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Public Health Emergency Credentialing Application

Print Name:_____ Date of Birth:_____

Prof. Title (M.D., Ph.D., etc.): _____ Gender: ☐ Male ☐ Female

Provider Type*: ☐ **PCP** ☐ **Specialist** ☐ **Both** ☐ **NP** ☐ **NPPCP** ☐ **PA** ☐ **PAPCP** ☐ **Other:** _____
(*Closed Panel Status only)

Medical/Professional School: _____ Graduation Date: _____

Residency:_____ Dates from: _____to: _____

Residency:_____ Dates from: _____to: _____

Residency:_____ Dates from: _____to: _____

Fellowship:_____ Dates from: _____to: _____

Fellowship:_____ Dates from: _____to: _____

Certification: ☐ Primary Specialist (% of time) _____ ☐ Secondary Specialty (% of time) _____

Name of collaborating/supervising clinician: _____

Primary Office Address:_____ Phone:_____

Office Address:_____ Phone:_____

Office Address:_____ Phone:_____

Email Address:_____ Fax:_____

National Practitioner Identification Number (NPI): _____ Social Security No._____

Please attach a separate sheet if additional space is necessary or attach a current curriculum vitae:

Please attest to having a current Massachusetts professional license in good standing #:

_____

(Please attach a copy of the 'license in good standing confirmation' given to MA licensing board, if applicable)

Please check and attest to the following boxes, as applicable:

☐ Current Federal DEA in good standing (as applicable)

☐ Malpractice Coverage in the amount of $1M/$3M for the duration of the Public Health Emergency

☐ Indicate Massachusetts Hospital Affiliation for Public Health Emergency: _____

Staff Category: _____ Date of Appointment: _____

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Please Return this Application to PHEexpeditedCred@BCBSMA.COM

APPLICANT'S AUTHORIZATION AND ATTESTATION

By applying for Public Health Emergency Credentialing:

I am willing to make myself available for interviews in regard to this application. I also agree to provide each Health Plan with updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the hospital(s), Health Plan(s) or their respective authorized representatives. I understand that failure to provide all information requested will prevent evaluation of and/or action on my application. I hereby attest that the information in or attached to this application is true and complete and fairly represents the current level of my training, experience, capability and competence to practice the clinical privileges requested. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, may constitute sufficient cause for rejection of this application resulting in denial of Hospital appointment and clinical privileges or Health Plan network participation. In the event that Hospital appointment or privileges, or Health Plan network participation, has/have been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in termination of such appointment or privileges, or network participation.

I understand that with the exception of information determined by the Health Plan to be peer review protected, I have the right to request in writing and subsequently review any information obtained by the Hospital or Health Plan to support its evaluation of my application and to correct any erroneous information.

I agree that if I am granted Hospital clinical privileges or Health Plan network participation, I will maintain during the term of my appointment or participation malpractice insurance coverage in an amount equal to or greater than the minimum required by the Hospital or Health Plan respectively and with a carrier acceptable to the Hospital or Health Plan respectively.

I hereby authorize the Hospital and the Health Plan to consult with any representative(s) of the medical/professional or administrative staff of any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications, and to inspect such records which shall be material to the evaluation of my professional qualifications and competence to carry out the privileges I am requesting, as well as to my moral and ethical qualifications.

I hereby authorize any health care organizations with which I have or have had employment, practice, association or privileges, and any other organizations (including without limitation state licensing boards and the National Practitioner Data Bank) or individuals who have information bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualification to provide and/or release information (both written and oral) to representatives of the Hospital and its medical/professional staff and to the Health Plan bearing on my credentials, competence, professional performance, clinical skills, judgment, character and ethical qualifications. Such information includes but is not limited to information regarding any and all malpractice actions, pending or final disciplinary actions and alterations in privileges, and any information with respect to whether I am able to perform the essential functions of the position for which I have applied or the privileges I have requested with or without a reasonable accommodation, according to accepted standards of professional practice and without posing a direct threat to patients or staff (including without limitation information regarding any impairment due to the use of drugs or alcohol).

I authorize and request my medical malpractice liability insurance carrier to release information to the Hospital and Health Plan regarding any claims or actions for damages pending or closed, whether or not there has been a final disposition. If requested, I agree to undergo a mental or physical examination, prior to or during the term of my appointment to determine whether I am able to perform the essential functions of the position for which I have applied or for the privileges which I have requested, with or without a reasonable accommodation, according to accepted standards of professional performance and without posing a threat to patients or staff.

I agree to notify the Hospital and Health Plan as soon as I become aware that any health care organization, Hospital or any licensing, certifying or regulatory authority has initiated or taken disciplinary action of any kind against me, or has initiated an investigation as a result of a complaint or allegation against me.

I hereby release from liability any and all individuals and organizations that, in good faith and without malice, provide information to the Hospital and Health Plan or to their respective medical/professional staff for the purpose of evaluating this application. I also hereby release

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from liability the Hospital and Health Plan, their respective medical/professional staffs and their respective agents and representatives for their acts performed in good faith and without malice in connection with the evaluation of my professional skills, competence, character, credentials and qualifications and the exchange of information with respect to my professional skills, competence, character, credentials and qualifications.

I agree that a photocopy of this Authorization and Release will be as valid as the original, and that this Authorization and Release will remain valid as to each Hospital and Health Plan unless revoked by me in writing, or the date on which the Hospital or Health Plan next conducts recredentialing of my status with the Hospital or Health Plan.

I acknowledge that (1) participation in the provider network or networks operated or contracted by the Health Plan is not a right of every licensed professional who makes application for the same; (2) acceptance of this application does not constitute approval or acceptance of participation until such time as a provider contract is executed by me and the Health Plan to which I have applied; (3) my request will be evaluated in accordance with prescribed procedures defined in the Health Plan's policies and procedures; (4) all recommendations relative to my application are subject to the ultimate action of the Health Plan's Credentialing & Peer Review Committee, or designee, whose decision shall be final; (5) I have the responsibility to keep this application current by informing the Health Plan of any change in my professional liability insurance coverage, the filing of a lawsuit against me, and any change in my medical/professional staff status, including but not limited to a disciplinary action, at any hospital, or with any other health care organization or professional organization; (6) my continued participation in the provider network remains contingent upon my continued demonstration of professional competence, continued compliance with the Health Plan's credentialing criteria, compliance with the Health Plan's policies and procedures for re-credentialing, and compliance with my contract with the Health Plan; and (7) may complete name and title, specialty or specialties, hospital affiliations, practice addresses, telephone number, languages spoken and handicap accessibility at my practice locations may be included in a physician directory prepared for enrollees of each Health Plan with whom I sign contract.

Further, I authorize the Health Plan(s) to provide my credentialing status to my affiliated provider organization's leaders and notwithstanding anything to the contrary contained in any agreement, I authorize the Health Plan(s) to release my name, address, telephone number, tax identification number and other identifying information to individuals and entities for legitimate business purposes related to the administration of Health Plan products and services.

Applicant's Signature: _____ **Date**: _____

Group Name:_____

Group NPI: _____ Group Tax ID:_____

Print name of Signatory:_____

Group Statement:

I am authorized by _____ (name of group) to request that this applicant be linked to this group for the duration of the Public Health Emergency, or as deemed appropriate by your Plan.

_____ Date:_____
Signature

Credentialing Contact:
Name:_____Phone:_____Email_____

For questions please contact our Provider Service Team at **1-800-882-2060.**

Please Return this Application to PHEexpeditedCred@BCBSMA.COM