ **COMPLETED CREDENTIALING APPLICATION – ATTESTATION, AUTHORIZATION & RELEASE SIGNED AND DATED -** ***Please Note: Proxy signatures and/or stamped signatures are not acceptable.***

☐ **EDUCATION & WORK HISTORY FOR THE PAST TEN (10) YEARS.** ***Provide months and years with description of activities during any gaps more than 90 days***

PLEASE INCLUDE COPIES OF THE FOLLOWING:

☐ **Current state license (s)**

☐ **Current state controlled substance license (s)**

☐ **Current Federal DEA Registrations for each location where you administer, dispense or store controlled substances**

☐ **Current professional liability insurance face sheet**

☐ **Professional liability insurance company case history, if applicable**

***ALSO ATTACH*:**

☐ **Completed Malpractice Release Form**

☐ **Professional Liability Explanation Form** ***(see application – this form must be completed if the answer to any of the disclosure questions is "yes")***

☐ **Written, detailed, explanation of "yes" answers on Disclosure Questions and Answers Form**

☐ **Documentation for specialty board certification**

Integrated Solutions Health Network
ATTENTION: Credentialing Department
208 Sunset Drive, Suite 401
Johnson City, TN 37604
Phone: (423) 952-2128
Fax: (423) 952-2145

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

Credentialing Requirements

Integrated Solutions Health Network (ISHN) credentials practitioners to meet National Committee for Quality Assurance (NCQA) standards, to assure quality of patient care.

The following are ISHN, SWVHN and NCQA requirements:

COMPLETED CREDENTIALING APPLICATION-ATTESTATION, AUTHORIZATION & RELEASE SIGNED AND DATED
Please Note: Proxy signatures and / or stamped signatures are not acceptable

EDUCATION & WORK HISTORY - *Provide dates with months and years and details of any of gaps more than 90 days* to show consistent work history with no gaps. Any gaps of more than 90 days will require detailed information regarding the absence of employment during that period.

HOSPITAL AFFILIATION – please list your current hospital affiliations.

PEER REFERENCE – please provider two peer references. One reference must be in your practicing specialty. Neither reference should be a partner or relative or program /department chairs.

PRACTITIONER LICENSURE AND SANCTION HISTORY, including allied health licensure and other professional licenses – we collect and verify Current licensure with each state-issuing department.

Sanction History – verified via the applicable state department, or the Federation of State Medical Boards.

State controlled substance license (s) and state controlled substance license history – we will verify Current licensure with each state-issuing department.
(if applicable)

Federal DEA Registration – please attach a copy – we will verify by obtaining a copy of the original document and including the copy in the practitioner Credentialing file.

Ten (10) years professional liability insurance history – please attach a face sheet *(showing minimum 1,000,000/ 3,000,000 limits of liability for TN and 2,050,000/6,150,000 for VA)* – we will verify current liability insurance by obtaining a copy of the original document and including the copy in the practitioner Credentialing file

Ten (10) years professional liability claims history – please attach descriptions of EACH case that is either open, pending, settled, judged, closed, with incident and final dates. Claims history – practitioner is requested to provide claims history with explanation, which is verified via the malpractice insurance company, or the National Practitioner Data Bank.

Malpractice Release Form – provides access for ISHN to obtain a certificate of insurance, as well as malpractice claims history. When the claims history is not released to ISHN, it will become the responsibility of the practitioner to secure information for the company.

Professional Liability Explanation Form (see application – this form MUST be completed if the answer to the disclosure questions is "yes") - practitioner is asked to provide claims history with DETAILED explanation(s), which is verified via the malpractice insurance company, or the National Practitioner Data Bank

Documentation for specialty board certification for each certification – verified by the ABMS

PRACTITIONER INITIAL CREDENTIALING APPLICATION

Medical School diploma

Internship / Residency certificate

Documentation and Verifications are obtained within the NCQA required 180 day time limit.

ISHN's Credentialing Committee reviews the practitioner's credentialing file and recommends approval for three (3) years, deferral for additional information, or denial.

Each practitioner will be recredentialed within 3 years, beginning at 30 month intervals.

Deferred files will be re-processed; to secure the additional information and to assure standards are met.

Practitioner Applications / credentials are returned to the Credentialing Manager, at the following address:

Integrated Solutions Health Network
ATTENTION: Credentialing Department
208 Sunset Drive, Suite 401
Johnson City, TN 37604
Phone: (423) 952-2128
Fax: (423) 952-2145

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

I. PERSONAL/PRACTICE INFORMATION

Last Name:	**First:**	**Middle:**
SSN:	**Gender: M ☐ F ☐**	**Date of Birth:**
Degree:	**NPI#:**	**CAQH#:**
UPIN #:	**MEDICARE #:**	**MEDICAID #:**
Name of Practice Group:		**TAX ID#:**
NP/PA - please list supervising physician:		

Primary address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	
Practicing Specialty:	
Are you a PCP? **Y ☐ N ☐**	**GRP NPI:**
PRACTICE NAME:	**START DATE:**

Mailing Address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	

Billing address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

Office Manager and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Email:

Credentialing Contact and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Email:

Additional address and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Back Office #:

Practicing Specialty:

Are you a PCP? Y ☐ N ☐ | GRP NPI:

PRACTICE NAME: | START DATE:

Additional address and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Back Office #:

Practicing Specialty:

Are you a PCP? Y ☐ N ☐ | GRP NPI:

PRACTICE NAME: | START DATE:

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

Additional address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	
Practicing Specialty:	
Are you a PCP? Y ☐ N ☐	GRP NPI:
PRACTICE NAME:	START DATE:

Additional address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	
Practicing Specialty:	
Are you a PCP? Y ☐ N ☐	GRP NPI:
PRACTICE NAME:	START DATE:

Additional address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	
Practicing Specialty:	
Are you a PCP? Y ☐ N ☐	GRP NPI:
PRACTICE NAME:	START DATE:

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

Additional address and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Back Office #:

Practicing Specialty:

Are you a PCP? Y ☐ N ☐ | GRP NPI:

PRACTICE NAME: | START DATE:

Additional address and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Back Office #:

Practicing Specialty:

Are you a PCP? Y ☐ N ☐ | GRP NPI:

PRACTICE NAME: | START DATE:

Additional address and contact information

Address

City/State/Zip

County

Telephone # | Fax #

Contact Person:

Back Office #:

Practicing Specialty:

Are you a PCP? Y ☐ N ☐ | GRP NPI:

PRACTICE NAME: | START DATE:

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

Additional address and contact information	
Address	
City/State/Zip	
County	
Telephone #	Fax #
Contact Person:	
Back Office #:	
Practicing Specialty:	
Are you a PCP? Y ☐ N ☐	GRP NPI:
PRACTICE NAME:	START DATE:

Are you accepting new patients at all practice locations? Y ☐ N ☐
Are you fluent in languages other than English? Y ☐ N ☐
If so, please list:

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

II. CURRENT PROFESSIONAL LICENSURE INFORMATION Please provide detailed professional license information for each professional license you have ever held. If necessary, please use an additional sheet of paper.

Medical License(s)

State:	License No.	Original Eff. Date:	Exp. Date:
State:	License No.	Original Eff. Date:	Exp. Date:
State:	License No.	Original Eff. Date:	Exp. Date:
State:	License No.	Original Eff. Date:	Exp. Date:

Fed. DEA Reg. No.	Exp. Date:	Schedules:
Fed. DEA 2 Reg.No.	Exp. Date:	Schedules:

State CDS Reg. No:	Exp. Date:
State CDS 2 Reg. No:	Exp. Date:

Other Professional License(s)

State	License No.	Type:	Original Eff. Date:	Exp. Date:
State	License No.	Type:	Original Eff. Date:	Exp. Date:
State	License No.	Type:	Original Eff. Date:	Exp. Date:
State	License No.	Type:	Original Eff. Date:	Exp. Date:

III. EDUCATION AND TRAINING – include MONTH and YEAR. *Please use separate page for additional information*

School ***(if you attended other training / medical schools please list those schools on a separate page)***

Institution Name:		
Mailing Address:		
Degree:	Med School Start date: (Month Year)	Grad date: (Month Year)

Foreign Graduates

Are you a foreign medical school graduate? Y ☐ N ☐

Are you certified by the Education Council for Foreign Medical Graduates? Y ☐ N ☐

ECFMG #:	Date Received :

Internship One

Institution Name:		
Mailing Address:		
Attended From: (Month Year)	To: (Month Year)	Type of Internship:

Did you complete this program? Y ☐ N ☐

Internship Two

Institution Name		
Mailing Address		
Attended From: (Month Year)	To: (Month Year)	Type of Internship:

Did you complete this program? Y ☐ N ☐

PRACTITIONER INITIAL CREDENTIALING APPLICATION

III. EDUCATION AND TRAINING (cont) – include MONTH and YEAR. *Please use separate page for additional information*

Residency One

Institution Name:		
Mailing Address:		
Attended From:	To:	Type of Residency:
Month Year	Month Year	

Did you complete this program? Y ☐ N ☐

Residency Two

Institution Name:		
Mailing Address:		
Attended From:	To:	Type of Residency:
Month Year	Month Year	

Did you complete this program? Y ☐ N ☐

Fellowship

Institution Name:		
Mailing Address:		
Attended From:	To:	Type of Fellowship:
Month Year	Month Year	

Did you complete this program? Y ☐ N ☐

Fellowship Two

Institution Name:		
Mailing Address:		
Attended From:	To:	Type of Fellowship:
Month Year	Month Year	

Did you complete this program? Y ☐ N ☐

IV. HOSPITAL AFFILIATIONS: Please include MONTH & YEAR. *Please use separate page for additional information – IF NO AFFILIATION, PLEASE COMPLETE THE FORM ATTACHED.*

Institution Name:		
Mailing Address:		
From:	To:	Type of Affiliation:
Month Year	Month Year	

Institution Name:		
Mailing Address :		
From:	To:	Type of Affiliation:
Month Year	Month Year	

Institution Name:		
Mailing Address:		
From:	To:	Type of Affiliation:
Month Year	Month Year	

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V. PEER REFERENCES – *Please provide two peer references. One reference must have your same practicing specialty. Partners or relatives are not acceptable peer references.*

1)

Name:		
Mailing Address:		
City:	State:	Zip:
Phone:	Fax:	Specialty:

2)

Name:		
Mailing Address:		
City:	State:	Zip:
Phone:	Fax:	Specialty:

VI. BOARD CERTIFICATION - Please submit a copy of your Board Certificate(s). For each certificate, indicate your specialty, the certificate number and the date of certification. Please include the issuing board (ABMS, AOA, OME, Canadian, etc.)

Are you American Board Certified in your specialty? *Y* ☐ *N* ☐

Specialty:	Certification Organization:	
Certification number:	Date Certified:	Re-certification Date:

If not Board Certified, are you planning to take Boards? *Y* ☐ *N* ☐ Date: _____
Are you American Board Certified in a sub-specialty? *Y* ☐ *N* ☐

Specialty:	Cert Org:	Date Cert:	*Re-cert Date:*
Specialty:	Cert Org:	Date Cert:	*Re-cert Date:*
Specialty:	Cert Org:	Date Cert:	*Re-cert Date:*

If American Board certification has not been achieved, please indicate the specialty in which you practice and your status in the certifying process of that specialty. What are your plans for taking the next exam or reasons for not seeking certification?

_____
Specialty Practice *Date(s) of Board Exam taken/retaken or Date Exam scheduled*

_____
Please relate results of above Exam

_____
Reasons for not seeking Certification

Have you ever lost any board certification(s), and / or failed to recertify? ☐ Y ☐ N
If yes, please explain the circumstances:

_____
_____
_____

NOTE: *It is at the discretion of Health Plans to request additional information to determine acceptance.*

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VII. PRACTICE OR EMPLOYMENT HISTORY - *Please use separate page for additional information*

Please provide the last ***Ten (10) YEARS*** practice and/or employment history. Use separate page if needed.
Indicate month and year

Facility, Group, Practice	***Position Held***	***From***	***To***
Name:		*MM/YY:*	*MM/YY:*
City/State:			
Name:		*MM/YY:*	*MM/YY:*
City/State:			
Name:		*MM/YY:*	*MM/YY:*
City/State:			

VIII. PROFESSIONAL LIABILITY INFORMATION

Please enclose a copy of the current face sheet(s) that shows 1,000,000/3,000,000 (TN) – 2,050,000/6,150,000 (VA) policy limits of liability.

Insurance Carrier:			
Address:			
Policy #:			
Retro Date:	**Eff. Date:**	**Exp. Date:**	
Policy Limits:	*Occurrence: $*	*Aggregate: $*	
Telephone Number:		**Fax Number:**	

IX. PREVIOUS Ten (10) YEARS PROFESSIONAL LIABILITY INFORMATION

Insurance Carrier:			
Address:			
Policy #:			
Retro Date:	**Eff. Date:**	**Exp. Date:**	
Policy Limits:	*Occurrence: $*	**Aggregate: $**	
Telephone Number:		**Fax Number:**	

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

X. DISCLOSURE QUESTIONS DECLARATION OF PROFESSIONAL AND HEALTH INFORMATION -If any of the following answers are "Yes", please provide detailed information on a separate page and/or the Professional Liability Form attached.

In the past ten (10) years:

1)	Has there been, or are there currently, any claims, settlements, or judgments against you, even if not resulting in monetary damages, or have you received any notice of "Intent to File"?	Y ☐ N ☐
1a)	Have there been changes/dismissals/settlements in the last 3 years to any previously disclosed issues?	Y ☐ N ☐
2)	Have you ever had any professional liability insurance coverage canceled, declined or modified (i.e. reduced limits, restricted coverage), or has any renewal ever been refused, or have you voluntarily given up coverage?	Y ☐ N ☐
3)	Have you had continuous professional malpractice liability insurance coverage?	Y ☐ N ☐
4)	Have you ever been denied membership or renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization, or professional society, or is such action pending?	Y ☐ N ☐
5)	Do you have clinical privileges in good standing at any hospital?	Y ☐ N ☐
6)	Have your clinical privileges at any hospital or healthcare institution been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions or have proceedings toward any of those ends been instituted or recommended by a hospital administration, medical staff or committee or governing boards?	Y ☐ N ☐
6a)	Have you ever withdrawn your application for appointment, reappointment, and clinical privileges or resigned from a medical staff before a decision by a hospital or health care facility's governing board was rendered?	Y ☐ N ☐
7)	Has your request for any specific clinical privileges been denied or granted with stated limitations *(aside from ordinary and initial requirements of proctorship)* or has such a denial or limitations been recommended by a medical staff or committee or governing board?	Y ☐ N ☐
8)	Have you had any previous or pending challenges to, or voluntarily or involuntarily relinquished any medical staff membership, clinical privilege(s), professional license(s), or narcotics registration as the result of any investigation or disciplinary action?	Y ☐ N ☐
9)	Have you been disciplined by any State Board of Medical Examiners, or by any Professional Conduct Board, or have you ever been reprimanded, or disciplined by any state or federal agency that disciplines physicians or allied health professionals?	Y ☐ N ☐
10)	Have you been reprimanded, censured, excluded, suspended, or disqualified by Medicare, Medicaid, CLIA, or any other health plan for which you provided services?	Y ☐ N ☐
11)	Has your Drug Enforcement Agency or other controlled substances authorization been limited, denied, revoked, suspended, reduced, under investigation or not renewed, or have proceedings toward any of those ends ever been instituted?	Y ☐ N ☐
12)	Has your specialty board certification or eligibility been denied, revoked, relinquished, not renewed, suspended, reduced, or have any proceedings toward any of those ends been instituted?	Y ☐ N ☐

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X. DISCLOSURE QUESTIONS DECLARATION OF PROFESSIONAL AND HEALTH INFORMATION *-If any of the following answers are "Yes" please provide detailed information on either on a separate page and/or on the Professional Liability Form attached. - (Continued)*

13) Has your authorization to practice in any jurisdiction (*state or country*) been revoked, suspended, or subject to probation or any conditions or limitations or have you ever been asked to surrender your license? Y ☐ N ☐

14) Have you been convicted of, or pleaded guilty or nolo contendere to a felony, serious or gross misdemeanor, or any crime involving dishonesty, assault or sexual misconduct or abuse, or are charges pending against you for any such crimes by information, indictment, or otherwise? Y ☐ N ☐

15) To your knowledge has any information pertaining to you been reported to the National Practitioner Data Bank (*NPDB)*? If "Yes" please attach an explanation. Y ☐ N ☐

16) Have you ever disputed a report to the National Practitioner Data Bank? Y ☐ N ☐

17) Have you ever been the subject of any disciplinary monitoring, proctoring, supervision, consultations, and/or similar restrictions imposed by any hospital for any reason, as well as similar restrictions imposed by any managed care entity including any HMO, POS, PPO, IPA, or PHO? Y ☐ N ☐

18) Do you have any medical condition or physical or mental impairment, treated or untreated, which in any way impairs and/or limits your ability to practice medicine to the fullest extent of your licensure and qualification, with reasonable skill and safety? Y ☐ N ☐

19) Have you ever been treated for the use or misuse of prescription drugs, alcohol or illegal substance chemicals? If "Yes", please attach an explanation. Y ☐ N ☐

20) I certify that I am able to perform the essential functions for which I am applying and am not presently using any legal or illegal drugs or any other substance that would impair my ability to perform those functions. Y ☐ N ☐

21) Have you been court-martialed, investigated, sanctioned, reprimanded or cautioned by a hospital or other healthcare facility or any military agency, been involuntarily terminated, forced to resign, or have you resigned voluntarily under investigation or threat of sanction from a hospital or healthcare facility or military agency? Y ☐ N ☐

22) Do you or does a member of your family own, have an investment in, or otherwise have a business dealing with the provision of ancillary health services equipment, or supplies? If "Yes", please provide explanations. Y ☐ N ☐

I certify that the information in this document and attached documents are true, correct and complete. I agree that Integrated Solutions Health Network (ISHN), or its designated agents and/or Health Plan contracted with Integrated Solutions Health Network (ISHN) providing information to Integrated Solutions Health Network (ISHN) in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the Practitioner Application.
I further agree to notify Integrated Solutions Health Network (ISHN) in a timely manner of any change to the information included in this form. ***THE FOREGOING CERTIFICATION AND RELEASE ARE IN ADDITION TO, AND NOT IN LIEU OF, THOSE SET FORTH IN THE ATTESTATION, AUTHORIZATION AND RELEASE BELOW.***

Name (Please print or type)	*Practitioner Signature (original required)* ***(Stamped Signatures are unacceptable)***	*Date*

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

XI. PROFESSIONAL MALPRACTICE LIABILITY ACTION EXPLANATION - CONFIDENTIAL

Please complete this information for each pending or settled professional liability action or payment on behalf of the practitioner reported on your application. All questions must be answered completely. If additional sheets are required, please photocopy this page prior to completing. Please provide a separate sheet for each malpractice action.

Date of alleged incident _____ Date Suit filed _____

Plaintiff Name _____

Your relationship to patient (*Attending Physician, Surgeon, Assistant Surgeon, Consultant, etc.*)

_____

_____

Allegation – your involvement in the care

_____

_____

Professional Liability Insurer at time of incident _____

Describe your role in the incident ☐ Primary Defendant ☐ Co-Defendant

Additional Defendant(s) _____

Present Status

☐ Open/Pending

☐ Dismissed

☐ Settlement out of Court Date Settled _____ Loss $ _____

☐ Judgment Date of Judgment _____ Loss $ _____

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, which describes your care and treatment of this patient. If additional space is necessary, attach clinical detail to allow proper evaluation by a committee of physicians. Include 1) the condition and diagnosis at time of incident; 2) dates and description of treatment rendered; 3) condition of patient subsequent to treatment. ***Please print or type this information.***

SUMMARY

_____

_____

I certify that the information in this document and attached documents is true, complete and correct. I agree that *Integrated Solutions Health Network (ISHN)* or its designated agents and/or Health Plan contracted with *Integrated Solutions Health Network (ISHN)* providing information to *Integrated Solutions Health Network (ISHN)* in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this document, which is part of the Physician Application. I further agree to notify *Integrated Solutions Health Network (ISHN)* in a timely manner of any change to the information included in this form. **THE FOREGOING CERTIFICATION AND RELEASE ARE IN ADDITION TO, AND NOT IN LIEU OF, THOSE SET FORTH IN THE ATTESTATION, AUTHORIZATION AND RELEASE BELOW.**

Name (Please print or type)	*Practitioner Signature (original required)* ***(Stamped Signatures are unacceptable)***	*Date*

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PRACTITIONER INITIAL CREDENTIALING APPLICATION

XII: PROFESSIONAL ADVERSE AND OTHER ACTIONS - CONFIDENTIAL

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies.
Use reverse side of this form if additional space is needed.

Applicant Name:

Last	First	MI

Indicate the number of ONE of the questions in Section "X" to which you answered "yes": Question number: _____

A. Describe the circumstances surrounding this occurrence. Please include the date of the occurrence.

_____

_____

_____

_____

B. Provide an explanation of any actions taken. Please include the date the action was taken.

_____

_____

_____

_____

C. Provide the current status of the issue.

_____

_____

_____

_____

D. If known: Contact: _____

Department/Committee: _____

Address: _____
Street City State Zip

Telephone: _____

Name (Please print or type)	*Practitioner Signature (original required)* ***(Stamped Signatures are unacceptable)***	*Date*

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XIII. MEDICAL CONDITION - CONFIDENTIAL

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies.
Use reverse side of this form if additional space is needed.

Applicant Name:

Last	First	MI

A. Describe this medical condition:

B. To what extent does or could this condition affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

C. What is the current status of your condition? Are you still under medical care?

Name (Please print or type)	*Practitioner Signature (original required)* ***(Stamped Signatures are unacceptable)***	*Date*

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XIV: CHEMICAL SUBSTANCES OR ALCOHOL ABUSE - CONFIDENTIAL

DUPLICATE this form as necessary to complete separate sheet for EACH occurrence that applies.
Use reverse side of this form if additional space is needed.

Applicant Name:

Last	First	MI

Describe the substance you use or have used:

A. To what extent does or could, your uses of this substance affect your current ability to practice medicine in your specialty area or to perform a full range of clinical activities?

B. Monitored by State Board Mandate (Name and Address)

C. Monitored Voluntarily (Name and Address)

D. Other information about the current status of your use of substances:

E. Abstinent since (mm/yy): _____

F. Has there ever been a relapse in your treatment? Please describe the relapse and recovery process.

Name (Please print or type)	*Practitioner Signature (original required)* ***(Stamped Signatures are unacceptable)***	*Date*

PRACTITIONER INITIAL CREDENTIALING APPLICATION

If you currently do not have admitting privileges at a participating hospital in the local geographic area, we require documentation of your admitting arrangements in order to complete the credentialing process.

PRIMARY ADMITTING FACILITY ARRANGEMENTS

I, , have made the following arrangements for admission of my patients with a participating facility with the customer organization identified above, as confirmed by my admitting physician, hospitalist group administrator, or supervising physician below:

Admitting Physician's Name (please print)

Admitting Physician's Signature Date

Hospitalist Group Administrator's Name, if applicable (please print)

Hospitalist Group Administrator's Signature Date

Please forward the requested information by facsimile to the attention of our Credentials Department at (423) 262-0269. Should you have any questions or require any additional information you may contact our credentialing department at 888-979-0535.

As you currently do not have admitting privileges at a participating hospital in the local geographic area, we require documentation of your admitting arrangements in order to complete the credentialing process.

PRIMARY ADMITTING FACILITY ARRANGEMENTS

I, , have made the following arrangements for admission of my patients with a participating facility with the customer organization identified above, as confirmed by my admitting physician, hospitalist group administrator, or supervising physician below:

Admitting Physician's Name (please print)

Admitting Physician's Signature Date

Hospitalist Group Administrator's Name, if applicable (please print)

Hospitalist Group Administrator's Signature Date

Please forward the requested information by facsimile to the attention of our Credentials Department at (423) 262-0269. Should you have any questions or require any additional information you may contact our credentialing department at 888-979-0535.

PRACTITIONER INITIAL CREDENTIALING APPLICATION

XV. ATTESTATION, AUTHORIZATION AND RELEASE

I UNDERSTAND THAT THIS ATTESTATION, AUTHORIZATION AND RELEASE (THIS "RELEASE") HAS IMPORTANT LEGAL CONSEQUENCES. I REPRESENT THAT I AM SIGNING THIS RELEASE VOLUNTARILY. I FURTHER REPRESENT THAT I HAVE READ AND UNDERSTAND THE TERMS OF THIS RELEASE AND THAT I HAD THE OPPORTUNITY TO SEEK AND CONSULT WITH LEGAL COUNSEL BEFORE SIGNING BELOW.

I present the information included on the foregoing pages as part of this credentialing process in the expectation that its confidentiality and privacy will be preserved by *Integrated Solutions Health Network* and the Interested Entities (as defined below) to the extent permitted by law, and that this information will be released or disclosed only as part of current and future credentialing, peer review, and quality assurance processes and only when authorized by me or otherwise when required by law or by any court or administrative agency. I understand that *Integrated Solutions Health Network* is gathering, verifying, and submitting this information, and the other information described below, to those entities (herein after referred to as "Interested Entities") with whom I have, or wish to establish, participation, membership and/or a contractual relationship as a network provider, staff physician, or other provider of professional medical services.

I understand that *Integrated Solutions Health Network* and each Interested Entity have their own credentialing criteria, and I may be accepted or rejected by each independently. I further understand that this application is not an application for participation or membership with *Integrated Solutions Health Network* or any Interested Entity and that acceptance of my application by *Integrated Solutions Health Network* or any Interested Entity does not guarantee that I will become a participant, member or contracted provider of *Integrated Solutions Health Network* or any Interested Entity.

In order for *Integrated Solutions Health Network* to prepare a complete personal credentials portfolio for me and for *Integrated Solutions Health Network* and the Interested Entities to evaluate this application and my credentials and qualifications, I hereby give permission to *Integrated Solutions Health Network/Southwest Virginia Health Network*, each Interested Entity, and their representatives, agents and employees, to request, copy, inspect and investigate information (both oral and written) regarding this application and my professional credentials and qualifications from: personal and professional references, medical groups with which I currently am or have been affiliated, health plans, health maintenance organizations, managed care organizations, law enforcement agencies, military services, the National Practitioner Data Bank, the Health Care Integrity and Protection Data Bank, educational facilities and institutions, hospitals in which I currently have or formerly have had staff privileges or was otherwise associated (including the chiefs of the clinical departments of such hospitals and such hospitals' medical staff and peer review and credentialing committees), professional medical societies, credentialing and professional certification boards, state regulatory and licensing departments and agencies, the Federation of State Medical Boards, insurance companies (including professional liability insurance carriers), other professional monitoring entities, and present and past employers (collectively, the "Third Parties").

I understand that this information requested may include otherwise privileged or confidential information relative to my professional credentials and qualifications, including my claims history, quality and utilization data, clinical and/or professional competence, character, mental and/or physical condition, behavior, ethics, or any other matter bearing on the credentialing process. I hereby forever and irrevocably release and agree to hold harmless *Integrated Solutions Health Network/Southwest Virginia Health Network*, those Interested Entities to whom this information is given, and their affiliates, owners, representatives, employees and agents, from and against any and all liability for any damages, costs and expenses which may result from (A) the gathering, receipt, release, exchange, reliance upon or use of such information and/or the information contained in this credentialing application, as long as such gathering, receipt, release, exchange, reliance or use is done in good faith and without malice by *Integrated Solutions Health Network* and/or the Interested Entities; or (B) any decision, opinion, action or proceeding taken or rendered in connection with such information or the credentialing process by *Integrated Solutions Health Network* and/or the Interested Entities, as long as such decision, opinion, action or proceeding was taken or rendered in good faith and without malice.

I hereby authorize the above Third Parties to provide information requested by *Integrated Solutions Health Network* or any Interested Entities, including otherwise privileged or confidential information, relative to my professional credentials and qualifications, including my past and present malpractice coverage, claims and suit information, quality and utilization data, clinical and/or professional competence, character, mental and/or physical condition, behavior, ethics, or any other matter bearing on the credentialing process. I understand that this authorization is irrevocable for any period during which this application is outstanding or during which I am a member, participant or contracted provider with *Integrated Solutions Health Network* or any Interested Entity. I hereby forever and irrevocably release and agree to hold harmless all such Third Parties and their affiliates, owners, representatives, employees and agents from and against any and all liability for any damages which may result from providing this information or making its available, as long as such information is provided or made available in good faith and without malice. I agree that the releases and indemnifications provided in this Release are in addition to, and not in limitation of, any applicable immunities and privileges provided by law in connection with peer review or credentialing activities or otherwise.

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I agree that a photocopy or facsimile of this document with my signature may be accepted by any Third Party from which such information is sought, with the same authority as the original, and I specifically waive written notice from any such Third Party who may provide information based upon this authorized request.

I represent that the information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application by *Integrated Solutions Health Network* and/or any Interested Entity and may result in denial of my application or termination of my participation in, or of any contracts with, the Interested Entities. I further understand that any misrepresentation, misstatement or omission from this application, if discovered after staff privileges or network participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I further understand that *Integrated Solutions Health Network* shall immediately inform any entity, including any Interested Entity, to which it has provided information of the fact of such misrepresentation, misstatement or omission. I agree to inform *Integrated Solutions Health Network* in writing within 15 days if there is any change in the information provided or the answers to the disclosure questions on this application as a result of developments subsequent to my signing this application.

I understand that Mountain States Medical Group and Integrated Solutions Health Network are gathering, verifying and submitting information to those entities with whom I have, or wish to establish a contractual relationship as a network provider, staff provider or other provider of professional medical services. I hereby consent to information provided in this application to be shared within Mountain States Health Alliance as necessary in order to establish the relationships for which I have made application.

Name (Please print or type)	*Practitioner Signature (original required)* ***(Stamped Signatures are unacceptable)***	***Date***