vivanthealth

CONFIDENTIAL/PROPRIETARY

California Participating Physician Application

This application is submitted to Vivant Health, herein, this Healthcare Organization.[1]

I. INSTRUCTIONS

If more space is needed than provided on this application, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Personal email addresses and phone numbers will not be used for any purpose other than contact between Vivant Health and the provider. Current copies of the following documents must be submitted with the application:

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

II. CASE INFORMATION

Last name:	First:	Middle:
Is there any other name under which you have been known? Name(s):		
Home mailing street address:	City:	
	State:	ZIP code:
Home telephone number:	Email address (mandatory):	
Home fax number:	Pager/cell phone number (mandatory):	
Birthdate:	Citizenship (if not a United States citizen, please include copy of alien registration card):	
Birthplace (city/state/country):		
Social Security #:	Gender:[2] ☐ Male ☐ Female	Race/ethnicity (voluntary):
Driver's license state/ number:		
Your intent is to serve as a(n): ☐ Primary care provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital based		
Specialty:		
Subspecialties:		

III. PRACTICE INFORMATION

Practice name (if applicable):	Department name (if hospital based):
Primary office street address:	City:

[1]As used in the Information Release/Acknowledgements 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.

Physician name: _____

Website (if applicable):	State:	ZIP code:
Telephone number:	Fax number:	
Office manager/administrator:	Telephone number:	
Email address:	Fax number:	
Name affiliated with tax ID number:	Federal tax ID number: ☐ Same as above:	
Type of practice (check all that apply): ☐ Solo practice ☐ Group practice ☐ Single-specialty group ☐ Multispecialty group	Group NPI #:	
Primary office hours of operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	Group medicare PTAN/UPIN #:	
Languages spoken by provider:	Languages spoken by staff:	
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None		

Secondary office street address:	City:	
	State:	ZIP code:
Telephone number:	Fax number:	
Office manager/administrator:	Telephone number:	
Email address:	Fax number:	
Name affiliated with tax ID number:	Federal tax ID number: ☐ same as above	
Type of practice (check all that apply): ☐ Solo practice ☐ Group practice ☐ Single-specialty group ☐ Multispecialty group	Group NPI #:	
Secondary office hours of operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	Group medicare PTAN/UPIN #:	
Languages spoken by provider:	Languages spoken by staff:	
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None		

Physician name: _____

Tertiary office street address:	City:	
	State:	ZIP code:
Telephone number:	Fax number:	
Office manager/administrator:	Telephone number:	
Email address:	Fax number:	
Name affiliated with tax ID number:	Federal tax ID number: ☐ Same as above	
Type of practice (check all that apply): ☐ Solo practice ☐ Group practice ☐ Single-specialty group ☐ Multispecialty group	Group NPI #:	
Tertiary Office Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	Group medicare PTAN/UPIN #:	
Languages spoken by provider:	Languages spoken by staff:	
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐ None		

Mailing Address

Which of your practices is your primary mailing address? ☐ Primary ☐ Secondary ☐ Other	If your mailing address is different from your practice address, please provide:

IV. BILLING INFORMATION

Which of your practices handles your billing?
☐ Primary ☐ Secondary ☐ Tertiary (If none, please provide billing information)

Billing company:	Contact person:	
	Telephone number:	
Mailing address:	City:	
	State:	ZIP code:
Federal tax ID number:	Name associated with tax ID:	

V. PRACTICE DESCRIPTION

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

Name:	Type of provider:	License #:
Name:	Type of provider:	License #:
Name:	Type of provider:	License #:
Physician assistant supervisor name:		License #:

Do you personally employ any physicians (do not include physicians who are employed by the medical group)?
If so, please list: ☐ Yes ☐ No

Name:	Cal. medical license #:	☐ Primary ☐ Secondary ☐ Tertiary
Name:	Cal. medical license #:	☐ Primary ☐ Secondary ☐ Tertiary
Name:	Cal. medical license #:	☐ Primary ☐ Secondary ☐ Tertiary
Name:	Cal. medical license #:	☐ Primary ☐ Secondary ☐ Tertiary

Below, please list any clinical services you perform that are not typically associated with your specialty:

Services:	Which office does this apply to? ☐ Primary ☐ Secondary ☐ Tertiary

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

Services:	Which office does this apply to? ☐ Primary ☐ Secondary ☐ Tertiary
Is your practice limited to certain ages? ☐ Yes ☐ No If yes, please specify limitation:	Which office does this apply to? ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of practice: List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering service company:		
Mailing address:	City:	
	State:	ZIP code:
Covering physician's name:		Telephone #:
Covering physician's name:		Telephone #:
Covering physician's name:		Telephone #:

Physician name: _____

VI. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Please reference this section number and title.)

College or university name:	Degree received:	Date of graduation: (mm/yy)
Mailing address:	City:	
	State:	ZIP code:
Website (if applicable):	Registrar's phone number:	

VII. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Please reference this section number and title.)

Medical/professional school:	Degree received:	Date of graduation: (mm/yy)
Mailing address:	City:	
	State:	ZIP code:
Website:	Telephone number:	Fax:
Medical/professional school:	Degree received:	Date of graduation: (mm/yy)
Mailing address:	City:	
	State:	ZIP code:
Website:	Telephone number:	Fax:

VIII. INTERNSHIP/PGY-1 (Attach additional sheets if necessary. Please reference this section number and title.)

Institution:	Program director:		
Mailing address:	City:		
	State:	ZIP code:	
Website:	Telephone number:	Fax:	
Type of training:	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain; attach additional sheets if necessary.)			

IX. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Please reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education completed in chronological order, giving name, address, city and ZIP code, and dates. Include all programs you have attended, whether or not completed.

Institution:		Program director:	
Mailing address:	City:		
	State:	ZIP code:	
Website:	Telephone number:	Fax:	
Type of training (e.g., residency, fellowship, etc.):	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain; attach additional sheets if necessary.)			

Institution:		Program director:	
Mailing address:	City:		
	State:	ZIP code:	
Website:	Telephone number:	Fax:	
Type of training (e.g., residency, fellowship, etc.):	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain; attach additional sheets if necessary.)			

Institution:		Program director:	
Mailing address:	City:		
	State:	ZIP code:	
Website:	Telephone number:	Fax:	
Type of training (e.g., residency, fellowship, etc.):	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain; attach additional sheets if necessary.)			

Physician name: ______________________________

Institution:		Program director:	
Mailing address:	City:		
	State:	ZIP code:	
Website:	Telephone number:	Fax:	
Type of training (e.g., residency, fellowship, etc.):	Specialty:	From (mm/yy):	To (mm/yy):
Did you successfully complete the program? ☐ Yes ☐ No (If "No," please explain; attach additional sheets if necessary.)			

X. MEDICAL LICENSURE/REGISTRATION. Please attach copies of documents.

California medical license:	Issue date:	Expiration date:
Drug Enforcement Administration (DEA):	Schedules:	Expiration date:
Controlled Dangerous Substances certificate (CDS) (if applicable):		Expiration date:
Educational Commission for Foreign Medical Graduates (ECFMG) number:	Issue date:	Valid through:
Medicare UPIN/ PTAN:	Medi-Cal number:	
National Physician Identifier (NPI):		

XI. ALL OTHER STATE MEDICAL LICENSES. List all medical licenses now or previously held. (Attach additional sheets if necessary. Please reference this section number and title.)

State:	License number:	Expiration date:
State:	License number:	Expiration date:
State:	License number:	Expiration date:

XII. OTHER CERTIFICATIONS (e.g. FLUOROSCOPY, RADIOGRAPHY, ETC.) Please attach copies of documents.

Type:	Number:	Expiration date:
Type:	Number:	Expiration date:

XIII. BOARD CERTIFICATION

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
- A 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 yes, list board(s) and date(s):

If not certified, please choose from the below options and describe your intent for certification, if any, and date of eligibility for certification below or on separate sheet.

☐ I have never sought board certification ☐ I have unsuccessfully attempted board certification

☐ I am board certified in an area other than the specialty for which i am seeking credentials (please specify)

Specialty:	Board name:	Exam date:

Describe here:

IX. 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. If you do not have hospital privileges, please explain. If more space is needed, attach additional sheet(s).

A. CURRENT AFFILIATIONS

Name and address of primary admitting hospital:	City:	
	State:	ZIP code:

Department:	Status (active, provisional, courtesy):	Appointment date (mm/yy):

Medical staff phone:	Medical staff fax:

Name and address of primary admitting hospital:	City:	
	State:	ZIP code:
Department:	Status (active, provisional, courtesy):	Appointment date (mm/yy):
Medical staff phone:	Medical staff fax:	
If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):		

B. PREVIOUS AFFILIATIONS DURING LAST TEN YEARS

Name and address of primary admitting hospital:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Reason for leaving:	
Name and address of primary admitting hospital:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Reason for leaving:	
Name and address of primary admitting hospital:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Reason for leaving:	
Name and address of primary admitting hospital:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Reason for leaving:	
Name and address of primary admitting hospital:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Reason for leaving:	

Physician name: ____

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Admitting Hospital Coverage Agreement

I, _____ , agree to provide admission and/or
(Print physician name providing admissions)

hospital coverage for _____ in the event that
(Print physician name without hospital privileges)

his or her Vivant Health patient(s) require admission and care at a participating Vivant Health hospital. I further state that I have been credentialed by Vivant Health to provide this care.

_____ _____
Date Signature of physician providing coverage

List all hospital affiliations below:

_____
Name of hospital

_____
Name of hospital

_____
Name of hospital

If more than one physician will be providing admitting and hospital coverage, a form for each must be submitted. Photocopy this page as needed.

XV. 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 clinical abilities, either via direct observation or through close working relations.

Name of reference:	Specialty:	Telephone number:	
		Fax number:	
Mailing address:		City:	
		State:	ZIP code:
Name of reference:	Specialty:	Telephone number:	
		Fax number:	
Mailing address:		City:	
		State:	ZIP code:
Name of reference:	Specialty:	Telephone number:	
		Fax number:	
Mailing address:		City:	
		State:	ZIP code:

XVI. WORK HISTORY

Chronologically list all work activities within the last five years (use extra sheets if necessary). This information must be complete. Curriculum vitae are sufficient provided it is current and contains all information requested below. **Please explain any gaps six months or more in professional work history.**

Current practice:	Contact name:	Telephone number:	
		Fax number:	
Mailing street address:		City:	
		State:	ZIP code:

From (mm/yy):	To (mm/yy):	Please explain any gaps between this and previous employment:

Previous practice/employer	Contact name:	Telephone number:	
		Fax number:	
Mailing street address:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Please explain any gaps between this and previous employment:	
Previous practice/employer	Contact name:	Telephone number:	
		Fax number:	
Mailing street address:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Please explain any gaps between this and previous employment:	
Previous practice/employer	Contact name:	Telephone number:	
		Fax number:	
Mailing street address:		City:	
		State:	ZIP code:
From (mm/yy):	To (mm/yy):	Please explain any gaps between this and previous employment:	

XVII. PROFESSIONAL LIABILITY. Please attach copies of professional liability policy or certification face sheet.

Current insurance carrier:	Policy number:	Effective date:
Mailing street address:	City:	
	State:	ZIP code:
Per claim amount: $	Aggregate amount: $	Expiration date:
Tail coverage: ☐ Yes ☐ No	Email:	Website (if applicable):

Please explain any surcharges/restrictions to your professional liability coverage (attach additional pages if necessary):			
Please list all of your professional liability carriers within the past 7 years, other than the one listed above.			
Name of carrier:	Policy No.:	From (mm/yy):	To (mm/yy):
Mailing street address:	City:		
	State:	ZIP code:	
Tail coverage: ☐ Yes ☐ No	Email:	Website (if applicable):	
Name of carrier:	Policy No.:	From (mm/yy):	To (mm/yy):
Mailing street address:	City:		
	State:	ZIP code:	
Tail coverage: ☐ Yes ☐ No	Email:	Website (if applicable):	

XVIII. PROFESSIONAL AND PRACTICE SERVICES

Are you a certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ Yes ☐ No

What type of anesthesia do you provide in your group/office? ☐ Local ☐ Regional ☐ Conscious sedation ☐ General ☐ None ☐ Other (Please specify)

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.

Do you have a CLIA certificate? ☐ Yes ☐ No	Do you have a CLIA waiver? ☐ Yes ☐ No
Certificate number:	Certificate expiration date:

Have you or your office received any of the following accreditations, certificates, or licensures?

- ☐ Medicare Certification
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ Child Health and Disability Prevention (CHDP)
- ☐ Other (please list)
- ☐ The Medical Quality Commission (TMQC)
- ☐ Family Planning
- ☐ California Children Services (CCS)

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

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

Are you a CHAMPUS provider?	☐ Yes ☐ No
Are you a veteran or reservist?	☐ Veteran ☐ Reservist ☐ N/A
Please list your affiliations with other healthcare entities (IPAs, health plans, etc.). ☐ Health Net ☐ Blue Cross ☐ EHS ☐ Hills ☐ Molina ☐ Other (please list below):	

Form Submitting (Please complete the following)	**This application and addenda were created and endorsed by:**
• Attestation Questions • Information Release/Acknowledgments • HIV Specialist Verification Form • Admitting Hospital Coverage Agreement	• American Medical Association - (310/430-1191 x223) • California Association of Health Plans - (916/552-2910) • California Healthcare Associations - (916/552-7574) • California Medical Association - (415/882-5166) • National IPA Coalition - (510/267-1999) • The Medical Quality Commission - (310/936-1100 x 230) • Industry Collaboration Effort (ICE)

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

The following addenda are required:

Addendum A – Professional Liability Action Explanation

Addendum B – Practitioner's Rights

Addendum C – Primary Care Experience Attestation (PCP only)

For more information on these requirements, please contact the Credentialing Department at **(916) 228-4300, ext. 2317**.

Physician name: _____

ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through S is "yes" or if your answer to T is "no," please provide full details on reverse or on a 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. Have you ever been denied certification/recertification by a specialty board?	☐ Yes ☐ No
G. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?	☐ Yes ☐ No
H. 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
I. 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 certify)?	☐ Yes ☐ No
J. Have you ever been convicted of or plead guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on a deferred adjunction or probation for a criminal offense (other than a minor traffic violation)?	☐ Yes ☐ No
K. Are any such actions pending?	☐ Yes ☐ No

Physician name: _____

Please answer the following questions "yes" or "no." If your answer to questions A through S is "yes" or if your answer to T is "no," please provide full details on reverse or on a separate sheet.	
L. Do you presently use any drugs illegally?	☐ Yes ☐ No
M. Do you have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice or unable to perform those essential functions without a direct threat to the health and safety of others? **If YES, please describe any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise.**	☐ Yes ☐ No
N. Have any judgments been entered against you or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/ arbitrations against you pending?	☐ Yes ☐ No
O. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? **If YES, please complete addendum A.**	☐ Yes ☐ No
P. 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
Q. Within the last five **(5)** years, has your membership, privileges, participation, or affiliation with any healthcare organization (e.g., a hospital or HMO) been terminated, suspended, or restricted, or have you taken a leave of absence from a healthcare organization for reasons related to the abuse of, or dependency on, alcohol or drugs?	☐ Yes ☐ No
R. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center), or an academic institution? If YES, have you, in the past seven **(7)** years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)?	☐ Yes ☐ No ☐ Yes ☐ No
S. Is your ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs?	☐ Yes ☐ No
T. 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, 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 physician participation agreement.

Print name here: _____

_____ _____

Physician's signature
(Stamped signature is not acceptable)

Date
(Not acceptable if not dated)

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 business and individuals acting as their agents [collectively, "Healthcare Organizations"]) for the purpose of evaluating this reapplication and any credentialing 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 800-809 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 taken or pending 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 taken against me by any Healthcare Organization that 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 reapplication 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 reapplication or termination of my privileges, employment or participation agreement with the Healthcare Organization. A photocopy of this document shall be as effective as the original.

Print name here: _____

_____ _____

Physician's signature
(Stamped signature is not acceptable)

Date
(Not acceptable if not dated)

[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.

California Participating Physician Application

Addendum A

Professional Liability Action Explanation

This addendum is submitted to Vivant Health, herein this Healthcare Organization

Please check here if there is no pending/settled claim to report: ☐

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 in the past five (5) years, whether the lawsuit or arbitration is pending, settled, or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum A prior to completing and complete a separate form for each lawsuit.

I. PRACTITIONER IDENTIFYING INFORMATION

Last name:	First:	Middle:

II. CASE INFORMATION

Patient's name:	Sex of patient:	Age of patient:
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:

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:	Telephone:	Fax:
Name:	Telephone:	Fax:

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 ☐ Judgment rendered, and I was found not liable. ☐ Lawsuit/arbitration settled, and payment made on my behalf. ☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.	Amount paid on my behalf: Amount paid on my behalf:	Date paid: Date paid:

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 LEGIBLY.

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's signature
(Stamped signature is not acceptable)

Date
(Not acceptable if not dated)

California Participating Physician Application

Addendum B

Practitioner Rights

I. RIGHT OF REVIEW

As an applicant for credentialing/recredentialing, you have the right to review information obtained by IPA for the purpose of evaluating your credentialing or recredentialing application. This includes nonprivileged 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. You may request to review such information at any time by sending a written request via fax or letter to the Credentialing Director at P.O. Box 869145, Plano, TX 75086; fax number (916) 228-4310. The Credentialing Director, or designee, will notify you within 72 hours of the date and time when such information will be available at the IPA Credentialing Department located in Sacramento, California.

II. RIGHT, UPON REQUEST, TO BE INFORMED OF STATUS OF CREDENTIALING/RECREDENTIALING APPLICATION

You have the right to be informed, upon request, of the status of your credentialing and/or recredentialing application. You may request such information by sending a written request via fax or letter to the Credentialing Manager at the above cited address/fax number. You will be notified in writing and within no more than ten (10) working days of receiving your fax or letter, by return fax or letter, of the current status of your application with respect to outstanding information required to complete the application process.

III. NOTIFICATION OF DISCREPANCY

Practitioners will be notified 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/certification, suspension or termination of hospital privileges, or board certification expiration when one or more of these examples have **not** been reported by the practitioner on his/her application. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

IV. CORRECTION OF ERRONEOUS INFORMATION

If a practitioner believes that erroneous information has been supplied to IPA by primary sources, the practitioner may correct such information by submitting written notification to the Director of Medical Services. Practitioners must submit a written notice (via fax or letter) along with a detailed explanation to the Director of Medical Services at P.O. Box 869145, Plano, TX 75086; fax number (916) 228-4310. Notification to IPA must occur within 48 hours of IPA notification to the practitioner of a discrepancy as provided in Section III or within 24 hours of a practitioner's review of his/her credential file as provided in Section II.

Upon receipt of notification from the practitioner, IPA will reverify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credential file. If, upon rereview, primary source information remains inconsistent with practitioner's notification, the Director of Medical Services will so notify the practitioner via fax or letter. The practitioner may then provide proof of correction by the primary source body to IPA Director, Network Contracts & Credentialing, via fax or letter at the address above within ten (10) working days. The Director of Medical Services will reverify primary source information if such documentation is provided. If, after ten (10) working days, primary source information remains in dispute, the practitioner will be subject to adverse action, up to administrative denial/termination.

Print name here: _____

_____ _____

Physician's signature
(Stamped signature is not acceptable)

Date
(Not acceptable if not dated)

California Participating Physician Application

Addendum C

Primary Care Experience Attestation (Required by PCPs Only)

This addendum is submitted to Vivant Health.

***To be completed by general practice and OB/GYN providers. Please note that if you would like to provide services to children under the age of 21, you must provide a copy of your CHDP certificate.**

Please indicate below the age of the patients for whom you have provided primary care services to in the last 5 years. For a category to apply, it must represent at least 20% of your average practice, and you must be familiar with and routinely follow standard preventive services, such as CHDP (for pediatrics only) and United States Preventive Task Force (USPTF). Please check all those that apply:

An OB/GYN requesting PCP status must have completed at least one year of stateside primary care medicine training and attest to practicing primary care medicine for the last five (5) years. Professional liability insurance must cover primary care as well as OB/GYN. The practitioner should also have primary care admitting privileges and/or appropriate continuity of care. OB/GYN must not limit member care as related to **sex and gender.**

- ☐ Adults (18 years of age and older)
- ☐ Pediatrics (0 to 21 years of age)
- ☐ If you desire age limitations different from above, please specify:

_____

I attest to the fact that all 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 the IPA.

Print name here: _____

_____ _____

Physician's signature
(Stamped signature is not acceptable)

Date
(Not acceptable if not dated)

Verification of Qualifications For HIV/AIDS Physician Specialist

Pursuant to California Standing Referral law, AB 2168, effective July 1, 2002, health plans and manage care organizations require verification of criteria for identification as a specialist in HIV/AIDS. To become a credentialed HIV specialist, a physician must meet defined criteria.

Please check here if you do not wish to be identified as an HIV specialist: ☐

Please check <u>any and all</u> of the criteria listed below that apply to you.

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine (attached AAHIVM verification); or

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☐ I am board certified in HIV medicine or have earned a Certificate of Added Qualification in the field of HIV medicine granted by a member board of the American Board of Medical Specialists; OR

☐ I am board certified in the specialty of infectious disease, and I meet the following qualifications:

☐ In the immediately preceding **12** months, I have provided continuous and direct medical care to a minimum of **25** patients who are infected with HIV; and

In the immediately preceding **12** months, I have successfully completed a minimum of **15** hours of category 1 continuing medical education (CME) in the prevention and diagnosis of treatment of HIV-infected patients, including a minimum of **5** hours related to antiretroviral therapy per year (attach copies of CME credits); or

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☐ In the immediately preceding 24 months, I have provided direct medical care to a minimum of 20 patients who are infected with HIV;
And
In the immediately preceding **12** months, I have completed any of the following (check all that apply):

- ☐ I have obtained board certification or recertification in the specialty of infectious disease; **or**
- ☐ I have successfully completed a minimum of **30** hours of category 1 CME in <u>the prevention and diagnosis or treatment</u> of HIV-infected patients (attach copies of CME credits); **or**
- ☐ I have successfully completed a minimum of **15** hours of category 1 CME in the <u>prevention and diagnosis or treatment</u> of HIV-infected patients, **and** I have successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine (attach copies of CME credits and exam verification).

Name of practitioner (please print) _____

License No./specialty _____

Office address: _____

Office telephone: _____

Office fax: _____

Signature _____

Date signed _____

Mail to: Credentialing Dept.
PO Box 15470
Sacramento, CA 95851-0470

Physician name: _____