Supplemental Provider Credentialing Application

Provider Name:

Part 1: Disclosure and Questions

Please answer all questions. **If all questions are not answered, your application will be delayed until the questionnaire is complete.** For any **Yes** response, please complete the **Affirmative Responses** section of this application.

Allied Health Providers: If you do not believe a question is applicable to you, answer **No**; do not leave any responses blank.

1. Has your license, registration, or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation, or any conditions or limitations by any state or professional licensing, registration, or certification board? ☐ Yes ☐ No
2. Has there been any challenge to your licensure, registration, or certification? ☐ Yes ☐ No
3. Have your clinical privileges or medical staff membership at any hospital or health care institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal, or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee, or governing board? ☐ Yes ☐ No
4. Have you voluntarily or involuntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation? ☐ Yes ☐ No
5. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations, including HMOs, PPOs, or provider organizations such as IPAs or PHOs? ☐ Yes ☐ No
6. Were you ever placed on probation, disciplined, formally reprimanded, suspended, or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended, or asked to resign? ☐ Yes ☐ No
7. Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No
8. Have any of your board certifications or eligibility ever been revoked? ☐ Yes ☐ No
9. Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ Yes ☐ No
10. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished? ☐ Yes ☐ No
11. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid programs, or in regard to other federal or state governmental health care plans or programs? ☐ Yes ☐ No
12. Are you currently the subject of an investigation by any hospital, licensing authority, DEA, or CDS authorizing entities, education, or training program, Medicare or Medicaid program, or any other private, federal, or state health program, or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse, a sexual offense, or sexual misconduct? ☐ Yes ☐ No

Provider Name:

		Yes	No
13.	Has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	☐ Yes	☐ No
14.	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agency (e.g., CLIA, OSHA, etc.)?	☐ Yes	☐ No
15.	Have you ever been convicted of, pleaded guilty to, pleaded nolo contendere to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the last 10 years for sexual harassment or other illegal misconduct?	☐ Yes	☐ No
16.	Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or health care facility of any military agency?	☐ Yes	☐ No
17.	Has your professional liability coverage ever been cancelled, restricted, declined, or not renewed by the carrier based on your individual liability history?	☐ Yes	☐ No
18.	Have you ever been assessed a surcharge or rated in a high-risk class for your specialty by your professional liability insurance carrier based on your individual liability history?	☐ Yes	☐ No
19.	Have you had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years? If ***yes***, provide information for each case in the **Professional Liability History** section of this application.	☐ Yes	☐ No
20.	Have you ever been convicted of, pleaded guilty to, or pleaded nolo contendere to any felony?	☐ Yes	☐ No
21.	In the past 10 years, have you been convicted of, pleaded guilty to, or pleaded nolo contendere to any misdemeanor (excluding minor traffic violations), or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse, a sexual offense, or sexual misconduct?	☐ Yes	☐ No
22.	Have you ever been court-martialed for actions related to your duties as a medical professional? Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or credentialing organization based upon all the relevant circumstances, including the nature of the crime.	☐ Yes	☐ No
23.	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of or within a matter of days or weeks before the date of application; rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. §812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)	☐ Yes	☐ No
24.	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	☐ Yes	☐ No
25.	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	☐ Yes	☐ No
26.	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation?	☐ Yes	☐ No

Provider Name:

Part 2: Professional Liability History

List all past or current professional liability claims or lawsuits which have been filed against you. Submit each claim/lawsuit separately.

Date of Occurrence	Date Claim(s) Filed	Professional Liability Carrier Involved

Patient Name	Age	Gender ☐ Male ☐ Female

Name of Claimant/Plantiff, of other than Patient	Your Role in the Claim/Lawsuit ☐ Primary Defendant ☐ Co-Defendant ☐ Other

Identify All Other Defendants

Describe the Allegations Against You

Explain in Detail Your Defenses to These Allegations

Describe the Alleged Injury to the Patient

Describe the Patient's Condition Post-Incident

Is the patient still living? ☐ Yes ☐ No Has the Claimant/Plantiff filed suit in court? ☐ Yes ☐ No

State Court Case Number	State	County/Parish	Federal Court (U.S. District Court) Case Number	District

Provider Name:

Present the status of the claim or case *(check all that apply)*:

- ☐ The case or claim is still pending.
- ☐ The verdict or judgment for the plaintiff was entered in the amount of $ ____________________.
- ☐ The portion of the verdict or judgment that was attributed to me was $ ____________________.
- ☐ The case or claim settled for $ ____________________.
- ☐ The portion of the settlement that was paid on my behalf was $ ____________________.
- ☐ Total amount of the settlement/judgment $ ____________________.
- ☐ The case was dismissed by the court.
- ☐ The claimant/plaintiff voluntarily withdrew the claim/lawsuit.
- ☐ The claim/lawsuit closed on (date) ____________________.

Identify your attorney for this claim/lawsuit:

Attorney's Name

Attorney's Firm

Address	City	State	Zip Code

With whom may we consult for further legal information about the suit?

Applicant Signature	Print Name	Date

Provider Name:

Part 3: Confidential Professional Information

Explanation for any **Affirmative Responses** from pages 1–2 *(please photocopy and attach additional sheets as necessary)*.

Question No.: ____________

Question No.: ____________

Question No.: ____________

Question No.: ____________

Question No.: ____________

Provider Name:

Part 4: Affirmation and Release.

All information submitted by me in this application is accurate and complete to the best of my knowledge and belief. I fully understand that any misleading statement or material omissions in this application may constitute cause for denial of my application or termination of my participation.

By applying for membership in MVP Health Plan Inc. (hereinafter collectively referred to as "MVP"), I hereby authorize MVP and its representatives to consult with administrators and members of medical staffs of hospitals, institutions, and professional associations with which I have been associated, and with others, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by MVP and its representatives of all documents that may be material to an evaluation of my professional qualifications and competence, as well as my moral and ethical qualifications for eligibility.

I hereby release from liability all representatives of MVP for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to MVP, in good faith and without malice, concerning my professional competence, ethics, character, and other qualifications for eligibility, and I hereby consent to the release and exchange of information relating to any disciplinary action, suspension, or curtailment of surgical/medical privileges to MVP.

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

MVP may share the information in the application for participation with the other MVP Health Care networks (MVP Select Care, MVP Services Corp, MVP Health Insurance Company).

A photocopy of this waiver shall be as effective as the original when so presented. This waiver shall remain valid unless revoked in writing.

I agree that I shall abide by the rules and regulations set forth in the bylaws and credentialing regulations, and any other regulations that may be adopted by MVP, concerning the conditions, criteria, and standards of participation in MVP.

By applying for membership with MVP, I am hereby notified that I have the right to the following:

1. To review the information obtained from any outside primary source that is presented to the credentials committee in support of my credentialing and/or recredentialing application. For example, malpractice insurance carriers, state licensing boards, and hospitals.

   Letters of reference and National Practitioner Data Bank (NPDB) documentation are not subject to this disclosure. (Note: Disclosure of NPDB documentation is a Federal violation.)

   a. Upon the MVP's receipt of a written, signed, and dated request by the applicant, MVP will release under confidential cover to the applicant by Certified Mail, Return Receipt Requested the information that is presented to the credentials committee in support of his/her credentialing/recredentialing application.
2. To correct erroneous information submitted by another party.
   a. The applicant may submit corrections to MVP within fifteen (15) days of the day in which he/she first becomes aware of the problem. Changes must be submitted in writing, signed, and dated by the practitioner, and addressed to the Plan or delegate. MVP will document receipt of the corrections in correlation with the specified section(s) of the practitioner's application. All such correspondence will be presented to the credentials committee.
3. MVP will notify the practitioner of any information obtained during the credentialing and/or recredentialing process that varies substantially from the information provided to MVP by the practitioner. The applicant will have fifteen (15) days from notification to clarify and/or correct these discrepancies.
4. To be informed of the status of my credentialing or recredentialing application. MVP, upon verbal or written request from the applicant directly, will notify the applicant of the status of their application.

Applicant Signature *(Signature stamp is not acceptable)* Print Name Date

Return this completed form to providerenrollment@mvphealthcare.com.