



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 in full, 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 in each state 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.

Questions?

For more information about credentialing or validation, please contact the Credentialing team at **541-684-3747** or Credentialing@PacificSource.com.

Washington Practitioner Application

To use the Washington Practitioner Application (WPA), follow these instructions:

- ❖ Keep an **unsigned** and **undated** copy of the application on file for future requests. When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate.
- ❖ Please sign and date pages 11 and 13 .
- ❖ Please document any YES responses on the Attestation Question page.
- ❖ Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- ❖ Attach copies of requested documents each time the application is submitted.
- ❖ If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- ❖ If a section does not apply to you, please check the provided box at the top of the section.
- ❖ Expect addendums from the requesting organizations for information not included on the WPA.

This application is submitted to:

1. INSTRUCTIONS

This form should be **typed 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. *Please do not use abbreviations.* **Current copies of the following documents must be submitted with this application:** (all are required for MDs, DOs; as applicable for other health practitioners).

- DEA Certificate
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application. Dates need to be listed in mm/yyyy Format)

**** All sections must be completed in their entirety. ****

2. PRACTITIONER INFORMATION – Legal Name Required

Last Name: (include suffix; Jr., Sr., III)		First:		Middle:		Degree(s):	
List any other name(s) under which you have been known by reference, licensing and or educational institutions:							
Home Mailing Address:				City:			
				State:		Zip Code:	
Home Telephone Number: ()		Pager Number: ()		Cell Phone Number: ()		E-Mail Address:	
Birth Date: (mm/dd/yyyy)		Birth Place (city, state, country):				Citizenship:	
Social Security Number:		<input type="checkbox"/> Male <input type="checkbox"/> Female		Languages Fluently Spoken by Practitioner:			
Have you ever voluntarily opted-out of Medicare? Yes <input type="checkbox"/> No <input type="checkbox"/>							
NPI:		Medicare Number: (WA)		Medicaid (DSHS) Number(s):		L & I Number(s):	
Specialty primarily practicing:				Sub specialties primarily practicing:			
Other Professional Interests in Practice, Research, etc.:							

3. PRACTICE INFORMATION		CHECK ALL THAT APPLY	
Effective Date at Primary Practice location (MM/YY) _____			
Practice Setting <input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other			
Practitioner Profile <input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Check if you are both PCP & OB OB in your practice <input type="checkbox"/> Yes <input type="checkbox"/> No Deliveries <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State:	Zip Code:
		Org. NPI#:	
Patient Appointment Telephone Number: ()		Fax Number: ()	
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:		Administration Telephone Number: ()	
E-mail Address:		Fax Number: ()	
Credentialing Contact (if different from above):		Telephone Number: ()	
E-mail Address:		Fax Number: ()	
Name Affiliated with Tax ID Number:		Federal Tax ID Number:	
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Hours	
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Monday: _____	
Have you limited your practice in any way (e.g. 18 years or older?)		Tuesday: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		Wednesday: _____	
_____		Thursday: _____	
_____		Friday: _____	
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No		Saturday: _____	
If yes, please provide the name and specialty below:		Sunday: _____	
_____		Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____		If no, please explain how your patients obtain	
Please list languages fluently spoken by office staff:		advice and care after hours:	
_____		_____	
_____		_____	
A. Inpatient Coverage Plan (for those without admitting privileges)			Does Not Apply <input type="checkbox"/>
Name of Admitting Physician/Practice/Clinic/Group:		Hospital Where privileged:	
_____		_____	
_____		_____	
_____		_____	
B. Covering Practitioners/Call Group			Does Not Apply <input type="checkbox"/>
<u>Provider Name, Degree</u>	<u>Specialty</u>	<u>Address</u>	<u>Phone Number</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Attach a list of additional covering practitioners if needed			

Effective Date at Secondary Practice location (MM/YYYY) _____		CHECK ALL THAT APPLY	
Practice Setting			
<input type="checkbox"/> Clinic/Group <input type="checkbox"/> Solo Practice <input type="checkbox"/> Home Based <input type="checkbox"/> Hospital Based <input type="checkbox"/> Primary Care Site <input type="checkbox"/> Urgent Care <input type="checkbox"/> Other			
Practitioner Profile			
<input type="checkbox"/> PCP <input type="checkbox"/> Specialist <input type="checkbox"/> Check if you are both PCP & OB OB in your practice <input type="checkbox"/> Yes <input type="checkbox"/> No Deliveries <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name of Secondary Practice / Affiliation or Clinic Name:		Department Name (if hospital based):	
Primary Office Street Address:		City:	
		State:	Zip Code:
		Org. NPI#	
Patient Appointment Telephone Number: ()		Fax Number: ()	
Mailing Address: (if different from above)			
Billing Address: (if different from above)			
Practice Website			
Office Manager / Administrator Name:		Administration Telephone Number: ()	
E-mail Address:		Fax Number: ()	
Credentialing Contact (if different from above):		Telephone Number: ()	
E-mail Address:		Fax Number: ()	
Name Affiliated with Tax ID Number:		Federal Tax ID Number:	
Is the office wheelchair accessible? <input type="checkbox"/> Yes <input type="checkbox"/> No		Office Hours	
Are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		Monday: _____	
Have you limited your practice in any way (e.g. 18 years or older?)		Tuesday: _____	
<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:		Wednesday: _____	
_____		Thursday: _____	
_____		Friday: _____	
Do you currently supervise ARNP's or PA's? <input type="checkbox"/> Yes <input type="checkbox"/> No		Saturday: _____	
If yes, please provide the name and specialty below:		Sunday: _____	
_____		Do you provide 24 hour coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
_____		If no, please explain how your patients obtain	
Please list languages fluently spoken by office staff:		advice and care after hours:	
_____		_____	
_____		_____	

A. Inpatient Coverage Plan (for those without admitting privileges)			Does Not Apply <input type="checkbox"/>
Name of Admitting Physician/Practice/Clinic/Group:		Hospital Where privileged:	
_____		_____	
_____		_____	
B. Covering Practitioners/Call Group			Does Not Apply <input type="checkbox"/>
Provider Name, Degree	Specialty	Address	Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Attach a list of additional covering practitioners if needed			

LIST OTHER OFFICE LOCATIONS WITH THE ABOVE INFORMATION ON A SEPARATE SHEET

4. PROFESSIONAL LICENSURE, REGISTRATIONS AND CERTIFICATIONS

(Attach Additional Sheet if Necessary)

Washington State Professional License/Registration/Cert Number:	Issue Date:	Expiration Date:
Name of Sponsor if required by licensure, (e.g. Physician's Assistant).		
Pharmacists Collaborative Drug Therapy Agreement (CDTA) Number(s):		
Drug Enforcement Administration (DEA) Registration Number:	Expiration Date:	
ECFMG Number (applicable to foreign medical graduates):	Date Issued:	

5. ALL OTHER PROFESSIONAL LICENSES, REGISTRATIONS AND CERTIFICATIONS

State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:
State:	Lic/Reg/Cert Number:	Date Issued	Exp. Date	Yr. Relinquish	Reason:

6. UNDERGRADUATE EDUCATION (Do not abbreviate)

Does Not Apply ☐

School/College/University/Vocational Education:	Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:
College or University Name:	Degree Received (be specific, e.g. BS Biology)		Graduation Date (mm/yyyy)
Mailing Address:	City:	State:	Zip Code:

7. MEDICAL/PROFESSIONAL EDUCATION (Do not abbreviate)

Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:
Medical/Professional School:	Start Date (mm/yyyy)	Graduation Date (mm/yyyy)	Degree Received
Mailing Address:	City:	State:	Zip Code:

8. MASTER DEGREE PROGRAM OR POST GRADUATE EDUCATION

Does Not Apply ☐

Institution:	Address	City	State	Zip Code:
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)	Program or Course of Study:	Faculty Director:		

9. INTERNSHIP/PGYI (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>	
Institution:		Phone Number:		Fax Number:	
Mailing Address:		City:		State:	
Type of Internship:		Specialty:		From (mm/yyyy):	
				To (mm/yyyy):	
10. RESIDENCIES (Attach Additional Sheet if Necessary)					
Institution:		Phone Number:		Fax Number:	
Mailing Address:		City:		State:	
Type of Residency:		Specialty:		From (mm/yyyy):	
				To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
Institution:		Phone Number:		Fax Number:	
Mailing Address:		City:		State:	
Type of Residency:		Specialty:		From (mm/yyyy):	
				To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
11. FELLOWSHIPS (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>	
Institution:		Phone Number:		Fax Number:	
Mailing Address:		City:		State:	
Course of Study:				From (mm/yyyy):	
				To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
Institution:		Phone Number:		Fax Number:	
Mailing Address:		City:		State:	
Course of Study:				From (mm/yyyy):	
				To (mm/yyyy):	
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No", please explain on separate sheet.)					
12. PRECEPTORSHIP (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>	
Institution:		Address:		City:	
				State:	
				Zip Code:	
Telephone Number ()		Fax Number ()		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)		Training:		Department Chairman:	

13. FACULTY/TEACHING APPOINTMENTS (Attach Additional Sheet if Necessary)				Does Not Apply <input type="checkbox"/>	
Institution:		Address:		City:	
				State:	
				Zip Code:	
Telephone Number ()		Fax Number ()		Email Address	
Dates Attended (mm/yyyy - mm/yyyy): (/) - (/)		Position:		Faculty Director:	
14. BOARD CERTIFICATION					
Does Not Apply <input type="checkbox"/>					
Are you board or otherwise professionally certified?					
<input type="checkbox"/> Yes If "Yes", please complete below:		<input type="checkbox"/> No If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.			
Issuing Board/Entity and State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)	
Have you applied for certification other than those indicated above? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If so, list certification and date:					
If you participate in a specialty which does not have board certification, please indicate specialty:					
15. OTHER CERTIFICATIONS ACLS, BLS, ATLS, PALS, NALS (e.g., Fluoroscopy, Radiography, etc.) (Attach Certificate if Applicable)					
Type:	Number:		Expiration Date:		
Type:	Number:		Expiration Date:		
16. HOSPITAL, MILITARY, AND OTHER INSTITUTIONAL AFFILIATIONS					
Does Not Apply <input type="checkbox"/>					
Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you (A) Current Hospital affiliation, (B) Previous Hospital Affiliations, (C) Current Military Affiliation, (D) Previous Military Affiliations (E) Applications in process This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.					
A. CURRENT HOSPITAL AFFILIATIONS (Do not abbreviate)					
Name of Primary Admitting Hospital:			Department:		
Mailing Address			City, State , Zip		
Phone number:			Fax Number:		
Status (active, provisional, courtesy, temporary, etc.):			Appointment Date (mm/yyyy):		
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/>					
<input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> can admit to for all locations					
Name of Secondary Admitting Hospital:			Department:		
Mailing Address			City, State, Zip		
Phone number:			Fax Number:		
Status:			Appointment Date (mm/yyyy):		
Can you admit / follow clients of your primary, secondary, other practice locations? Does Not Apply <input type="checkbox"/>					
<input type="checkbox"/> Primary practice admits only <input type="checkbox"/> Secondary Practice admits only <input type="checkbox"/> Can admit to for all locations					

Name of Other Institutions:	Department:
Mailing Address	City, State, Zip
Phone number:	Fax Number:
Status:	Appointment Date (mm/yyyy):

Can you admit / follow clients of your primary, secondary, other practice locations? **Does Not Apply** ☐
☐ Primary practice admits only ☐ Secondary Practice admits only ☐ Can admit to for all locations

B. PREVIOUS HOSPITAL AFFILIATIONS (Do not abbreviate)

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

Name of Admitting Hospital:	Department:	
Mailing Address	City, State, Zip	
Previous Status (active, provisional, courtesy, temporary, etc.):	From (mm/yyyy):	To (mm/yyyy):
Reason for Leaving:		

C. CURRENT MILITARY AFFILIATIONS (Do not abbreviate) Please include Military Reserves

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

D. PREVIOUS MILITARY AFFILIATIONS (Do not abbreviate)

Name of Primary Base:	Division
Mailing Address	City, State , Zip
Phone number:	Fax Number:
Status (active, provisional, courtesy, temporary, etc.):	Appointment Date (mm/yyyy):

E. APPLICATIONS IN PROCESS (Do not abbreviate)					
Hospital/Institution:		Phone Number/Fax Number:		Date Application Submitted:	
Mailing Address:		City:		State:	Zip Code:
Hospital/Institution:		Phone Number/Fax Number:		Date Application Submitted(mm/yyyy)	
Mailing Address:		City:		State:	Zip Code:
17. WORK HISTORY (Do not abbreviate)					
Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. Curriculum vitae is <u>not</u> sufficient.					
Name of Practice / Employer:		Contact Name:		Telephone Number: ()	
Reason for Leaving:		Email Address		Fax Number: ()	
Mailing Address		City:	State:	Zip:	From (mm/yyyy) To (mm/yyyy)
Name of Practice / Employer:		Contact Name:		Telephone Number: ()	
Reason for Leaving:		Email Address		Fax Number: ()	
Mailing Address:		City:	State:	Zip Code:	From (mm/yyyy): To (mm/yyyy):
Name of Practice / Employer:		Contact Name:		Telephone Number: ()	
Reason for Leaving:		Email Address		Fax Number: ()	
Mailing Address:		City:	State:	Zip Code:	From (mm/yyyy): To (mm/yyyy):
18. GAPS IN HISTORY. Please account for all gaps between dates of medical/professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable:					
				From (mm/yyyy):	To (mm/yyyy):
19. PEER REFERENCES					
List at least three professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. If you have been out of residency or fellowship for a period of less than three years, one reference must be from the Program Director. Allied Health Provider must provide at least one reference from the same discipline.					
Name of Reference:		Title and Specialty:		E-mail Address:	
Mailing Address:		City:		State:	Zip Code:
Telephone Number: ()		Fax Number: ()		Cell Phone Number: (Optional) ()	

Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()	
Name of Reference:	Title and Specialty:	E-mail Address:	
Mailing Address:	City:	State:	Zip Code:
Telephone Number: ()	Fax Number: ()	Cell Phone Number: (Optional) ()	

20. PROFESSIONAL AFFILIATIONS (*Do not abbreviate*)

Please List Membership In All Professional Societies Complete Name of Society:	Date Joined	Current Member
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO
	/ / .	<input type="checkbox"/> YES <input type="checkbox"/> NO

21. PROFESSIONAL LIABILITY (*Do not abbreviate*)

A. Current Insurance Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

B. PREVIOUS PROFESSIONAL LIABILITY CARRIERS WITHIN THE LAST TEN YEARS (*Do not abbreviate*) (Attach Additional Sheet if Necessary)

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):
Name of Carrier:		Policy Number:	
Mailing Address:	City:	State:	Zip Code:
Phone Number:		Fax Number:	
Per claim amount: \$	Aggregate amount: \$	Date Began (mm/yyyy):	Expiration Date (mm/yyyy):

WASHINGTON PRACTITIONER ATTESTATION QUESTIONS - To be completed by the practitioner

Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. <i>If you attach additional sheets, sign and date each sheet.</i>			
A. PROFESSIONAL SANCTIONS			
1.	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?		
	a.	License to practice any profession in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Other professional registration or certification in any jurisdiction	YES <input type="checkbox"/> NO <input type="checkbox"/>
	c.	Specialty or subspecialty board certification	YES <input type="checkbox"/> NO <input type="checkbox"/>
	d.	Membership on any hospital medical staff	YES <input type="checkbox"/> NO <input type="checkbox"/>
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	YES <input type="checkbox"/> NO <input type="checkbox"/>
	f.	Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program	YES <input type="checkbox"/> NO <input type="checkbox"/>
	g.	Professional society membership or fellowship	YES <input type="checkbox"/> NO <input type="checkbox"/>
	h.	Participation/membership in an HMO, PPO, IPA, PHO, Health Plan or other entity	YES <input type="checkbox"/> NO <input type="checkbox"/>
	i.	Academic Appointment	YES <input type="checkbox"/> NO <input type="checkbox"/>
	j.	Authority to prescribe controlled substances (DEA or other authority)	YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		YES <input type="checkbox"/> NO <input type="checkbox"/>
B. CRIMINAL HISTORY			
1.	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		YES <input type="checkbox"/> NO <input type="checkbox"/>
	a.	Do you have notice of any such anticipated charges?	YES <input type="checkbox"/> NO <input type="checkbox"/>
	b.	Are you currently under governmental investigation?	YES <input type="checkbox"/> NO <input type="checkbox"/>
C. AFFIRMATION OF ABILITIES			
1.	Do you presently use any drugs illegally?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Do you have, or have you had in the last five years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. <u>If the answer to this question is yes</u> , please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		YES <input type="checkbox"/> NO <input type="checkbox"/>
D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
1.	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	Are there any such claims being asserted against you now?		YES <input type="checkbox"/> NO <input type="checkbox"/>
4.	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		YES <input type="checkbox"/> NO <input type="checkbox"/>
5.	Are any of the privileges that you are requesting <u>not</u> covered by your current malpractice coverage?		YES <input type="checkbox"/> NO <input type="checkbox"/>

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: _____

Date _____

Type or Print name here _____

22. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL	Does Not Apply <input type="checkbox"/>
Practitioner Name:(print or type)	
Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. <u>Please do not include patient names or other HIPAA protected PHI.</u> Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.	
Date and clinical details of the incident, with preceding events:	
Date:	Details:
Your role and specific responsibility in the incident:	
Subsequent events, including patient's clinical outcome:	
Date suit or claim was filed:	
Name and Address of Insurance Carrier that handled the claim:	
Your status in the legal action (primary defendant, co-defendant, other):	
Current status of suit or other action:	
Date of settlement, judgment, or dismissal:	
If case was settled out-of-court, or with a judgment, settlement amount attributed to you? \$	

23. ATTESTATION

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name

Here: _____

Signature:

(Stamped signature is not acceptable)

Date:

Review dates and initials:

Healthcare Organization:

And/or Designated Agent:

WASHINGTON PRACTITIONER APPLICATION AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Washington Practitioner Application (WPA) and/or the Washington Practitioner Attestation or Credentials Update (CU) form, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated on the WPA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by the healthcare organization.
2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.
3. I authorize all individuals, institutions and entities or organizations with which I am currently or 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 release the aforementioned information to the designated Healthcare 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 or provide 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 providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.
6. I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of the Healthcare Organization.
7. I acknowledge that I am responsible for notifying the Healthcare Organization of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.
8. I attest to the accuracy, currency and completeness of the information provided. I understand and agree that any misstatements in or omissions from the CU, WPA, Washington Practitioner Attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.
9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
10. I understand that completion and submission of the Authorization and Release does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the WPA/CU or Attestation.
11. I hereby further authorize and consent to the release of information and/or reporting by the Healthcare Organization(s) to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which the Healthcare Organization(s) may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Healthcare Organization(s) and its staff and representatives for so doing.
12. 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/attestation.

Print Name

Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____

****Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).***

Modification to the wording or format of the WPA/Attestation/Authorization and Release may invalidate an application.

WPA January 2011