Medica LOCUM TENENS CREDENTIALING APPLICATION

Credentialing Contact Information

Name_____Phone_____
Email_____Fax_____
Return signed forms to
Credentialing_Apps@medica.com
or
Credentialing Department CP412
Medica
PO Box 9310, Minneapolis MN 55440-9310

Practitioner Information

Last_____First_____MI____ Degree_____

Social Security Number_____Date of Birth _____Gender_____

NPI Number _____ CAQH ID _____ Medicare Number_____

Race and/or ethnicity: (The following information is optional and may be used in provider directories to help members make informed choices and/or to help ensure that our network of providers is adequate to meet the needs of our members.)

Check here if you do not wish for your race and/or ethnicity to be displayed in provider directories: ☐

Select one or more Categories

☐American Indian or Alaska Native
☐Asian
☐Black or African American
☐Native Hawaiian or Other Pacific Islander
☐White
☐Other_____
☐Hispanic or Latino
☐Prefer not to say

Languages Spoken_____

Medical School Institution, City & State_____City_____State_____

Graduated Month_____Year_____

Residency Specialty_____

Institution Name_____City_____State_____

Dates Attended: From _____To _____

Fellowship Specialty_____

Institution Name_____City_____State_____

Dates Attended: From _____To _____

Medical License State_____Number_____Expiration Date_____

DEA Registration State_____Number_____Expiration Date_____

(Enclose a copy of current DEA registration)

Hospital Admitting Privileges, if applicable, or describe plan for continuity of care _____

Hospital Name_____City_____State_____

Liability Insurance (*Enclose a copy of current professional liability policy covering practitioner at this location)*

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Primary Practice Location

Clinic Name_____

Street Address_____

City_____ State_____ Zip_____

Clinic NPI_____ Fed ID _____

Start Date_____ End Date_____

Specialty / Subspecialty in which care will be provided_____

Directory Suppress? ☐Yes ☐No Accepting New Patients? ☐Yes ☐No

Primary Care Practitioner? ☐Yes ☐No Sees Patients at least once per week? ☐Yes ☐No

Do you offer Telehealth at this location? ☐Yes ☐No

Telehealth Type (if Telehealth is offered)

☐ Telehealth Only ☐ Telehealth and In person

Telehealth Modalities

☐ Phone ☐ Chat ☐ Video

Alternate Practice Location *(if more than two locations copy this page and attach)*

Clinic Name_____

Street Address_____

City_____ State_____ Zip_____

Clinic NPI_____ Fed ID _____

Start Date_____ End Date_____

Specialty / Subspecialty in which care will be provided_____

Directory Suppress? ☐Yes ☐No Accepting New Patients? ☐Yes ☐No

Primary Care Practitioner? ☐Yes ☐No Sees Patients at least once per week? ☐Yes ☐No

Do you offer Telehealth at this location? ☐Yes ☐No

Telehealth Type (if Telehealth is offered)

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Please provide a complete, signed and dated explanation on a separate sheet if the answer to any of the following questions is "yes"

1. ☐ Yes ☐ No Do you have a condition that would affect your ability, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice without posing a significant health or safety risk to your patients?

2. ☐ Yes ☐ No In the past five (5) years, have you been involuntarily terminated from professional employment or a hospital medical staff or resigned from professional employment or a hospital medical staff after knowledge of an investigation into your conduct, or in lieu of disciplinary action?

3. ☐ Yes ☐ No Has your certificate or participation in any **private, federal (i.e. Medicare, Medicaid, etc.) or state health insurance program** ever been revoked or otherwise limited or restricted, or is any investigation or proceeding with respect to any such action presently underway?

4. ☐ Yes ☐ No Have you ever been found liable, guilty or responsible for **sexual impropriety** or misconduct or sexual harassment \with a patient, co-worker, or other?

5. ☐ Yes ☐ No In the past five (5) years, have you had any **professional liability claims or lawsuits** brought against you**,** including pending claims or lawsuits, dismissed or dropped claims or lawsuits, settlements or final judgments? **If yes, please complete the enclosed Malpractice Litigation and Professional Complaints Addendum.**

6. ☐ Yes ☐ No Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions in your area of practice without posing a health risk to your patients? If yes, what accommodations would help you provide appropriate care to patients and perform other essential functions?

7. ☐ Yes ☐ No Are you currently using illegal 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. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. sec. 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.)

8. ☐ Yes ☐ No Are there any **charges pending or are you currently charged** with or have you ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense?

9. ☐ Yes ☐ No Have you ever been reprimanded, censored, or otherwise disciplined by, or have you ever been subject to a corrective action agreement/plan with any licensing **board, peer review organization, third party payer, clinic, hospital, medical staff, or any health-related agency or organization?**

Notice of Applicant's Rights

You may review your application and information from publicly available documents at any time during the verification process. This does not include documents protected by hospital policy and/or applicable Minnesota state laws. If there are discrepancies in the information received during the process, you will be notified and allowed an opportunity to add information to your application.

Attestation Signature and Date

I hereby certify that all the information on this application form is complete, true and accurate. I further agree to update this information as necessary so that it remains complete, true and accurate while my application is being processed.

Signature _____Date _____

Name _____

(please print or type)

Authorization and Release

(Please read carefully before signing)

I understand and acknowledge that, as an applicant for membership, participation and/or clinical privileges (hereinafter, referred to as "Participation") at MEDICA HEALTH PLANS AND ITS ENTITIES (hereafter referred to as Entity), it is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character, ethics and any other criteria adopted by the Entity for Participation.

I further acknowledge that I am responsible for knowing the contents of the applicable bylaws, rules and regulations, and requirements of the Entity and its professional/medical staff/network, and agree to be bound by them in the application process and if granted Participation.

I further understand and acknowledge that the Entity, its designated agent(s) and/or other authorized representatives, including, without limitation, the Entity's designated professional credentials verification organization (CVO), collectively referred to as "Agents", will investigate the information in this Application. By submitting this Application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Entity and its Agents as follows:

1. **Authorization of Investigation and Release of Information Concerning Application for Participation.** I authorize the Entity and its Agents to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation and authorize such third parties to release such information to the Entity and its Agents.

2. **Authorization of Release and Exchange of Disciplinary Information.** I hereby further authorize any health care organization at which I have applied for, currently have or had Participation or employment to release Disciplinary Information about any disciplinary action taken against me to the Entity and/or its Agents, including, without limitation, the CVO, and as otherwise may be required by law. I hereby further authorize the CVO to release Disciplinary Information about any disciplinary action taken against me to its participating entities at which I have Participation, and as otherwise may be required by law. As used herein, Disciplinary Information means information concerning (i) any action taken by such health care organizations, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition my Participation or impose a corrective action plan; (ii) any other disciplinary actions involving me including but not limited to discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges but after I have knowledge that such formal charges are contemplated and/or in preparation.

3. **Release from Liability**. I hereby further release from liability the Entity and its Agents, state licensing board(s), health care organizations, including, without limitation, hospitals, clinics, and third party payers, medical malpractice insurance carrier(s), and any staff, and all individuals, institutions and entities providing information in accordance with this authorization, for their acts performed in good faith and without malice in connection with the gathering and release and exchange of information as consented to above. This release shall be in addition to any other applicable immunities provided by law for peer review activities.

I understand that communication regarding my application may occur via e-mail.

I understand and agree that this Authorization and Release is irrevocable for any period during which I am an applicant for Participation at the Entity, or I am a member of Entity's medical or health care staff, or a participating provider of the Entity. I agree to execute another consent if law or regulation limits the application of this irrevocable authorization. Failure to promptly provide another consent may be grounds for termination or discipline of the Participant by the Entity in accordance with the applicable bylaws, rules and regulations, and requirements of the Entity.

I acknowledge that the investigation of information in this Application and the release and exchange of Disciplinary Information by the Entity and its Agents are done to achieve, maintain and improve quality patient care.

All information provided by me in the Application is true to the best of my knowledge and belief. I understand and agree that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of Participation. I understand and acknowledge that the Entity shall be solely responsible for all decisions concerning the granting of Participation.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original.

Signature_____ Date _____

Name (please print or type)_____