

Individual Provider Credentialing Application

Application Instructions

In compliance with Ohio laws, the following *Individual Provider Credentialing Application* is required for all dentists applying for network participation. Please complete the highlighted sections on the following pages of this *Application*.

As referenced on the *Application*, if you require a *Supplemental Form* or need to reference a *Table*, visit the **Dentist Support Center** on our website at **SuperiorDental.com**.

Provider Type, Specialty and Language Codes

Codes will be needed to complete portions of the application. The code lists for these sections follow this cover sheet for your convenience.

Required Dentist Agreement and W-9 Form

In addition to the *Application*, please complete a *Summary Disclosure and Dentist Participation Agreement*, *Medicare Advantage Addendum* or *Medicare Advantage Opt Out Form*, and a *W-9 Form*. These forms are also available in the **Dentist Support Center** on the SDC website—they can be found below the application.

Send the completed forms listed above with copies of your **DEA License** (if applicable), **Professional Liability**, and any other supporting documentation to SDC by mail, fax, secure upload from our website or secure email:



Superior Dental Care Attn: Dental Services 6651 Centerville Business Pkwy Centerville, OH 45459



(866) 788-7301



Secure Upload at SuperiorDental.com



SDCredentialing@ SuperiorDental.com Secure email only

If you have any questions, please contact Dental Services at **1-800-762-3159** (select provider, option 2 – dentist contracting) or **SDCredentialing@SuperiorDental.com**.

Please be aware that SDC's minimum professional liability coverage requirements are \$1 million/incident, \$3 million/aggregate for Oral Surgeons and \$200,000/incident, \$600,000/aggregate for General Dentists and all other specialties.

Provider Type, Specialty and Language Codes

The following codes will be needed to complete the application:

Provider Type Codes (page 1, section 1)

002 Doctor of Dental Surgery (DDS)

003 Doctor of Dental Medicine (DMD)

Specialty Codes - DDS / DMD (page 5, section 3)

- 2 Dentist
- 13 Dentist, Dental Public Health
- 14 Dentist, Endodontics
- 438 Dentist, General Practice
- 16 Dentist, Oral and Maxillofacial Pathology
- 439 Dentist, Oral and Maxillofacial Radiology
- 20 Dentist, Oral and Maxillofacial Surgery
- 15 Dentist, Orthodontics and Dentofacial Orthopedics
- 17 Dentist, Pediatric Dentistry
- 18 Dentist, Periodontics
- 19 Dentist, Prosthodontics

Language Codes (page 1, section 1 and page 10, section 4)

001	Abkhazian	036	Frisian	071	Macedonian	106	Slovak
002	Afan (Oromo)	037	Galican	072	Malagasy	107	Slovenian
003	Afar	038	Georgian	073	Malay	108	Somali
004	Afrikaans	039	German	074	Malayalam	109	Spanish
005	Albanian	040	Greek	075	Maltese	110	Sundanese
006	Amharic	041	Greenlandic	076	Maori	111	Swahili
007	Arabic	042	Guarani	077	Marathi	112	Swedish
800	Armenian	043	Gujarati	078	Moldavian	113	Tagalog
009	Assamese	044	Hausa	079	Mongolian	114	Tajik
010	Zerbaijani	045	Hebrew	080	Nauru	115	Tamil
011	Bashkir	046	Hindi	081	Nepali	116	Tatar
012	Basque	047	Hungarian	082	Norwegian	117	Telugu
013	Bengali;Bangla	048	Icelandic	083	Occitan	118	Thai
014	Bhutani	049	Indonesian	084	Oriya	119	Tibetan
015	Bihari	050	Interlingua	085	Pashto;Pushto	120	Tigrinya
016	Bislama	051	Interlingue	086	Persian (Farsi)	121	Tonga
017	Breton	052	Inuktitut	087	Polish	122	Tsonga
018	Bulgarian	053	Inupiak	088	Portuguese	123	Turkish
019	Burmese	054	Irish	089	Punjabi	124	Turkmen
020	Byelorussian	055	Italian	090	Quechua	125	Twi
021	Cambodian	056	Japanese	091	Rhaeto-Romance	126	Uigur
022	Catalan	057	Javanese	092	Romanian	127	Ukrainian
023	Chinese	058	Kannada	093	Russian	128	Urdu
024	Corsican	059	Kashmiri	094	Samoan	129	Uzbek
025	Croatian	060	Kazakh	095	Sangho	130	Vietnamese
026	Czech	061	Kinyarwanda	096	Sanskrit	131	Volapuk
027	Danish	062	Kirghiz	097	Scot Gaelic	132	Welsh
028	Dutch	063	Kurundi	098	Serbian	133	Wolof
140	English	064	Korean	099	Serbo-Croatian	134	Xhosa
030	Esperonto	065	Kurdish	100	Sesotho	135	Yiddish
031	Estonian	066	Laothian	101	Setswana	136	Yoruba
032	Faroese	067	Latin	102	Shona	10	Zerbaijani
033	Fiji	068	Latvian;Lettish	103	Sindhi	137	Zhua
034	Finnish	069	Lingala	104	Singhalese	138	Zulu
035	French	070	Lithuanian	105	Siswati		

Provider Application

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	FIRST NA	AME*							_				•	MIDDLE	NAME								
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National Identification Number if you do not have a SSN. Do not enter National Provider Identification (NPI) Number here.	CITYOF	BIRTH																STATE OF	F	COUNTRY	' OF		
Code lists are found on pages 36-43. Enter the	SSN*			-						FORE	IGN N	ATION	AL IDEI	NTIFICA	TION NU	MBER	(FNIN)			FNIN CO	UNTRY	OF ISSUE	Ξ
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Section 1	Personal Information and Professional IDs (Contin	ued)
Professional IDS Include all state licenses, DEA Registration and State Controlled Dangerous	FEDERAL DEA NUMBER DEA STATE OF REGISTRATION	M M D D Y Y Y Y DEA ISSUE DATE M M D D Y Y Y Y DEA EXPIRATION DATE
Substance (CDS) certification numbers. Provide all current and previous licenses/ certifications.	CDS CERTIFICATE NUMBER CDS STATE OF REGISTRATION	M M D D Y Y Y Y CDS ISSUE DATE M M D D Y Y Y Y CDS EXPIRATION DATE
Non-licensed professionals should enter certification/ registration number in the space provided for license number. If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE	LICENSE ISSUING STATE LICENSE ISSUE DATE M M D D Y Y Y Y LICENSE EXPIRATION DATE Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
	STATE LICENSE NUMBER IF THIS IS A STATE LICENSE, ARE YOU CURRENTLY PRACTICING IN THIS STATE? Code list is found on page 36; use license status codes. Enter 3-digit code in space provided. LICENSE STATUS CODE LICENSE TYPE	LICENSE ISSUING STATE LICENSE ISSUE DATE M M D D Y Y Y Y LICENSE EXPIRATION DATE Code list is found on page 36; use provider type codes. Enter 3-digit code in space provided.
Other ID Numbers If you have additional Professional IDs to report, use the Professional IDs Supplemental Form on page 19.	ARE YOU A PART- ICIPATING MEDICARE PROVIDER?* ARE YOU A PART- ICIPATING MEDICAID PROVIDER?* NO MEDICARE NUMBER NO MEDICAID NUMBER INDIVIDUAL NPI - TYPE 1 USMLE NUMBER (WI WORKERS COMPENSATION NUMBER	UPIN MEDICAID STATE ITHOUT HYPHENS)
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Section 2	Education and Training
Undergraduate	UNDERGRADUATE SCHOOL
School(s) Provide the appropriate	
information for the school that issued your	OFFICIAL NAME OF UNDERGRADUATE SCHOOL
undergraduate degree and all schools	
attended.	ADDRESS
Professional	CITY STATE ZIP/POSTAL CODE
School(s)	
Provide the appropriate	COUNTRY CODE TELEPHONE FAX
information for the school that issued your	
professional degree.	START DATE END DATE (GRADUATION DATE) DEGREE AWARDED
Fifth Pathway Graduates please complete the following sections: U.S. School that issued your	DID YOU COMPLETE YOUR UNDERGRADUATE EDUCATION AT THIS SCHOOL? YES NO
certificate, the Non-U.S. School where you	GRADUATE TYPE*:
attended, and the Fifth Pathway institution where you completed your training on	U.S. OR CANADIAN GRADUATE NON-U.S./CANADIAN GRADUATE FIFTH PATHWAY GRADUATE
Supplemental Page 20.	U.S. OR CANADIAN SCHOOL
Code lists are found on pages 36-43. Enter the associated 3-digit code	SCHOOL CODE (U.S./ CANADIAN ONLY) NAME OF U.S./ CANADIAN SCHOOL:
in the space provided. If you have additional	M M Y Y Y Y START DATE* END DATE (GRADUATION DATE)* DEGREE AWARDED
Undergraduate or Professional Schools to report, use the Education Supplemental	DID YOU COMPLETE YOUR GRADUATE EDUCATION AT THIS SCHOOL? YES NO
Form on page 20.	NON - U.S. OR CANADIAN SCHOOL
	OFFICIAL NAME OF NON-U.S. PROFESSIONAL SCHOOL
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ction 4	Practice Location Information (Continued)	
rtners/	LIST ALL PARTNERS/ASSOCIATES AT THIS PRACTICE	
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e lists are found on	LAST NAME	SPECIALTY CODE COVERING
es 36-43. Enter the	LASI NAME	COLLEAGE (Y/N)?
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	LAST NAME	SPECIALTY CODE
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ction 5	Hospital Affiliations	, ,
Ction 5	Tiospital Attituations	
mitting	DO YOU HAVE HOSPITAL YES NO TYPE OF ADMITTING ARRANGEMENTS DO	
rangements	PRIVILEGES?* YOU HAVE?	

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Section 6	Professional Liability	ınsura	ance (Jarri	er																	
Professional Liability	CARRIER OR SELF-INSURED NAME*																SELF	-INSU	RED?*		YES	N
Insurance Carrier																						
IMPORTANT IF YOU DO NOT CARRY MALPRACTICE	NUMBER* ST	REET*																SUIT	E/BUIL	.DING		٦
INSURANCE, CHECK THIS BOX AND SKIP	CITY*														STA	TE*		ZIP	CODE*	•)		
THIS SECTION.	ORIGINAL EFFECTIVE DATE*	M EFFEC	M Y	E*)	Υ	Υ		M EXPIR.	M	Y	Υ	Υ	Υ		YPE (OF AGE?*)	IND	IVIDUA	.L	SHA	RED
	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?*		YES	NO		AMOU	NT OF	COVE	DACE	DED.	,	- I		\$	MOU	NT OF	COVE	DACE	ACCE.	,		
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Liability Insurance	CARRIER OR SELF-INSURED NAME																					_
Carrier																						
List other current,	NUMBER* ST	REET*																SUIT	E/BUIL	DING		
future, or previous carrier(s) if current																						
carrier is less than ten (10) years.	CITY*														STA	TE*		ZIP	CODE*	,		
NOTE: A longer period may be required by	MMYYYY	M	M Y	Υ	Υ	Υ		M	М	Υ	Υ	Υ	Υ		YPE (OF AGE?*	,	IND	IVIDUA	ıL	SHA	RED
your healthcare entity.	ORIGINAL EFFECTIVE DATE*	EFFEC	JIIVE DAI	=				EXPIR	ATION	DATE												
If you have additional Insurance, use the Supplemental	DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?		YES	NO		AMOU	NT OF	COVE	RAGE	PER (OCCURI	RENCE		\$	MOU	NT OF	COVE	RAGE	AGGR	REGATE	<u> </u>	
Insurance Form on page 31.	POLICY INCLUDES TAIL COVERAGE?		YES	NO																		
	POLICY NUMBER*																					
Section 7	Work History and Refe	rence	s																			
Military Duty	Are you currently on active militar duty or military reserve?*	/	YES	NC)																	
Work History	WORK HISTORY																					
Include a chronological work history for the past 10 years.	PRACTICE / EMPLOYER NAME																					
A longer period may be required by your healthcare entity.	NUMBER ST	REET)																SUI	TE/BUI	ILDING		
If you have additional work history, use the Supplemental Work History Form on page	СПУ									STATI	E	(ZIP/P(OSTA	L COI	DE)						
32.	ı				•	30	2 0															I

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 7 Work History and References (Continued) **Work History** Do not list current positions. Those TELEPHONE should be listed in Section 4. Include a chronological END DATE COUNTRY CODE START DATE work history for the REASON FOR DEPARTURE (IF APPLICABLE) past 10 years. A longer period may be required by your healthcare entity If you have additional work history, use the **WORK HISTORY** Supplemental Work History Form on page 32. PRACTICE / EMPLOYER NAME NUMBER STREET SUITE/BUILDING CITY STATE ZIP/POSTAL CODE TELEPHONE COUNTRY CODE START DATE **END DATE** REASON FOR DEPARTURE (IF APPLICABLE) WORK HISTORY PRACTICE / EMPLOYER NAME STREET SUITE/BUILDING NUMBER CITY ZIP/POSTAL CODE TELEPHONE COUNTRY CODE START DATE REASON FOR DEPARTURE (IF APPLICABLE)

3090

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP. Section 8 **Disclosure Questions** LICENSURE Disclosure Questions Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, YES denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any con-Answer all questions. ditions or limitations by any state or professional licensing, registration or certification board?* For any "Yes" response, provide an YES NO Has there been any challenge to your licensure, registration or certification?* explanation on the Supplemental Disclosure Question HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS Explanation Form on Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever page 34. been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for YES reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, Allied Health or governing board?* **Providers** YES NO Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?* If you are an Allied Health Provider and you do not believe a Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action. YFS question is applicable by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?* to you, you should answer the question EDUCATION, TRAINING AND BOARD CERTIFICATION "NO". Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, resi-YES NO dency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?* NO Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status YES as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?* YES NO Have any of your board certifications or eligibility ever been revoked?* 8. 9. YES NO Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?* DEA OR STATE CONTROLLED SUBSTANCE REGISTRATION Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been chal-10. YES lenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?* MEDICARE, MEDICAID OR OTHER GOVERNMENTAL PROGRAM PARTICIPATION Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or other-YES wise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental healthcare plans or programs?* OTHER SANCTIONS OR INVESTIGATIONS Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, educa-12. YES tion or training program, Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare 13 YFS Integrity and Protection Data Bank?* Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, 14 YES NO OSHA, etc.)?* Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or 15. YES NO resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal Are you currently being investigated or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility, or 16 YES agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility of any military agency?* PROFESSIONAL LIABILITY INSURANCE INFORMATION AND CLAIMS HISTORY Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your 17 YFS NO individual liability history?*

3092

Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance

carrier, based on your individual liability history?*

18

YES

* REQUIRED RESPONSE. NO RESPONSE MAY CAUSE PROCESSING DELAYS AND REQUIRE FOLLOW-UP.

25.

26.

YES

YES

accommodation?

Section 8 **Disclosure Questions** (Continued) Disclosure MALPRACTICE CLAIMS HISTORY Questions Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years?* YES 19 Answer all questions. If yes, provide information for each case. For any "Yes" response, provide an CRIMINAL/CIVIL HISTORY explanation on the Supplemental Disclosure Question NO Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?* 20. YES Explanation Form on page 34. In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor YES NO traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, compe-**IMPORTANT** If you answered "Yes" tence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual to question #19, you must complete the YES NO Have you ever been court-martialed for actions related to your duties as a medical professional?* Supplemental Malpractice Claims Explanation Form on Note: A criminal record will not necessarily be a bar to acceptance. Decisions will be made by each health plan or page 35 for each credentialing organization based upon all the relevant circumstances, including the nature of the crime. malpractice claim. **ABILITY TO PERFORM JOB** Are you currently engaged in the illegal use of drugs?* YES ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) NO Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the func-YES 24. tions of your job with reasonable skill and safety?*

NO Do you have any reason to believe that you would pose a risk to the safety or well being of your patients?*

NO Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulatio

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*	Name (print)*	
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