Practitioner Credentialing

Thank you for your interest in becoming a participating provider with PacificSource Health Plans. Prior to execution of a new contract or addition to an existing group contract, you will need to complete the credentialing process with PacificSource. Please complete the credentialing application and return to the PacificSource Health Plans Credentialing Department. The following information lists criteria to be verified by our Credentialing team and your rights as an applicant.

PacificSource Health Plans makes every effort to contract with highly qualified practitioners by using clear and standardized credentialing requirements. Before a practitioner can be participating with PacificSource, the practitioner is required to successfully complete the credentialing process, which includes submitting an application supported by qualifying criteria. Credentialing applications are processed within 90 days of receipt of a complete application. Incomplete applications will be returned (to address any missing information), which will delay the credentialing process.

Qualifying Criteria Checklist

- ☐ Submit a completed application with all necessary attachments and supporting documentation.
- ☐ Include the attestation page; make sure the information is completed, signed, and dated.* Explanations for any "yes" answers must be provided.
- ☐ Include the authorization and release form with the application; make sure the form is signed and dated.*
- ☐ Provide a current, valid, and unrestricted license to practice for each state in which you will be providing services to PacificSource members.
- ☐ Provide a copy of all valid DEA certificates or prescribing plan for each state in which you will be providing services to PacificSource members.
- ☐ Include proof of admitting privileges at a participating hospital, or a written admit plan.
- ☐ Include the most recent five years of relevant work history with an explanation for any gaps of 60 days or more.
- ☐ Provide proof of board certification, or completed, verifiable education/training as applicable to your degree. Board certification is required for all MDs, DOs, and DPMs.
- ☐ Provide evidence of current professional liability insurance coverage with amounts of at least $1,000,000 per occurrence and $3,000,000 aggregate. Please include a copy of the face sheet when returning the application.

* Signatures: Faxed, digital, electronic, scanned, or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired and the disability is documented in the practitioner's file. Signatures cannot be older than 180 days at the time of credentialing approval.

Other qualifying considerations

The National Practitioner Data Bank (NPDB) will be queried and the received information will be stored with the credentialing file.

A review of Medicare's opt-out list to ensure those listed are not applying for participation in Medicare Advantage plans.

You will be notified if anything is missing. Failing to submit the necessary information by the timeframe communicated by the PacificSource Credentialing Department will disqualify the application from consideration.

Applicant rights

1. The applicant/practitioner has the right to review information submitted to support their credentialing application, e.g., malpractice claims history, state licensing board actions, board certification, etc. The practitioner is not allowed to review references, recommendations, or other peer-review-protected information.
2. PacificSource will notify applicants of any information received that is possibly erroneous, or that substantially deviates from the information provided by the practitioner on the application, curriculum vitae, supplemental documents, or from other sources. Examples might include substantial variations in information on license actions, malpractice claims, or undisclosed board certification decisions. Written notification to the practitioner will occur upon discovery of conflicting information and will include a clear explanation of the conflicting information received. If information is not received within the requested timeframe of the notification, a second request will be sent by certified mail or secured email by the credentialing specialist/coordinator with a new response timeframe indicated in the letter. Lack of response to the second request may result in closing the initial file, or termination of recredentialing/revalidation and contract participation. The practitioner must provide a complete and written explanation and documentation to support their response to the Credentialing team and/or Chief Medical Officer within the timeframe outlined in the request. Upon receipt of corrected information, Credentialing will date-stamp and initial the corrected documents. Practitioners will be promptly notified via email, telephone, fax, or mail that their explanation and/or supporting documents have been received.
3. Credentialing will provide updates on status of credentialing/validation processing upon reasonable request, informing the applicant of projected timelines, information pending, or missing and substantial variations in information, but will not share peer-protected information. Credentialing will respond to these requests via email, telephone, fax, or mail.
4. Practitioners will receive notification of these rights at the time of initial credentialing/validation included in the application packet, upon request for a new contract, or a request for an application for a practitioner wishing to be added to an existing group contract.
5. PacificSource will take steps to protect the confidentiality of information obtained and generated during the credentialing/validation process.
6. Initial applicants completing the credentialing/validation process are not subject to appeal rights.
7. Credentialing decisions are not based on applicant's age, race, ethnicity, nationality, gender, sexual orientation, or the patient population they treat (such as Medicaid).

Questions?

For more information about credentialing or validation, please contact the Credentialing team at **541-225-3747,** TTY: 711. We accept all relay calls. Or email Credentialing@PacificSource.com.

Provider Information Request

PacificSource

The information provided on this form is required for claims processing and directory listings.
Please use separate forms for additional practice locations or practitioners/organizations.

☐ Credential new provider
Effective date at your organization _____
CAQH # _____

☐ Change information
☐ Add provider to new/additional location
☐ Add provider at facility-based location only*
☐ Termination Date _____
Termination Reason _____

1. Provider information (name as shown on CMS 1500 field 31 or UB box 1)

☐ Facility ☐ Primary care practitioner ☐ Specialist care practitioner

Name _____ SSN _____ Birth date _____

NPI _____ Specialty _____

Medical license number _____ DEA number _____

☐ Male ○ Female ○ X Race/ethnicity (optional) _____

Languages spoken by provider _____

Offers telehealth ☐ Yes ○ No (If it differs from practice location, list telehealth location in section 4.)

Note: Telehealth regulations require practitioners to be licensed by the state listed in section 2.

2. Practice location information (for patient visits and directory listing)

Practice name (as it should appear in directories) _____

Address _____

City _____ State _____ Zip _____ County _____

Practitioner specialty (as practicing at this location) _____

List this location in directories? Note: facility-based locations will not be listed. ☐ Yes ○ No

Location NPI _____ Tax ID number (attach matching IRS W9) _____

Practice contact name _____ Practice contact email _____

Practice contact phone _____ Practice contact fax _____

3. Billing information (as listed on CMS 1500 field 33 or UB box 2)

☐ Same as above

Billing name (as it appears on claims) _____

Address _____

City _____ State _____ Zip _____ County _____

Billing contact name _____ Billing contact email _____

Billing contact phone _____ Billing contact fax _____

Credentialing contact name _____ Credentialing contact email _____

Credentialing contact phone _____ Credentialing contact fax _____

***Facility-based providers** are those who practice exclusively in an inpatient setting; a credentialing application is not required.

Continued >

4. Summary of changes/notes

Form completed by _____

Email _____ Phone _____

How to submit form: If credentialing a new provider, email form to: Credentialing@PacificSource.com.
For all other reasons, please email form to: ProvNetSup@PacificSource.com.
Questions? Please contact your Provider Relations Representative. Visit PacSrc.co/PRV-Reps for contact info.

OREGON PRACTITIONER CREDENTIALING APPLICATION

- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)**

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RECREDENTIAL PRACTITIONERS WITHIN OREGON.

REVIEWED, AMENDED & APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
JANUARY 29, 2024

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing application, please read and observe the following:

I. Instructions

This form should be **typed (*using a different font than the form*) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.**
- **Complete the application in its entirety**. **Keep an <u>unsigned</u> and <u>undated</u> copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 13, Attestation Questions and page 14, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable)**.
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.**
- **Submit application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (*if applicable*)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

***Note: Please return completed application to the health care related organization to which you are applying not to the state.**

OREGON PRACTITIONER CREDENTIALING APPLICATION

II. Practitioner Information *Please provide the practitioner's full legal name.*

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? Yes No
Name(s) and Year(s) Used:

Home street address:	Home telephone number: - -	Mobile/alternate number: - -
	Email address:	

City:	State:	ZIP:
Country:	Birth date: Month/Day/Year / /	Birth place:
Citizenship:	Social Security number:	Gender: Male ☐ Female ☐ X ☐

Immigrant Visa number *(if applicable)*:	Visa expiration date:	Status:	Type:

Educational Commission for Foreign Medical Graduates (ECFMG) number *(if applicable)*:	Month/Year Issued: /

III. Specialty Information *This information may be included in directory listings.*

Principal clinical specialty **(For most current specialties list, see: https://x12.org/codes/provider-taxonomy-codes):**	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐

Additional clinical practice specialties:

Category of professional activity, check all boxes that apply:

Clinical practice:

- ☐ Full Time
- ☐ Part Time
- ☐ Locum /Temporary
- ☐ Telemedicine
- ☐ Other (explain)

Other professional activities:

- ☐ Administration
- ☐ Teaching
- ☐ Research
- ☐ Retired
- ☐ Other (explain)

IV. Board Certification/Recertification *This section does not apply to licensure.* Does not apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name of issuing board	Board Certification Number (as applicable)	Specialty	Date certified/ recertified month/year	Expiration date *(if any)* month/year
			/	/
			/	/
			/	/

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and or intended future testing for certification below. Please attach additional sheets, if necessary.

V. Other Certifications *Please attach copy of certificate(s), if applicable.*

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type:	Number:	Month/Year of certification: /	Month/Year of expiration: /
Type:	Number:	Month/Year of certification: /	Month/Year of Expiration: /
Type:	Number:	Month/Year of certification: /	Month/Year of Expiration: /
Type:	Number:	Month/Year of certification: /	Month/Year of Expiration: /

For additional certifications, please attach a separate sheet.

VI. Practice and Employment Information

Name of primary practice/affiliation or clinic:		Department name *(if hospital based):*	
Primary Clinical Practice street address:			Entity type 2 (*group*) NPI number:
City:	County:	State:	ZIP:
Primary office telephone number: - - Ext.	Primary office fax number: - -		Patient appointment telephone number: - - Ext.
Mailing/Billing Address (if different from above):			Attn:
Office manager:	Office manager's telephone number: - - Ext.		Office manager's fax number: - -
Exchange/answering service number: - - Ext.	Pager number: - -		Office email address:
Credentialing Contact and Address:			
Credentialing contact's telephone number: - - Ext.	Credentialing contact's fax number: - -		Credentialing contact's email address:
Federal tax ID number or social security number, if used for business purposes:			
Name affiliated with tax ID number:			

Name of secondary practice/affiliation or clinic:		Department name *(if hospital based):*	
Secondary Clinical Practice street address:			Entity type 2 (*group*) NPI number:
City:	County:	State:	ZIP:
Primary office telephone number: - - Ext.	Primary office fax number: - -		Patient appointment telephone number: - - Ext.
Mailing/Billing Address (if different from above):			Attn:
Office manager:	Office manager's telephone number: - - Ext.		Office manager's fax number: - -
Exchange/answering service number: - - Ext.	Pager number: - -		Office email address:
Credentialing Contact and Address:			
Credentialing contact's telephone number: - - Ext.	Credentialing contact's fax number: - -		Credentialing contact's email address:
Federal tax ID number or social security number, if used for business purposes:			
Name affiliated with tax ID number:			

Please list other office locations with above information on a separate sheet.

VII. Practice Call Coverage

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

	Name:	Specialty:
1.		
2.		
3.		
4.		
5.		

VIII. Undergraduate Education (*Please attach additional sheets, if necessary*.)

Complete school name and street address:	Degree received:	Month/year of start: /
		Month/year of graduation: /
City:	State:	Course of study or major:

IX. Graduate Education (*Please attach additional sheets, if necessary.)*

Does not apply ☐

Complete school name and street address:	Degree received:	Month/year of start: /
		Month/year of graduation: /
City:	State:	Course of study or major:

X. Medical / Professional Education (*Please attach additional sheets, if necessary*.)

Complete medical/professional school name and street address:

City:	State	ZIP:	Contact email:	
Degree received:		Phone number: - -		Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /	

Did you complete the program? Yes No (*if you did not complete the program, please explain on a separate sheet.*)

Complete medical/professional school name and street address:

City:	State	ZIP:	Contact email:	
Degree received:		Phone number: - -		Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /	

Did you complete the program? Yes No (*if you did not complete the program, please explain on a separate sheet.*)

XI. Post-Graduate Year 1 / Internship (*Please attach additional sheets, if necessary.*)

Does not apply ☐

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Type of internship/specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /
Did you complete the program? Yes ☐ No ☐ **(if you did not complete the program, please explain on a separate sheet.)**			

XII. Residencies (*Please attach additional sheets, if necessary.*)

Does not apply ☐

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /
Did you complete the program? Yes ☐ No ☐ ***(if you did not complete the program, please explain on a separate sheet.)***			

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /
Did you complete the program? Yes ☐ No ☐ **(if you did not complete the program, please explain on a separate sheet.)**			

XIII. Fellowships, Preceptorships, or Other Clinical Training Programs

(*Please attach additional sheets, if necessary.)*

Does not apply ☐

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /
Did you complete the program? Yes ☐ No ☐ ***(If you did not complete the program, please explain on a separate sheet.)***			

Complete institution name and street address:

City:	State	ZIP:	Contact email:
Specialty:		Phone number: - -	Fax number, if available - -
From month/year: /	To month/year: /		Month/year of completion: /
Did you complete the program? Yes ☐ No ☐ ***(if you did not complete the program, please explain on a separate sheet.)***			

Initials: Date:

XIV. Health Care Licensure, Registrations, Certificates & ID Numbers

(*Please attach additional sheets, including Physician Assistant Collaboration Agreement, if necessary*.)

Oregon license or registration number:	Type:	Month/Day/Year of Expiration: / /
Drug Enforcement Administration (DEA) registration number (*if applicable*):		Month/Day/Year of Expiration: / /
Controlled substance registration (CSR) number (*if applicable*):		Month/Day/Year of Issue: / /
Entity type 1 (*individual*) NPI number:	Medicare number:	Oregon Medicaid provider number:
Physician Assistant Collaborating Physician or Group Full Name and Oregon License Number:		

XV. Other State Health Care Licenses, Registrations & Certificates

Does not apply ☐

***Please include all ever held.* (*Please attach additional sheets, if necessary*.)**

State/Country:	Number:	Type:
Year obtained:	Month/Day/Year of expiration: / /	Year relinquished:
Reason:		

State/Country:	Number:	Type:
Year obtained:	Month/Day/Year of expiration: / /	Year relinquished:
Reason:		

State/Country:	Number:	Type:
Year obtained:	Month/Day/Year of expiration: / /	Year relinquished:
Reason:		

***Please attach additional sheets, if necessary*.**

XVI. Hospital and Other Health Care Facility Affiliations

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). **If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.**

A. Current Affiliations

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email:			
Do you have admitting privileges at this facility? Yes No		Professional liability carrier:	
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email:			
Do you have admitting privileges at this facility? Yes No		Professional liability carrier:	
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email:			
Do you have admitting privileges at this facility? Yes No		Professional liability carrier:	
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):		Month/day/year of appointment / /	
Contact email:			
Do you have admitting privileges at this facility? Yes No		Professional liability carrier:	

If you do not have hospital admitting privileges at any of the affiliations listed in this section, please explain below your plan for continuity of care for patients who require admitting. You may also attach a separate sheet to explain your continuity of care plan.

B. Applications in Process

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.*):	Month / day / year of submission / /		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (*e.g. active, courtesy, provisional, allied health, etc.*):	Month / day / year of submission / /		

C. Previous Affiliations *Please attach additional sheets, if necessary.*

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year: / /	To month / day / year: / /		
Professional liability carrier:	Reason for leaving:		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year: / /	To month / day / year: / /		
Professional liability carrier:	Reason for leaving:		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year: / /	To month / day / year: / /		
Professional liability carrier:	Reason for leaving:		

XVII. Professional Practice / Work History

Curriculum vitae is not sufficient.

A. **Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. (*Please attach additional sheets, if necessary*.)**

Name of practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Contact's position:
From month / year: /	To month / year: /	Complete address:
Contact's email address, if available:		Professional liability carrier:
Name of practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Contact's position:
From month / year: /	To month / year: /	Complete address:
Contact's email address, if available:		Professional liability carrier:
Name of practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Contact's position:
From month / year: /	To month / year: /	Complete address:
Contact's email address, if available:		Professional liability carrier:
Name of practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Contact's position:
From month / year: /	To month / year: /	Complete address:
Contact's email address, if available:		Professional liability carrier:

Initials: Date:

B. ***Please explain any gaps greater than two (2) months*. Include activities and/or names and dates where applicable. (*Please attach additional sheets, if necessary*.)** Does not apply ☐

Activities and/or names:	From month / year:	To month / year:
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/
	/	/

XVIII. Peer References

Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

Name of reference: Specialty: Credentials: Professional relationship:		Complete address, include department if applicable:
Telephone number: - - ext	Fax number: - -	Email address, if available:
Name of reference: Specialty: Credentials: Professional relationship:		Complete address, include department if applicable:
Telephone number: - - ext	Fax number: - -	Email address, if available:
Name of reference: Specialty: Credentials: Professional relationship:		Complete address, include department if applicable:
Telephone number: - - ext	Fax number: - -	Email address, if available:

XIX. Continuing Medical Education

Please list activities for which you have received CME credit(s) during the past two (2) years.
(*Please attach a separate sheet, if needed*.)

Does not apply ☐

Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**
Name:	**Month / year attended:** /	**Hours:**

XX. Professional Liability Insurance

Current insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /	Month / day / year of expiration: / /	

Please list all previous professional liability carriers within the past five (5) years.
(*Please attach additional sheets, if necessary*.)

Does not apply ☐

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /	Month / day / year of expiration: / /	
Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /	Month / day / year of expiration: / /	
Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	

Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /	Month / day / year of expiration: / /

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (*check one*): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	

Month / day / year effective: / /	Month / day / year retroactive date, if applicable: / /	Month / day / year of expiration: / /

XXI. Attestation Questions – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.** NOTE: Answering "yes" to Question L does not require any further details.

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES	NO
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES	NO
C.	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*****, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization***** while under investigation or potential review?	YES	NO
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization*** ever been** withdrawn on your request prior to the organization's final action?	YES	NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
G.	Have you **ever** voluntarily or involuntarily left or been discharged from any education or training programs related to your current licensure or certification?	YES	NO
H.	Have you **ever** had board certification revoked?	YES	NO
I.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES	NO
J.	Have you ever been charged with a criminal violation (*felony or misdemeanor*)?	YES	NO
K.	Do you presently use any illegal drugs?	YES	NO
L.	We recognize that providers encounter health conditions, including those involving physical and mental health and substance use disorders, just as their patients do. It is imperative that providers address their health concerns for their own well-being, as well as for patient safety. Do you attest to no current physical, mental health, or chemical dependency conditions (alcohol or other substances) that currently affect your ability to practice, with or without reasonable accommodation? Please disclose any current conditions that require employer-provided accommodations on a separate sheet.	YES	NO
M.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/ hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES	NO
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES	NO
O.	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?	YES	NO

e.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:	**Date:**

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Jon McElfresh at jonathan.p.mcelfresh@oha.oregon.gov or 503-385-3075 (voice). We accept all relay calls.

Attachment A

Professional Liability Action Detail — Confidential

Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's name *(print or type)*:

Month/day/year of the incident: - - and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month/day/year the suit or claim was filed: - -

Was this claim reported to any state or federal agency? YES ☐ NO ☐

If yes, please state which agency:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action *(primary defendant, co-defendant, other)*:

Current status of suit or other action:

Month/day /year of settlement, judgment, or dismissal: - -

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature: Date:

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.