

**SOUTH CAROLINA UNIFORM MANAGED CARE PRACTITIONER
CREDENTIALS UPDATE FORM**

(Note: The following information will be held strictly confidential)

I. DEMOGRAPHIC DATA:

- A. Name in full: _____ Date of birth: _____
- B. Practice Name: _____
PCP: Yes No Specialty: _____
- C. Social Security Number: _____ NPI: _____
Tax ID: _____ Group NPI: _____
- D. Address: _____
Office (appointment) Phone #: _____ Office Fax #: _____
Office Credentialing Contact Person: _____ Contact #: _____
a) New Office Address: _____
b) New Telephone #: _____ New Fax #: _____
- E. Primary Admitting Facility: _____
If incorrect, please update: _____
Are your hospital privileges active and in good standing? Yes No
If you do not admit, please list below the physician that covers your hospitalized patients:

Are you accepting new patients? Yes No
Describe any limitations (other than gender listed below):
Male only:

Female only:

Both/No restrictions:

Please indicate the amount of your malpractice coverage, ie, \$ 1,000,000/\$ 3,000,000?
Carrier Name _____ JUA and PCF: Yes No
Effective Dates: From _____ To _____
- F. Office e-mail address (if any): _____
- G. Practice Web site address (if any): _____

II. CERTIFICATION/EDUCATION UPDATE:

- A. Board Status: _____ If incorrect, please update: _____
Certified by American Board of: _____ Date certified: _____ Re-Certified: _____
- B. Medical School: _____ Year of Graduation: _____
- C. Professional License number where currently in practice: _____

III. PLEASE ANSWER THE FOLLOWING QUESTIONS (This section must be completed by practitioner):

Managed Care Organizations must have updated liability information and written explanations to begin the recredentialing process.

(If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)

- | | | | |
|-----|---|-----|----|
| 1. | Do you have any pending misdemeanor or felony charges? | Yes | No |
| 2. | In the past three years have you been convicted of a felony? | Yes | No |
| 3. | In the past three years has your license to practice medicine in any jurisdiction been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited? | Yes | No |
| 4. | In the past three years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodations, to perform the essential functions of a practitioner in your areas of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? | Yes | No |
| 5. | Considering the essential functions of a practitioner in your area of practice, in the past three years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients? | Yes | No |
| 6. | In the past three years have you been publicly reprimanded or disciplined by a professional licensing agency or board? | Yes | No |
| 7. | In the past three years has your DEA certification or state controlled drug permit been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? | Yes | No |
| 8. | In the past three years have any of your privileges or memberships at any hospital or institution been denied, suspended, reduced, revoked, not renewed or otherwise limited? | Yes | No |
| 9. | In the past three years has your participation in Medicare, Medicaid, or any other government program been limited or curtailed, or have you voluntarily excluded yourself from any of these programs? | Yes | No |
| 10. | In the past three years has your participation in an Insurance Company network been limited or terminated? | Yes | No |
| 11. | In the past three years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? | Yes | No |
| 12. | In the past three years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? | Yes | No |
| 13. | In the past three years has any malpractice carrier made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf, or are any medical malpractice suits pending against you? | Yes | No |
| 14. | In the past three years has your professional liability insurer placed conditions or restrictions on your coverage or ability to obtain coverage? | Yes | No |

(THE ABOVE INFORMATION WILL BE HELD STRICTLY CONFIDENTIAL)

Signature:

Date:

Please print name:

Must be signed in ink

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.

Rubber Stamped and Electronic Signatures Are Not Acceptable

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.

V. AUTHORIZATION:

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS CREDENTIALS UPDATE FORM AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

- A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;
- B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;
- C. All the information contained in this application or attachments is subject to the Managed Care Organization's investigation and review and;

NOTICE: The National Practitioner Data Bank will be queried. If you are not recredentialed for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your credentials, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including, without limit, past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment or participation status, membership and/or privileges of any type to or from the Managed Care Organization.

SIGNATURE: _____

DATE: _____

***EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.
ELECTRONIC AND RUBBER STAMPED SIGNATURES ARE NOT ACCEPTABLE***

CLAIM INFORMATION FORM

If you answered "yes" to any of the malpractice questions, please complete this form or submit a written explanation. Attach any supplemental information necessary. Please copy this form and complete for each additional claim.

1. Patient's Name: _____ Age: _____ Sex: _____

2. Date of first examination: _____

3. Please describe the pertinent details of the patient's history, examination and care, and the allegations made against you:

4. Subsequent condition or health of patient: _____

5. Date of Claim: _____

6. What Insurance Company, if any, was Involved? _____
Name: _____
Address: _____

7. Is Claim Still Pending? YES NO

8. Amount of any settlement or judgment: _____

9. Names of other Doctors and Hospital, if any, involved in the Claim or Suit:

10. Comments: _____

I hereby certify that the above information is, to the best of my knowledge, accurate and complete.

Signature of Applicant

Date



CREREDENTIALING ATTESTATION AND RELEASE FORM

Applicant agrees to participate in the credentialing/re-credentialing and interviewing program as established by **Select Health**. Applicant consents to the release of information for the purpose of proper evaluation of his/her professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Applicant agrees that the decision of the Total Quality Management Committee of **Select Health** shall be final and binding, and to release the Plan and its shareholders, respective officers, trustees, agents, employees and all members of the Committees of the Plan from any and all liability. Applicant further agrees to release, from any and all liability, any physician, hospital, or other person or entity providing information which, but for such waiver, would be privileged and confidential.

Applicant understands that any and all information submitted on or with this form and/or the CAQH Universal Provider Datasource that is found to be false or intentionally misleading may result in rejection or termination with **Select Health**. Furthermore, a copy of these statements shall be as binding as the original. Applicant also understands that all information submitted on or with this form and/or the CAQH Universal Provider Datasource is subject to investigation and review by **Select Health**.

Notice: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) will be queried. If you are not credentialed/re-credentialed for reasons relating to professional conduct or professional competence, the rejection may be reported to the NPDB and/or HIPDB.

Applicant understands and agrees that he/she has the burden of producing information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. Applicant further understands that it is his/her responsibility to notify **Select Health** in writing within 30 days of any changes or additions to the information submitted on or with this form and/or the CAQH Universal Provider Datasource.

Practitioner Rights

Applicant understands that he/she has the right to:

- Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer review protected information.
- Be notified if any credentialing information is received that varies substantially from application information submitted by the practitioner. Practitioner will be notified of any of the following types of variances: e.g., actions on license, malpractice claim history, suspension or termination of hospital privileges, or board-certification decisions with the exception of references, recommendations or other peer-review protected information.

I CERTIFY THAT ALL INFORMATION INCLUDED IN MY APPLICATION AND THE ACCOMPANYING DOCUMENTS ARE CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

Applicant Signature

Date

Applicant Name (printed)

Must be signed in ink
EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE
Rubber Stamped and Electronic Signatures Are Not Acceptable

Please list the hours you are available to see patients in this office:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From/To							

FOR PRIMARY CARE PRACTITIONERS ONLY

ACTIVE PATIENT LOAD:

(An active patient is one who has been seen by this practitioner within the last three months. Select Health's maximum allowable active patients per full time practitioner are 2500).

_____ Less than 500 _____ 500-1000 _____ 1000-1500 _____ 1500-2500

PLEASE SELECT ONE:

- This practice will accept **new** members.
- This practice will accept **existing** patients only.
- This practice is **closed** to all new members.
- Other restrictions (Please Describe)_____

If you wish to change status following activation, please notify Select Health of South Carolina, Inc., in writing.

ADDITIONAL PRACTICE LOCATIONS:

Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S
Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S
Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S
Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S
Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S
Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S
Street:			City:					
State:		Zip:		County:				
Phone:		Fax:		Contact:				
Hrs. staffed by physician: M			T	W	T	F	S	S