**Part 3 Chapter 11: (**98-1) Heath Care Professional Credentialing Verification (As Amended).

**Rule 11.01**: Authority

This Regulation is promulgated pursuant to the authority vested in the Commissioner of Insurance under Article 7 and Article 9 of Chapter 41 of Title 83 of the Mississippi Code of 1972, Annotated, and is promulgated in accordance with Mississippi Insurance Department Regulation No. 88-101, being the Rules of Practice and Procedure Before the Mississippi Insurance Department.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.02**: Purpose and Intent

This Regulation requires a managed care entity to establish a comprehensive health care professional credentialing verification program to ensure that its participating health care professionals meet specific minimum standards of professional qualification. The standards set out in this Regulation address the initial credentialing verification and subsequent recredentialing process

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.03**: Definitions

For purposes of this Regulation:

A. "Commissioner" means the Commissioner of Insurance.

B. "Credentialing verification" is the process of obtaining and verifying information about a health care professional, and evaluating the professional credentials of that health care professional, when that health care professional applies to become a participating provider in a managed care plan offered by a managed care entity.

C. "Health care professional" means a physician or other health care practitioner licensed or certified by the state to perform specified health services.

D. **"**Health care services" or "health services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

E. "Managed care contractor" means a person or corporation that:

1. Establishes, operates or maintains a network of participating providers;

2. Conducts or arranges for utilization review activities; and

3. Contracts with an insurance company, a hospital or medical service plan, an employer or employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

F. "Managed care entity" means a licensed insurance company, hospital or medical service plan, health maintenance organization (HMO), an employer or employee organization, or a managed care contractor as defined under G. above, that operates a managed care plan.

G. "Managed care plan" means a plan operated by a managed care entity that provides for the financing and delivery of health care services to persons enrolled in such plan through:

1. Arrangements with selected providers to furnish health care services;

2. Explicit standards for the selection of participating providers;

3. Organizational arrangements for ongoing quality assurance, utilizationreview programs and dispute resolution; and

4. Financial incentives for persons enrolled in the plan to use the participating providers, products and procedures provided for by the plan.

"Participating provider" means a health care professional licensed or certified by the state, that has entered into an agreement with a managed care entity to provide health care services, products or supplies to a patient enrolled in a managed care plan.

H. "Physician" means one who is educated and trained to practice the art and scienceof medicine and who has received the degree of doctor of medicine or osteopathyfrom an accredited and recognized school or college of medicine or osteopathicmedicine.

I. "Primary verification" means verification by the managed care entity of a healthcare professional's credentials based upon evidence obtained from the issuingsource of the credential.

J. "Secondary verification" means verification by the managed care entity of a health care professional's credentials based upon evidence obtained by meansother than direct contact with the issuing source of the credential (e.g., copies of certificates provided by the applying health care professional).

Source: Miss Code Ann §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.04:** Applicability AndScope

This Regulation shall apply to managed care entities that offer, operate or participate in managed care plans.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.05**: General Responsibilities Of The Managed Care Entity

A. A managed care entity shall:

1. Establish written policies and procedures for credentialing verification of all health care professionals with whom the managed care entity contractsand apply these standards consistently;

2. Verify the credentials of a health care professional when entering into a contract with that health care professional. The medical director of the managed care entity or other designated health care professional shall have responsibility for, and shall participate in, health care professionalcredentialing verification;

3. Establish a credentialing verification committee consisting of licensedphysicians and other health care professionals to review credentialingverification information and supporting documents and make decisionsregarding credentialing verification;

4. Make available for review by the applying health care professional upon written request all application and credentialing verification policies and procedures; and

5. Keep confidential all information obtained in the credentialingverificationprocess, except as otherwise provided by law.

B. Nothing in this regulation shall be construed to require a managed care entity to select a provider as a participating provider solely because the provider meets the managed care entity's credentialing verification standards, or to prevent a managed care entity from utilizing separate or additional criteria in selecting the health care professionals with whom it contracts.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.06**: Verification Responsibilities of the Managed Care Entity

A managed care entity shall:

A. Obtain primary verification of at least the following information about the applicant:

1. Current license or certification to practice in this and all other states andhistory of licensure or certification;

2. Status of primary admitting hospital privileges, if applicable;

3. Specialty board certification status, or, if not board certified, the highest level of education obtained;

4. Malpractice history within the last five (5) years.

B. Obtain by either primary or secondary verification at the managed care entity's discretion:

1. Current level of professional liability coverage;

2. Practice history for at least five (5) years;

3. Status of hospital privileges other than the primary admitting hospital, if applicable;

4. Completion of medical, health care professional and/or post graduatetraining, other than the highest level of education obtained;

5. Current Drug Enforcement Agency (DEA) registration certificate, ifapplicable.

C. Every three (3) years obtain primary verification of a participating health careprofessional's:

1. Current license or certification to practice in this and all other states;

2. Status of primary admitting hospital privileges, if applicable;

3. Specialty board certification status, if applicable;

4. An update regarding the health care professional's malpractice history.

D. Every three (3) years obtain, by either primary or secondary verification, at themanaged care entity's discretion:

1. Status of the health care professional's hospital privileges other than theprimary admitting hospital, if applicable;

2. Current level of professional liability coverage;

3. Current DEA registration certificate, if applicable;

E. Require all participating providers to notify the managed care entity of changes in the status of any of the items listed in this Section at any time and identify for participating

providers the individual to whom they should report changes in the status of an item listed in this Section.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.07:** Uniform Application for Physician Credentialing and Recredentialing

A. In order to simplify the application process for physicians who are applying to multiple managed care entities, the Commissioner hereby adopts a basic uniform credentialing application which shall be used by all managed care entities performing physician credentialing and recredentialing activities in Mississippi. The uniform application is attached hereto as Exhibit "A" and hereby made a part of this Regulation.

B. The uniform application may be augmented by an individual managed care entity for the purpose of obtaining additional necessary and material information which is not requested in the uniform application, and further, for the purpose of providing more detailed instructions regarding the completion and submission of the application. The additional information/instructions may only be requested/provided on supplemental sheets which are attached to the uniform application. Any proposed supplemental sheets must be submitted by the managed care entity to the Commissioner for prior approval.

C. The form prescribed by this Section shall apply only to the credentialing and recredentialing of physicians.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.08:** Health Care Professional's Right to Review Credentialing Verification Information

Subject to the provisions of Subsections A., B., C., and D. of this Section, a managed care entity shall provide a health care professional with the sources from which credentialing information is received, notification of any information that varies substantially from the information the health care professional provided, and the opportunity to correct information received from a third party that is incorrect or misleading.

A. Each health care professional who is subject to the credentialing verification process shall have the right to request information regarding the sources utilized by the managed care entity to verify credentialing information, including asummary of information obtained by the managed care entity to satisfy therequirements of this Regulation.

B. A managed care entity shall notify a health care professional of any information obtained during the managed care entity's credentialing verification process that does not meet the managed care entity's credentialing verification standards or that varies substantially from the information provided to the managed care entity by the health care professional, except, that the managed care entity shall not be required to allow the health care

professional to (1) review the contents of a verification, (2) identify the source of information, or (3) provide a summary of differing information, if the information is not obtained to meet the requirements of this Regulation or if disclosure is prohibited by law. Responses provided by personal or professional references shall not be available to the health care professional.

C. A health care professional shall have the right to correct any erroneous information submitted by a third party when the health care professional feels that the managed care entity's credentialing verification committee has received information that is incorrect or misleading. The managed care entity shall have a formal process by which the health care professional may submit supplemental or corrected information to the managed care entity's credentialing verification committee. Supplemental information shall be subject to confirmation by the managed care entity.

D. Nothing in this Section 8 shall prohibit a managed care entity from denying an application or reapplication or terminating privileges, employment or a provider participation agreement where a health care professional intentionally withholds material information, intentionally omits material information, or intentionally submits material false or misleading information in a credentialing or re-credentialing application which is submitted to a managed care entity.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.09**: Contracting

Whenever a managed care entity delegates the credentialing functions required by this Regulation to another entity, the commissioner shall hold the managed care entity responsible for monitoring the activities of the delegatee entity in order to ensure that the requirements of this Regulation are met.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.10**: Separability

If any provision of the Regulation, or the application of the provision to any person or circumstance, shall be held invalid, the remainder of the Regulation, and the applicationof the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.11**: Effective Date

This Regulation shall become effective thirty (30) days after filing with the Office of the Secretary of State of the State of Mississippi.

Source: *Miss Code Ann* §25-43-3.113(Rev. 2010)

**Rule 11.12:** Instructions for Completing the Mississippi Participating Physician Application

To effectively use the Application, the following is suggested:

Type or legibly complete the Application in **black ink.**

A. Complete all of the Application **except for line 1, "This application is submitted to,___". Do not sign and date the original.** Keep the completed original on file and keep a blank original for future up-dates. Sign and date as directed below.

B. When submitting the Mississippi Participating Physician Application to a credentialing entity:

    1. copy the original Application and any addenda the credentialing entity has requested;
    2. fill in the name of the IPA, medical group, health plan, hospital, etc., to which the Application is being submitted on the top of page 1;
    3. sign and date the copy in the spaces provided;
    4. mail the signed and dated copy to the requesting organization.

C. By doing the above, your signature will be an original and the date will be current. Remember that the information on the Application must be complete and accurate. An incomplete Application may delay processing.

D. Submit completed Applications and do not rely on attached information unless requested.

E. If an item in the Application does not apply to you, write N/A in the box provided.

F. Attach copies of the documents requested on page 1 of the Application **each time** the Application is submitted.

G. For your convenience and to ensure information accuracy, keep Application current at all times.

If you have any questions, please call the Managed Care Entity to which you are submitting this Application.

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

**Rule 11.13:** Mississippi Participating Physician Application

(See below.)

Source: *Miss Code Ann* §§83-5-1; 83-41-413 (Rev. 2011)

# Mississippi Participating Physician Application

lease check one:
] Original Application
] Reapplication
his application is submitted to: _____, herein, this Managed Care Entity[1].

## Section A.
*Practice, Educational, Licensure and Work History Information*

### I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attach additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided. **Current copies of the following documents must be submitted with this application:**

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

### II. IDENTIFYING INFORMATION

| | | |
|---|---|---|
| Last Name: | First: | Middle: |
| Is there any other name under which you have been known (AKA/Maiden Name)? Name(s): | | |
| Home Mailing Address: | City: | |
| | State: | ZIP: |
| Home Telephone Number: ( ) | E-Mail Address: | |
| Home Fax Number: ( ) | Pager Number: ( ) | |
| Birthday Date: Birth Place (City/State/Country): | Citizenship (If not a United States citizen, please include copy of Alien Registration Card). | |
| Social Security # : | Gender[2]: ☐ Male ☐ Female | |
| Specialty: | Race/Ethnicity[2] (voluntary): | |
| Subspecialties: | | |

### III. PRACTICE INFORMATION

| | |
|---|---|
| Practice Name (if applicable): | Department Name (if Hospital based): |
| Primary Office Street Address: | Primary Office Mailing Address if different from Street Address: |
| City: State: County: Zip: | City: State: County: Zip: |
| Telephone Number: ( ) | Fax Number: ( ) |
| Office Manager/Administrator: | Telephone Number: ( ) |
| | Fax Number: ( ) |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |

[1] As used in the Information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.
[2] This information will be used for consumer information purposes only.

| | |
|---|---|
| Secondary Office Street Address: | City:<br>State: ZIP: |
| Office Manager/Administrator: | Telephone Number: ( )<br>Fax Number: ( ) |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |
| Teritary Office Street Address: | City:<br>State: ZIP: |
| Office Manager/Administrator: | Telephone Number: ( )<br>Fax Number: ( ) |
| Name Affiliated with Tax ID Number: | Federal Tax ID Number: |
| Handicap Access: ☐ Yes ☐ No | 24-Hour Coverage: ☐ Yes ☐ No |
| Will you accept new patients? ☐ Yes ☐ No | Back Office Telephone Number: ( ) |

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

| Name of Network | Address | Reason for Denial or Deselection |
|---|---|---|
| | | |
| | | |
| | | |

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc.? ☐ Yes ☐ No

If yes, please list:

Medical Group(s) / IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No

Do you intend to serve as a specialist? ☐ Yes ☐ No

If yes, please list specialty(s):

Please check all that apply:

☐ Solo Practice ☐ Single Specialty

☐ Group Practice ☐ Multi Specialty

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

If so, please list:

| Name: | Type of Provider: | License Number: |
|---|---|---|
| | | |
| | | |
| | | |

Do you personally employ any physicians? (Do not include physicians that are employed by the medical group) ☐ Yes ☐ No

| Name: | Mississippi Medical License Number: |
|---|---|
| | |
| | |
| | |

Please list any clinical services you perform that are not typically associated with your specialty:

Please list any clinical services you do not perform that are typically associated with your specialty:

Is your practice limited to certain ages? ☐ Yes ☐ No If yes, specify limitations:

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

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

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

Has your office received any of the following accreditations, certifications or licensures?
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) ☐ Medicare Certification
☐ Mississippi Department of Health Licensure ☐ Other_____

## IV. BILLING INFORMATION

Billing Company:

Street Address:

City:

State: ZIP:

Contact:

Telephone Number: ( )

Name Affiliated with Tax ID Number:

Federal Tax ID Number:

## V. OFFICE HOURS - Please indicate the hours your office is open:

| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday | Holidays |
|---|---|---|---|---|---|---|---|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

## VI. COVERAGE OF PRACTICE

(List your answering service and covering physicians by name. Attach additional sheets if necessary. Reference this section number and title.)

Answering Service Company:

Telephone Number: ( )

Fax Number: ( )

Mailing Address:

City:

State: ZIP:

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

Covering Physician's Name:

Telephone Number: ( )

If you do not have hospital privileges, please provide written plan for continuity of care:

## VII. FOREIGN LANGUAGES SPOKEN

| Fluently by Physician: | Fluently by Staff: |
|---|---|
| | |

## VIII. LABORATORY SERVICES

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 if you have one.

| Tax ID# | Billing Name: | Type of Service Provided: |
|---|---|---|
| | | |

| Do you have a CLIA Certificate? ☐ Yes ☐ No | Do you have a CLIA waiver? ☐ Yes ☐ No |
|---|---|
| Certificate Number: | Certificate Expiration Date: |

## IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

| Medical School: | Degree Received: | Date of Graduation: (mm/yy) |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Medical/Professional School: | Degree Received: | Date of Graduation: (mm/yy) |
| Mailing Address: | City: | |
| | State & Country: | ZIP: |

## X. INTERNSHIP/PGYI (Attach additional sheets if necessary. Reference this section number and title.)

| Institution: | Program Director: | |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Type of Internship: | | |
| Specialty: | From: (mm/yy) | To: (mm/yy) |

## XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include <u>all</u> programs you attended, whether or not completed.

| Institution: | Program Director: | | |
|---|---|---|---|
| Mailing Address: | City: | | |
| | State & Country: | ZIP: | |
| Type of Training (eg. residency, etc.): | Specialty: | From: (mm/yy) | To: (mm/yy) |
| | | | |

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

| Institution: | Program Director: | | |
|---|---|---|---|
| Mailing Address: | City: | | |
| | State & Country: | ZIP: | |
| Type of Training: | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

| Institution: | Program Director: | | |
|---|---|---|---|
| Mailing Address: | City: | | |
| | State & Country: | ZIP: | |
| Type of Training (eg. residency, etc.): | Specialty: | From: (mm/yy) | To: (mm/yy) |

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

## XII. BOARD CERTIFICATION (Attach copies of documents.)

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 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: | Certification Number: | Date Certified/Recertified: | Expiration Date (if any): |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? ☐ Yes ☐ No If yes, provide details.

## XIII. OTHER CERTIFICATIONS (e.g., Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

| Type: | Number: | Expiration Date: |
|---|---|---|
| Type: | Number: | Expiration Date: |

## XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents.)

| Mississippi State Medical License Number: | Issue Date: | Expiration Date: | Active: ☐ Yes ☐ No |
|---|---|---|---|
| Drug Enforcement Administration (DEA) Registration Number:<br>Unlimited? ☐ Yes ☐ No If no, please explain on separate sheet | | Expiration Date: | |
| Controlled Dangerous Substances Certificate (CDS) (if applicable): | | Expiration Date: | |

| ECFMG Number (applicable to foreign medical graduates): | | Date Issued: | Valid Through: |
|---|---|---|---|
| Visa Number: | | Date Issued: | Valid Through: |
| Medicare UPIN/National Physician Identifier (NPI): | Mississippi Medicare Number: | Mississippi Medicaid Number: | |

## XV. ALL OTHER STATE MEDICAL LICENSES – List all Medical Licenses Now or Previously Held.

(Attach additional sheets if necessary. Reference this section number and title.)

| State: | License Number: | Expiration Date: | Active: ☐ Yes ☐ No |
|---|---|---|---|
| State: | License Number: | Expiration Date: | Active: ☐ Yes ☐ No |
| State: | License Number: | Expiration Date: | Active: ☐ Yes ☐ No |

## XVI. PROFESSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

| ORGANIZATION NAME | Applicant | Member |
|---|---|---|
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |
| | ☐ | ☐ |

Are you an Officer or Director of any of the professional organizations listed above? ☐ Yes ☐ No
If yes, please list:

## XVII. PROFESSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet.)

| Current Insurance Carrier: | Policy Number: | Original effective date: |
|---|---|---|
| Mailing Address: | City: | |
| | State & Country: | ZIP: |
| Telephone Number: ( ) | Fax Number: ( ) | |
| Per Claim Amount: $ | Aggregate Amount: $ | Expiration Date: |

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
|---|---|---|---|
| Mailing Address: | | City: | |
| | | State and Country: | Zip: |
| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
| Mailing Address: | | City: | |
| | | State and Country: | Zip: |

| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
|---|---|---|---|
| Mailing Address: | | City: | |
| | | State and Country: | Zip: |
| Name of Carrier: | Policy # : | From: (mm/yy) | To: (mm/yy) |
| Mailing Address: | | City: | |
| | | State and Country: | Zip: |

## XVIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

**A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference this section number and title.)**

| Name and Mailing Address of Primary Admitting Hospital: | City: | |
|---|---|---|
| | State: | Zip: |
| Department/Status (Active, provisional, courtesy, etc.): | Appointment Date: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | Zip: |
| Department/Status | Appointment Date: | |
| Name and Mailing Address of Other Hospital/Institution: | City: | |
| | State: | Zip: |
| Department/Status | Appointment Date: | |

If you do not have hospital privileges, please explain.

**B. PREVIOUS AFFILIATIONS (Limit to last ten years. Attach additional sheets if necessary. Reference this section number and title.)**

| Name and Mailing Address of Other Hospital/Institution: | | City: | |
|---|---|---|---|
| | | State: | Zip: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: | |
| Name and Mailing Address of Other Hospital/Institution: | | City: | |
| | | State: | Zip: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: | |
| Name and Mailing Address of Other Hospital/Institution: | | City: | |
| | | State: | Zip: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: | |

| Name and Mailing Address of Other Hospital/Institution: | | City: | |
|---|---|---|---|
| | | State: | Zip: |
| From: (mm/yy) | To: (mm/yy) | Reason for Leaving: | |

## XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list 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. Do not include program directors previously listed under post graduate training and education in Section X.

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

| Name of Reference: | Specialty: | Telephone Number: ( ) |
|---|---|---|
| Mailing Address: | | City: |
| | | State: Zip: |
| Name of Reference: | Specialty: | Telephone Number: ( ) |
| Mailing Address: | | City: |
| | | State: Zip: |
| Name of Reference: | Specialty: | Telephone Number: ( ) |
| Mailing Address: | | City: |
| | | State: Zip: |

## XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

| Current Practice: | Contact Name: | Telephone Number: ( ) |
|---|---|---|
| | | Fax Number: ( ) |
| Mailing Address: | | City: |
| | | State: Zip: |
| From: (mm/yy) | To: (mm/yy) | |
| Name of Practice/Employer: | Contact Name: | Telephone Number: ( ) |
| | | Fax Number: ( ) |
| Mailing Address: | | City: |
| | | State: Zip: |
| From: (mm/yy) | To: (mm/yy) | |

| Name of Practice/Employer: | Contact Name: | Telephone Number: ( ) |
|---|---|---|
| | | Fax Number: ( ) |
| Mailing Address: | | City: |
| | | State: / Zip: |
| From: (mm/yy) | To: (mm/yy) | |

## Section B.
### *Professional Liability Action Explanation*

Please complete this Section 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 Section B prior to completing, and complete a separate form for each lawsuit.

## I. CASE INFORMATION

| 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: | Sex of patient: | Age of patient: |

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 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 to serve as your authorization:

Name_____ Phone Number (_____)_____

Name_____ Phone Number (_____)_____

## II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (Circle One)

☐ Lawsuit/arbitration still ongoing, unresolved.

☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____

☐ Judgment rendered and I was found not liable.

☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____

☐ 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.

## SUMMARY

## Section C.
### *Certification*

I certify that the information in Sections A and B of this application and any attached documents (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 intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity 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 Mississippi Participating Physician Application. In order for participating Managed Care Entities or 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 Managed Care Entity information about 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 in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

# Section D.
## *Attestation Questions*

Please answer the following questions "yes" or "no". If your answer to any question is "yes," please provide full details on separate sheet.

1. 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 ☐

2. 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 ☐

3. 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 ☐

4. 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 ☐

5. 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 ☐

6. 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 ☐

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)?
Yes ☐ No ☐

8. Have you ever been convicted of any crime (other than a minor traffic violation)?
Yes ☐ No ☐

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceeding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.)
Yes ☐ No ☐

10. Have any judgments or claims 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 ☐

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?
Yes ☐ No ☐

12. 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 ☐

13. Are you capable of performing all the services required by your agreement with, or the professional staff by laws of, the Managed Care Entity 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, yourself or others?
Yes ☐ No ☐

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services?
Yes ☐ No ☐

I hereby affirm that the information submitted in this Section D 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 intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

# Section E.

## *Information Release/Acknowledgements*

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 Managed Care Entity" 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 businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing 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 Managed Care Entity engaged in quality assessment, peer review and credentialing on behalf of this Managed Care Entity and all persons and entities providing credentialing information to such representatives of this Managed Care Entity from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Managed Care Entity 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 Managed Care Entity as may be required by state and federal law and regulation.

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 Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (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 Managed Care Entity 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 against me by the Mississippi Board of Medical Licensure 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 against me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of 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 Managed Care Entity or 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 understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy or facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 10, 11 and 12 of this application.

Print Name Here _____

Physician Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

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Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements should be addressed to the Managed Care Entity requesting them.

**This Application is endorsed by:**
- **Mississippi Association of Health Plans**
- **Mississippi State Medical Association**
- **Mississippi Hospital Association**

[3] The intent of this release is to apply, at a minimum, protections comparable to those available in Mississippi to any action, regardless of where such action is brought.