Application Checklist for Practitioners

AmeriHealth Caritas Louisiana

Please use the following checklist to complete the credentialing process. Current copies of all items listed below are required for each practitioner to participate with AmeriHealth Caritas Louisiana.

Use this Application Checklist as a fax cover sheet. Fax all applicable items on the checklist to the Credentialing Department at **1-225-300-9199**, or signed documents may be scanned and submitted by secure e-mail to **Credentialing@amerihealthcaritasla.com.** Please ensure this checklist is submitted with the documents.

Please provide AmeriHealth Caritas Louisiana with the following:

Practitioner information	
Applicant's full name:	Legal name:
Date of birth:	Gender: ☐ Male ☐ Female
Practice name to appear in directory (DBA):	
This practice is a: ☐ Federally qualified health center (FQHC) ☐ Rural health clinic (RHC) ☐ Indian tribal organization	
Practice Tax ID Number (TIN):	
Medical license number (state):	
Group National Provider Identifier (NPI) number:	
Applicant's NPI number:	
Individual Medicaid number:	
Council for Affordable Quality Healthcare (CAQH)-issued ID number (if applicable):	
Drug Enforcement Agency (DEA) number:	
Clinical Laboratory Improvement Amendments (CLIA) certificate type:	
CLIA certificate number:	
☐ Primary care provider (PCP) ☐ Specialist ☐ Hospital-based only ☐ Allied health ☐ Behavioral health	
Patient-centered medical home? ☐ Yes ☐ No	
Add to an existing practice/group? ☐ Yes ☐ No If yes, please indicate affiliated practice/group:	
When did this practitioner start with this group/practice?	
Applicant's specialty:	Secondary specialty:
Taxonomy:	County/parish:
Fax number:	Hours of operation:
Accepting new patients? ☐ Yes ☐ No	Patient ages seen:
Maximum number of members accepted by PCP:	Remit address:
Remit phone number:	Remit fax number:
Credentialing contact name:	
Credentialing contact email address:	Credentialing contact phone number:

Practitioner information (continued)

*Applicant race (choose only one): ☐ Black or African American ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Asian ☐ American Indian or Alaska Native ☐ Middle Eastern/North African ☐ Other race ☐ Decline to state
*Applicant ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino ☐ Unknown or decline to state
*Language(s) spoken by applicant and/or clinical staff:

*Providing race, ethnicity, and language information is optional. We collect this data to assist members in selecting a provider.

Please provide the following:

☐ CAQH authorization allowing AmeriHealth Caritas Louisiana to access practitioner information. **(Please ensure all current copies of the below supporting documents are updated on the CAQH application. Do not submit until all documents are current.)**

Non-CAQH participants must submit copies of the following support documents:

☐ Practitioner application (completed, signed, and dated within the last 90 days) NOTE: You may access the Practitioner credentialing application packet on our website here: **http://www.amerihealthcaritasla.com/provider/resources/credentialing/index.aspx**)

☐ State medical license

☐ Board certification (if applicable)

☐ Certifications for the following practitioners (if applicable)

- Social workers, professional counselors, and psychologists (behavioral health).
- Nurse practitioners.
- Physician assistants.
- Nurse midwives.

☐ Federal Drug Enforcement Agency (DEA) registration certificate (if applicable)

- DEA must have the state in which the practitioner is rendering services to our members.

☐ State controlled dangerous substance (CDS) license (if applicable)

☐ Declarations page of malpractice insurance policy and Patient Compensation Fund certificate showing expiration dates and limits of liability. (Provider's name must be on declarations page. If name is not included, then a roster is required.)

☐ Curriculum vitae (CV)/resumé (if applicable)

- CV/resumé must cover five years of work experience with no gaps. Provide an explanation of any gaps greater than six months.

☐ Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)

☐ W-9 form

☐ Hospital privileges indicating the practitioner's primary admitting hospital. Please forward a copy of a coverage agreement if the practitioner does not have admitting privileges, or a letter stating hospitalist service used.

☐ Practitioner office hours must be completed on the application

☐ Allied health practitioners outlined below are required to provide a collaborative agreement:

- Nurse practitioner (NP).
- Physician assistant (PA).
- Osteopathic assistant (OA).
- Certified nurse midwife (CNM).

☐ Ownership disclosure (behavioral health providers only)

To check the status of your application or if you have any questions or concerns regarding this process, please contact the AmeriHealth Caritas Louisiana Credentialing Department at **1-888-913-0349**.

If you are new to AmeriHealth Caritas Louisiana and you or your group does not have a provider contract, you must first call **1-877-588-2248** to discuss obtaining an AmeriHealth Caritas Louisiana Provider Agreement.

LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 9 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

LAST NAME	SUFFIX	FIRST	MIDDLE	GENDER MALE FEMALE

DEGREE: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ OTHER_____

Any other name under which you have been known? (AKA) LIST	ECFMG NUMBER	UPIN NUMBER	
HOME STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	PAGER NUMBER/ANSWERING SERVICE	HOME E-MAIL ADDRESS (Optional)

SOCIAL SECURITY NUMBER	DATE OF BIRTH	BIRTH PLACE (CITY, STATE)	RACE/ETHNICITY (Voluntary)

NPI - INDIVIDUAL	NPI – GROUP	MEDICAID PROVIDER NUMBER	MEDICARE PROVIDER NUMBER

PRIMARY PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)	OFFICE MANAGER

STREET ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER	FAX NUMBER	**OFFICE E-MAIL**

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER	TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION

Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)

BILLING ADDRESS (Address to which you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	**BILLING E-MAIL**	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	____-____	____-____	____-____	____-____	____-____	____-____	____-____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑ Yes ❑ No

Is this facility handicapped accessible? ❑ Yes ❑ No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians: _____ _____ _____

SECOND PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)			OFFICE MANAGER
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	**OFFICE E-MAIL**	

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER	TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION

Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)

BILLING ADDRESS (Address to which you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	**BILLING E-MAIL**	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify): _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify): _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑ Yes ❑ No | Is this facility handicapped Accessible? ❑ Yes ❑ No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians: _____ _____ _____

THIRD PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)			OFFICE MANAGER
STREET ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	**OFFICE E-MAIL**	

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER	TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION

Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)

BILLING ADDRESS (Address to which you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	**BILLING E-MAIL**	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify): _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

THIRD PRACTICE LOCATION CONTINUED

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify): _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑ Yes ❑ No

Is this facility handicapped Accessible? ❑ Yes ❑ No

Emergency After Hours Number

Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians: _____

_____

_____

FOURTH PRACTICE LOCATION

If you have more than four locations, attach additional sheets with the following information

INSTITUTION/GROUP/CLINIC NAME (If applicable)

OFFICE MANAGER

STREET ADDRESS

CITY

STATE

ZIP CODE

PHONE NUMBER

FAX NUMBER

OFFICE E-MAIL

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER

TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION

Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)

BILLING ADDRESS (Address to which you want payments sent)

CONTACT PERSON

TELEPHONE NUMBER

CITY STATE ZIP CODE

BILLING E-MAIL

FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify): _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify): _____

Age group(s) treated: ❑ 0-6 years ❑ 7-11 years ❑ 12-18 years ❑ 19-65 years ❑ Over 65 ❑ All Ages ❑ Other (Specify): _____

Are PAs and/or nurse/paraprofessional practitioners used? ❑ Yes ❑ No

Is this facility handicapped Accessible? ❑ Yes ❑ No

Emergency After Hours Number

Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians: _____

_____

_____

CORRESPONDENCE

Please check location where you would like correspondence sent.

❑ Primary ❑ Second ❑ Third ❑ Fourth ❑ All

❑ Other Address_____

_____

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER

FAX NUMBER

E-MAIL

MEDICAL RECORDS

Please check location where you would like medical records requests sent.

❑ Primary ❑ Second ❑ Third ❑ Fourth ❑ Correspondence

❑ Other address _____

If different from practice or correspondence located checked above

PHONE NUMBER	FAX NUMBER	**E-MAIL**

SPECIALTY

TYPE OF PROVIDER: ❑ PRIMARY CARE PHYSICIAN ❑ PHYSICIAN SPECIALIST ❑ BOTH ❑ OTHER SPECIALTY: _____

PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)	**BOARD CERTIFIED (ABMS)**
Specialty:	❑ Yes ❑ No
Sub-Specialty:	❑ Yes ❑ No
Sub-Specialty:	❑ Yes ❑ No

BOARD CERTIFICATION

(as recognized by American Board of Medical Specialties)
(Please attach a copy of current certification(s).)

PRIMARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
SECONDARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
THIRD SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE

DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by healthcare organization**

Primary Location	**Second Location**	**Third Location**	**Fourth Location**
❑ Specialty ❑ Directory	❑ Specialty ❑ Directory	❑ Specialty ❑ Directory	❑ Specialty ❑ Directory
❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory
❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER	FAX NUMBER	E-MAIL

PHO / IPA AFFILIATIONS*

List any other PHO's, IPA's, which you participate in and dates of participation: _____

** The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

HOSPITAL	LOCATION/ADDRESS	TYPE OF PRIVILEGES	EFFECTIVE DATE MO/YR

IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHO ADMITS FOR YOU AND TO WHAT HOSPITAL? PLEASE LIST PROVIDER'S NAME, SPECIALTY AND HOSPITAL.

EDUCATION

IF ADDITIONAL TRAINING HAS BEEN COMPLETED, PLEASE ATTACH ON A SEPARATE FORM.

MEDICAL/PROFESSIONAL SCHOOL:

CITY	STATE	ZIP
DEGREE	YEAR OF GRADUATION	DATES ATTENDED **(MO/YR)** From To
INTERNSHIP: INSTITUTION NAME	TYPE OF TRAINING	
CITY	STATE	
UNIVERSITY AFFILIATION	COMPLETED ❑ YES ❑ NO	DATES ATTENDED **(MO/YR)** From To
RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	❑ Clinical ❑ Research
CITY	STATE	DATES ATTENDED **(MO/YR)** From To
UNIVERSITY AFFILIATION	COMPLETED ❑ YES ❑ NO	
RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	❑ Clinical ❑ Research
CITY	STATE	DATES ATTENDED **(MO/YR)** From To
UNIVERSITY AFFILIATION	COMPLETED ❑ YES ❑ NO	
FELLOWSHIP: INSTITUTION NAME	SPECIALTY FIELD	DATES ATTENDED **(MO/YR)** From To
CITY	STATE	COMPLETED ❑ YES ❑ NO
	TYPE OF FELLOWSHIP	❑ Clinical ❑ Research
FELLOWSHIP: INSTITUTION NAME	SUBSPECIALTY FIELDS	DATES ATTENDED **(MO/YR)** From To
CITY	STATE	COMPLETED ❑ YES ❑ NO
	TYPE OF FELLOWSHIP	❑ Clinical ❑ Research

WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the month and year for each entity listed**. **Work history is critical. Failure to provide this information may delay your credentialing.**

CODE:

C = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments) **H** = Civilian Hospital Medical Staff Appointment
M = Military Service (Including Hospital Staff Appointments) **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE (From MO/YR to MO/YR)

In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history:

PROFESSIONAL LICENSES

PROFESSIONAL LICENSES	LICENSE NUMBER	DATE OBTAINED	EXPIRATION DATE
STATE LICENSE			
FEDERAL DEA REG NUMBER			
STATE CDS LICENSE NUMBER			
CLIA CERTIFICATE			

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?
❑ Yes ❑ No **If yes, a current copy of your CLIA Registration must accompany this application.**

FOR DENTISTS ONLY - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?)
❑ Yes ❑ No **If yes, a copy of your Anesthesia Permit must accompany this application.**

Have you been or are you <u>currently</u> licensed in any other state? If YES, please complete the following:

LICENSE NUMBER STATE DATE OBTAINED EXPIRATION DATE

LICENSE NUMBER STATE DATE OBTAINED EXPIRATION DATE

LICENSE NUMBER STATE DATE OBTAINED EXPIRATION DATE

(Please attach a copy of all licenses listed above and additional ones in other states not listed.)

REFERENCES

List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.
(References should not be relatives or current partners.)

NAME SPECIALTY PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

NAME SPECIALTY PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

NAME SPECIALTY PHONE NUMBER

STREET ADDRESS CITY STATE ZIP

PROFESSIONAL LIABILITY INSURANCE COVERAGE

NAME OF CARRIER	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF CARRIER	
AMOUNTS PER OCCURRENCE/AGGREGATE	DATES OF COVERAGE

Do you participate in the Louisiana Patients' Compensation Fund? ❑ YES ❑ NO

Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation) ❑ YES ❑ NO

Are you self-insured in accordance with the Louisiana Medical Malpractice Act? ❑ YES ❑ NO

Please attach a copy of the current Certificates of Insurance.

GENERAL QUESTIONS

Please check the appropriate response to the following questions:
If you answered YES to any of the questions below, please attach a full explanation on a separate page.

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you?	❑	❑	❑
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending?	❑	❑	❑
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence?	❑	❑	❑
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	❑	❑	❑
5. Have your clinical privileges at any hospital or healthcare institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board?	❑	❑	❑
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	❑	❑	❑
7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed healthcare practitioner.	❑	❑	❑
8. Do you currently 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?	❑	❑	❑
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business?	❑	❑	❑
10. Are you presently a named defendant in a pending professional liability lawsuit? If YES, please enter the number of cases _____ and attach a full explanation of each.	❑	❑	❑
11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action? If YES, please enter the number of cases _____ and attach a full explanation of each.	❑	❑	❑

REQUIRED ATTACHMENTS

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 8.
- ✓ Current Employer Identification Number (EIN) **and** W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009 (A) (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

	X	
NAME (Please Print)	**SIGNATURE**	**ORIGINAL ATTESTATION DATE**

SECOND ATTESTATION DATE	**THIRD ATTESTATION DATE**

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.