CONFIDENTIAL/PROPRIETARY

Midlevel Practitioner Application

This application is submitted to: **River City Medical Group**, herein, this Healthcare Organization[1].

I. INSTRUCTIONS

This form should be typed. 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. **Current copies of the following documents must be submitted with the application:**

- State Medical License(s)
- DEA Certificate
- Curriculum Viate
- Face Sheet of Professional Liability Certification
- Delineation of Supervising Physician Responsibility
- Delegation of Service Agreement between Supervising Physician

II. IDENTIFYING 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:
Pager/Cell Number:	E-Mail Address:	
Birthdate:	Birthplace (City/State/Country):	

Social Security #:	Gender[2]: ☐ Male ☐ Female	Race/Ethnicity: (Voluntary)
Provider Type [PA, NP, FNP, CRNA, etc.]:		

III. PRACTICE INFORMATION

Supervising Physician Name(s):		
Practice Name (if applicable):		
Primary Office Street Address:	City:	
	State:	Zip:
Telephone Number:	County:	
Fax Number:	Send Authorization to Fax Number:	
Office Manager/Credentialer's Name:	Telephone Number:	
Email Address:	Federal Tax ID Number:	
Type of Practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Single Specialty Group ☐ Multi Specialty Group ☐ FQHC/RHC/IHS	Group NPI #:	

[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.

Primary Office Hours of Operation: Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	Group Medicare PTAN/UPIN #:
Languages Spoken by Provider:	Languages Spoken by Staff:

Secondary Office Street Address:	City:	
	State:	Zip:
Telephone Number:	Fax Number:	
Office Manager/Credentialer's Name:	Authorization Fax to Number:	
Email Address:	Telephone 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 ☐ Multi Specialty Group ☐ FHQC/RHC/IHS	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:	

Tertiary Office Street Address:	City:	
	State:	Zip:
Telephone Number:	Fax Number:	
Office Manager/Credentialing Specialist Name::	Authorization Fax to Number:	
Email Address:	Telephone 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 ☐ Multi Specialty Group ☐ FHQC/RHC/IHS	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:	

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:

Midlevel Name: ____

V. 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:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	Zip:

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

California Medical License:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA):		Expiration Date:
Educational Commission for Foreign Medical Graduates (ECFMG) Number :		Issue Date:
National Physician Identifier (NPI):		

VII. 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:

VIII. BOARD CERTIFICATION

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):

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:
Department:	Status(active, provisional, courtesy):	Appointment Date (mm/yy):
If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):		

ADMITTING HOSPITAL
COVERAGE AGREEMENT

I, ____________________________________, agree to provide admission and/or
(Print Physician Name Providing Admissions)

Hospital coverage for ____ in the event that
(Print Midlevel Name without Hospital Privileges)

his or her RCMG patient(s) require admission and care at a participating River City Medical Group hospital. I further state that I have been credentialed by RCMG 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.

(Hospital coverage agreement)

X. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

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

Name of Reference:	Specialty:	Telephone Number:
		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:

XI. 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 6 months or more in professional work history.**

Current Practice:	Contact Name:	Telephone Number:
		Fax Number:

Mailing Street Address:	City:	
	State:	Zip:

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:

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

XII. 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:
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:
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 years, other than the one listed above. (Attach additional sheets if necessary)

Name of Carrier:	Policy No.:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City:		
	State:	Zip:	

Name of Carrier:	Policy No.:	From (mm/yy):	To (mm/yy):
Mailing Street Address:	City:		
	State:	Zip:	

XIII. SUPPLEMENTAL PRATICE INFORMATION

Are you a participating provider of any of these program?

☐ Comprehensive Perinatal Services Program (CPSP)
☐ Child Health and Disability Prevention (CHDP)
☐ California Children Services (CCS)

Are you a CHAMPUS provider? Yes ☐ No ☐

Are you a veteran or reservist? Veteran ☐ Reservist ☐ N/A ☐

Please list your affiliations with other health care entities (IPAs, health plans)

Midlevel Name: ______________________________

Form Submitting (Please complete the following)	*This Application and Addenda A were created and are endorsed by:*
• Admitting Hospital Coverage Agreement (page 4 of 16) • Attestation Questions (pages 9 of 16 & 10 of 16) • Information Release/Acknowledgments (page 11 of 16) • Agreement by supervising physician (page 12 of 16)	• 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 health care organization from which it was provided.

The following additional addenda are also required:

Addendum A – Professional Liability Action Explanation

Addendum B – Practitioner's Rights

Addendum C – Age Range

For more information on these requirements, please contact the Credentialing Department at 916-228-4300 ext. 2704.

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 and 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
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 (page 13 of 16 & page 14 of 16)	☐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	☐Yes ☐No

Midlevel Name: ___________________________

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?	
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 health care 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 an 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: ____

Provider's Signature: ______________________________ **Date:** ________________
(Stamped signature is not acceptable) (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 which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, non-renewal 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; however, current dates are required on pages 11, 12,14,15, and 16.

Print Name Here ____

Provider's Signature: ____________________________________ **Date:** ________________
(Stamped Signature Is Not Acceptable) (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.

Midlevel Name: ______________________________

Midlevel Practitioner Application

STATEMENT OF AGREEMENT BY SUPERVISING PHYSICIAN

Name: ______________________________ **Employed as:** ______________________
Midlevel Practitioner

Name: ______________________________ **License #:** ______________________
Supervising Provider Supervising Provider

I, ________________________, M.D./D.O./D.D.S., supervising Practitioner for the above named Non-Physician Medical Practitioner (hereinafter referred to as NPMP), do hereby make the following statements of agreement in accordance with the policies/procedures regulating the NPMP program:

1. I hereby accept full legal and ethical responsibility for the performance of all duties and acts performed by the above named NPMP whom I have agreed to supervise.

2. I hereby request approval to allow above named NPMP to perform, outside my immediate supervision, the specific activities and duties.

3. I agree to immediately notify our organization's director who will then relay my notification to River City Medical Group, in writing, in the event my approval to supervise an NPMP is removed, limited or otherwise altered by action of the Medical Board of California, or in the event of any notification of investigation of my supervision by the Board, or if there is a change in employment status of the NPMP hereby applying.

4. I agree to inform all patients that said NPMP will participate in the total care of the patient and agree to ensure that the NPMP will be clearly identified by badge.

5. I agree to comply with all regulations and policies of the Medical Board of California and/or other regulating agencies and RCMG with respect to the supervision of the NPMP, specifically including such regulations and policies which have been or may, from time to time, be adopted by said Board and/or other regulating agencies with respect to:

   a. Billing for the services of the NPMP;

   b. Requirements for supervision of the NPMP with respect to the type and scope of services approved by the Medical Board of California for the NPMP to perform; and

   c. Requirement for identification of the NPMP while rendering services.

   It is understood that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by RCMG of the performance of services by the NPMP.

6. I understand the right of the NPMP to render medical services under my contract shall be contingent upon my continued membership and contract with RCMG. If I terminate my membership or contract, or if my membership or contract is suspended, revoked or terminated, the NPMP's clinical activities shall automatically be changed accordingly. Similarly, if my membership or contract is restricted, the NPMP's activities shall be restricted accordingly.

7. I understand that the above named NPMP shall have only such authority as is necessary to perform the duties and tasks indicated in this application. Questions of authority shall be referred to me for case by case resolution.

Supervising Physician's Signature: ______________________________ **Date:** ______________
(Stamped Signature Is Not Acceptable) (Not acceptable if not dated.)

Midlevel Practitioner Application

Addendum A

Professional Liability Action Explanation

This Addendum is submitted to **River City Medical Group** 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 B 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. Amount paid on my behalf: $__________________ Date paid: __________
☐ Judgment rendered, and I was found not liable.
☐ Lawsuit/arbitration settled, and payment made on my behalf. Amount paid on my behalf: $__________________ Date paid: __________
☐ Lawsuit/arbitration settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment. **PLEASE PRINT LEGIBLY.**

SUMMARY

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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 ____

Provider's Signature: ____ **Date:** __________________
(Stamped Signature Is Not Acceptable) (Not acceptable if not dated.)

Midlevel Practitioner Application

Addendum B

Practitioner Rights

I. RIGHT OF REVIEW

As an applicant for credentialing/re-credentialing, you have the right to review information obtained by IPA for the purpose of evaluating your credentialing or re-credentialing application. This includes non-privileged information obtained from any outside source (e.g., Malpractice insurance carriers, state licensing boards, National Practitioner Data Bank) but does not extend to review of information, references, or recommendations protected by law from disclosure. 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 re-credentialing 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 re-verify 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 re-review, 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 re-verify 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: ______________________________________

Provider's Signature: ____ Date: __________________

(Stamped Signature is not acceptable) (Not acceptable if not dated.)

Midlevel's Name: ____

Midlevel Practitioner Application

Addendum C

Age Range (Required by Midlevel's)

This Addendum is submitted to:________________**River City Medical Group**____________________.

Please indicate below the age(s) of the patient whom you provider services to:

0-120 ☐	Provider accepting all ages, children and adults
0-18 ☐	Provider accepting children, birth to age 18
0-21 ☐	Provider accepting children, birth to age 21
5-120 ☐	Provider accepting children and adults, ages 5 to adult
18-120 ☐	Provider accepting adults, ages 18 and older
21-120 ☐	Provider accepting adults, ages 21 and older
Other ☐	Provider accepting this specific age range __________

The California Department of Health Care Services (DHCS) released an All Plan Letter 18-005 regarding guidance on new annual network certification, network reporting requirements and associated network adequacy standards for managed care health plans by way of requirements issued in CMS-2390-F (Final Rule) sections 438.68, 438.206 and 438.207.

Participating provider must demonstrate and maintain a network adequate to serve adult and pediatric members within its service areas via the number, types, and geographic location of providers.

PROVIDER AGE RANGES: The patient age range categories are displayed above for PPGs to use when validating the information for its network. This information will be displayed in the online and hard copy provider directories for members.

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: _____________________________________

Provider's Signature: ____ Date: ___________________

(Stamped Signature is not acceptable) (Not acceptable if not dated.)