Application Checklist for Maryland Medical Assistance Program Application GROUP

If you are applying to enroll as a group of providers, please include the items in the following checklist with your enrollment packet.
Should you have any questions, please contact Scion Dental at Credentialing@sciondental.com (855) 812-9211

A completed application will include the following:

- ❑ Completed and signed Group Provider Application. Please mark all blank fields "N/A".
- ❑ A copy of your group NPI printout from NPPES
- ❑ If you provide services in a state other than Maryland, please include a copy of your board issued license from the state in which you are practicing.
- ❑ Include a copy of any certifications that indicate any specialties
- ❑ Completed and signed Disclosure of Ownership and Control
- ❑ Completed and signed Provider Agreement
- ❑ Completed Electronic Funds Transfer (EFT) form if you wish to receive payments via direct deposit. NOTE: this form is to be submitted only to the Comptroller of Maryland at the address indicated at the top of the form. Any EFT forms that are submitted directly to DHMH will not be processed.
- ❑ Any additional material including application addenda that may be required by specific programs.

Instructions for Maryland Medical Assistance Program Application GROUP

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR GROUPS

Should you have any questions, please contact Scion Dental at Credentialing@sciondental.com (855) 812-9211

GENERAL INSTRUCTIONS	
1. Complete ALL items on the form unless otherwise instructed below. Failure to complete all required fields will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid. 2. Completion of signature fields is required. Initials or stamped signatures will not be accepted. 3. Please attach a copy of all requested documents. 4. These instructions do not need to be submitted with the application.	
MAIL TO	Unless instructed otherwise please mail completed enrollment applications and documentation to: Maryland Healthy Smiles: Credentialing P.O. Box 2059 Milwaukee, WI 53201

TYPE OF REQUEST	
NEW ENROLLMENT	The group attempting to enroll in Maryland Medicaid has never been enrolled with Maryland Medicaid as a Fee for Service Provider.
RE-ENROLLMENT	The group has previously been enrolled with Maryland Medicaid as a Fee for Service Provider, but the group has been suspended or terminated from Maryland Medicaid.
RE-VALIDATION	The group is actively enrolled in Maryland Medicaid Fee for Service, but, due to required law, is verifying their information with Medicaid on or before their five year Maryland Medicaid enrollment anniversary date.
INFORMATION UPDATE	The group is actively enrolled in Maryland Medicaid and would like to change the information that is currently on file with Maryland Medicaid for the group.
REQUESTED ENROLLMENT BEGIN DATE	If the group has already rendered services, please indicate a Requested Enrollment Begin Date.
APPLICATION SUBMITTED DATE	Date filling out the application.
GROUP INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the unique 10-digit NPI (Entity Type 2 Organization) of the group who will be providing services to Maryland Medicaid participants. To obtain a NPI, please visit the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do. Please attach a printout from the previous website that lists the NPI information.
MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER	This is a unique provider number generated by Maryland Medicaid for each group. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid group, please fill in your group's 9-digit Maryland Medicaid Number.
GROUP PROVIDER TYPE	Enter the two-digit code for the appropriate group provider type from the listing provided at the end of these instructions.
TYPE OF PRACTICE	For internal use only. DO NOT COMPLETE.
SPECIALTY CODE	If applicable enter the three-digit code for the appropriate specialty code from the listing provided at the end of these instructions.
COUNTY CODE	Enter the two-digit code for the appropriate county code from the listing provided at the end of these instructions.
MEDICARE PROVIDER NUMBER	If you participate in Medicare, please list the provider number that has been assigned to you.
GROUP NAME	Enter the legal name of the group as it appears on federal tax documents.
DOING BUSINESS AS (NAME)	If the group operates under a different name than the legal name, enter that name here.
TAX IDENTIFICATION NUMBER	Enter the 9-digit tax identification number of the group.
NAME OF TAX IDENTIFICATION NUMBER OWNER	Enter the name to which the tax identification number of the group is assigned.
TELEPHONE NUMBER	Enter the best number to reach the group or contact person who can speak on behalf of the group regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the group or contact person who can speak on behalf of the group regarding Maryland Medicaid participation.

Instructions for Maryland Medical Assistance Program Application GROUP

CORRESPONDENCE INFORMATION	
CONTACT INFORMATION	If the application is being filled out on behalf of the group, enter the Name, Position/Title, Telephone and E-Mail address of the contact person who can speak on behalf of the group regarding Maryland Medicaid participation.
PRACTICE ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the primary address of the group.
CORRESPONDENCE ADDRESS	Enter the Street Number, street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any letters or correspondence should be sent. This address must be kept up to date. Requests to Re-Validate or Update Information are NOT issued electronically and will be sent to this address.
PAY TO ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any paper checks and paper remittance advices should be sent.
ELECTRONIC CORRESPONDENCE	If you prefer to receive electronic correspondence and Remittance Advice through an established eMedicaid account, check Yes.

LICENSE/PERMIT INFORMATION If applicable attach a copy of each license or certificate that is listed.	
PROFESSIONAL	Enter your professional license number, the State that issued the license, beginning effective date, and expiration date for each practice location in which you service Maryland Medicaid participants.
CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER*	Enter your CLIA ID Number, beginning effective date, and expiration date.
DRUG ENFORCEMENT ADMINISTRATION (DEA)	Enter your Drug Enforcement Administration number if applicable.
MARYLAND LABORATORY PERMIT (MDLAB) OR LETTER OF PERMIT EXCEPTION NUMBER*	Enter your Office of Health Care Quality (OHCQ) issued MDLAB Number, beginning effective date, and expiration date. OR enter your OHCQ issued Letter of Permit Exception Number, beginning effective date, and expiration date.
NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP)	Enter your NCPDP number if applicable.
ANESTHESIA LICENSE	Enter your state issued license if applicable.
***Medical laboratory providers:** Practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** a copy of CLIA and MDLAB Permit/Letter of Permit Exception. Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland. Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.	

ADDITIONAL INFORMATION	
INDIVIDUALS ASSOCIATED WITH THIS GROUP	Please enter the name, individual NPI, Maryland Medicaid Number, and the effective date of all individual members that are associated with the group.
GROUP ADDENDUM	If the group is affiliated with a healthcare institution or medical school, please fill in the required fields and attach the required documentation.
LABORATORY INFORMATION	Answer the three questions listed in this section.
AUTHORIZATION	Please have the administrator or authorized professional representative sign and date the application.
DISCLOSURE OF OWNERSHIP AND CONTROL	Maryland Medicaid is required to obtain disclosures on ownership and control from disclosing entities, fiscal agents, and managed care entities. Please fill out the six (6) sections and sign and date the Disclosure of Ownership and Control addendum. Failure to complete all required sections will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER AGREEMENT	Failure to complete the provider agreement will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
ELECTRONIC FUND TRANSFER (EFT)	If you wish to receive EFT, please complete this form and return to the address listed on this form, separately from the provider application.
PROVIDER ADDENDUM	If applicable to your provider type, please complete the attached addendum.

Instructions for Maryland
Medical Assistance Program Application
GROUP

COUNTY CODE					
ALLEGANY	01	DORCHESTER	09	SOMERSET	19
ANNE ARUNDEL	02	FREDERICK	10	ST. MARY'S	18
BALTIMORE CITY	30	GARRETT	11	TALBOT	20
BALTIMORE COUNTY	03	HARFORD	12	WASHINGTON	21
CALVERT	04	HOWARD	13	WASHINGTON, DC	40
CAROLINE	05	KENT	14	WICOMICO	22
CARROLL	06	MONTGOMERY	15	WORCESTER	23
CECIL	07	PRINCE GEORGE'S	16	OTHER STATE	99
CHARLES	08	QUEEN ANNE'S	17		

Application for Participation in Maryland Medical Assistance Program GROUP

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION	**Unless Instructed Otherwise, Mail to:** Maryland Healthy Smiles: Credentialing P.O. Box 2059 Milwaukee, WI 53201

TYPE OF REQUEST Please select one.			
☐ **NEW ENROLLMENT** (Applicant has never enrolled with Maryland Medical Assistance)	☐ **RE-ENROLLMENT** (Provider is currently excluded/terminated from the Maryland Medicaid Program)	☐ **RE-VALIDATION** (Provider is enrolled and required to revalidate)	☐ **INFORMATION UPDATE** (Provider is enrolled and updating information to the provider's file)
Requested Enrollment Begin Date		Application Submitted Date	

GROUP INFORMATION	
NPI (Organization)	Maryland Medical Assistance Provider Number (If existing provider)
Group Provider Type (Refer to instructions for appropriate codes.)	Type of Practice (Refer to instructions for appropriate codes.) **TYPE PRACTICE: 35 or 99**
Specialty Code (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)
Medicare Provider Number	
Group Name	Doing Business As (DBA)
Tax Identification Number	Name of Tax Identification Number Owner
Telephone Number + extension	E-Mail Address

CONTACT INFORMATION The contact name and email relate to the person who can answer questions about the information provided in this packet.	
Contact Name	Position/Title
Telephone	E-Mail Address
PRACTICE ADDRESS	
Street Address	Suite/Department/Floor

City	State	Zip Code (9 Digit)
Telephone Number + extension		Fax Number

Application for Participation in Maryland Medical Assistance Program GROUP

CORRESPONDENCE ADDRESS Please indicate where letters and claims forms, if any, should be sent.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

PAY TO ADDRESS Please indicate where checks & remittance statements should be sent.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

ELECTRONIC CORRESPONDENCE		
Would you prefer to receive electronic correspondence in lieu of paper when available?	☐ YES	☐ NO

LICENSE/PERMIT INFORMATION A copy of the license or certificate from the appropriate board or authority must be included as an attachment to this application. If more space is needed, please attach additional pages.				
Professional	State Issued	License Number	Date Issued	Expiration Date
CLIA	State Issued	License Number	Date Issued	Expiration Date
DEA	State Issued	License Number	Date Issued	Expiration Date
MDLAB	State Issued	License Number	Date Issued	Expiration Date
NCPDP	State Issued	License Number	Date Issued	Expiration Date
Anesthesia	State Issued	License Number	Date Issued	Expiration Date

Application for Participation in Maryland Medical Assistance Program GROUP

INDIVIDUALS ASSOCIATED WITH THIS GROUP Please attach additional pages if necessary.			
Name	NPI (Individual)	Maryland Medical Assistance Number	Begin Date
Name	NPI (Individual)	Maryland Medical Assistance Number	Begin Date
Name	NPI (Individual)	Maryland Medical Assistance Number	Begin Date
Name	NPI (Individual)	Maryland Medical Assistance Number	Begin Date
Name	NPI (Individual)	Maryland Medical Assistance Number	Begin Date
Name	NPI (Individual)	Maryland Medical Assistance Number	Begin Date

GROUP ADDENDUM			
If your group is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties.			☐ NOT APPLICABLE
Name of Institution			
Title		Duties	
Street Address		Suite/Department/Floor	
City	State		Zip Code (9 Digits)
Certification Date		Certification Number	

Is your group salaried by the above institution?	☐ YES	☐ NO
If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as pharmacy)?	☐ YES	☐ NO
If you are an O.D., are you practicing optometry exclusively?	☐ YES	☐ NO
Or optometry as well as preparing and dispensing eyeglasses (as an optician)?	☐ YES	☐ NO
Is your group operating a Local Health Department Clinic?	☐ YES	☐ NO
Is your group operating a Freestanding Clinic?	☐ YES	☐ NO

Application for Participation in Maryland Medical Assistance Program GROUP

LABORATORY INFORMATION		
Reimbursement for medical laboratory services you provide to eligible recipients are dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.		
Do you provide medical laboratory services for your own patients?	☐ YES	☐ NO
Do you provide medical laboratory services for other than your own patients?	☐ YES	☐ NO
Do you receive specimens that are obtained from other sites located in Maryland?	☐ YES	☐ NO
All Maryland laboratories are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§Health General Article §17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.		

AUTHORIZATION

I, the administrator or authorized professional representative of this group, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my group is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my group is salaried.

Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps) **Date**

Name of Administrator or Authorized Professional Responsible for the Quality of Patient Care (Type or Print) **Date**

Application for Participation in Maryland Medical Assistance Program GROUP

DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned. Attach additional pages as needed.

SECTION 1:

Disclosing Entity/Applicant (Group named on page 1 of this application)

Name		NPI (Organization)
Address – Street	City & State	Zip Code (9 Digits)
Federal Employer Identification Number (FEIN)		

Ownership in Applicant (Has direct or indirect ownership interest[1] of 5% or more. Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104 (b)(1)(i) for more information.)

Name of Individual or Entity	% of Ownership	NPI (Individual)
Address (Home Address if individual)	City & State	Zip Code (9 Digits)
SSN (if individual)		Federal Employer Identification Number (if entity)
Date of Birth (MM/DD/YYYY)		Familial Relationship (if individual, if any)

[1] A) "Ownership interest" means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.
B) "Indirect ownership interest" means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.
C) "Determination of ownership or control percentage"

1) Indirect ownership interest – the amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A's interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B's interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest – in order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity's assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider's assets, A's interest in the provider's assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider's assets, B's interest in the provider's assets equates to 4 percent and need not be reported.

SECTION 2:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider. If the applicant is a non-profit organization please include all board members, directors, and managers. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any. If additional space is needed, copy form; all entries must be on the form.)

Name	Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship
Name	Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship
Name	Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship

SECTION 3:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104 (b)(3)) – (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE

Application for Participation in Maryland Medical Assistance Program GROUP

SECTION 4:

Ownership in Subcontractors (If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number

SECTION 5:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a familial relationship (parent, child sibling spouse))

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 6:

Respond to these questions on behalf of:

1. The Applicant
2. All individuals and entities identified in Sections 1& 5.
3. Any entity in which the Applicant has a 5% or more ownership.

1. Have any of the individuals/entities (1,2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in Maryland or in any other State, Medicare, or any other governmental or private medical insurance program?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

2. Have any of the individuals/entities (1,2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

3. Have any of the individuals/entities (1,2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interested over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/entities (1, 2 and 3)?

☐ YES ☐ NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

EXCLUSION
☐ Check this box only if this application is for a group of practitioners[2] and the information requested in Section 1 – 6 of the Provider Ownership and Disclosure Form has been deemed not applicable.

[2] "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

Application for Participation in Maryland Medical Assistance Program GROUP

SIGNATURE AND AFFIRMATION

An application is not considered complete unless the applicant signs below. Failure to provide a signature will cause the application to be returned.

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of $25,000.00 and

B. Any significant business transactions[3], occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier[4] or any subcontractor.

Authorized Signature (No Stamps) **Date**

Position (Type or Print)

[3] "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of $25,000 or 5 percent of the total operating expense of a provider.

[4] "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).

Provider Agreement for Participation in Maryland Medical Assistance Program

This Agreement (the "Agreement"), entered into between the Maryland State Department of Health and Mental Hygiene (the "Department") and

_____

(Provider Name)

the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the "Provider"), is made pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder to provide medical, healthcare, and home- and community-based services and/or remedial care and services ("Service(s)") to eligible Maryland Medical Assistance recipients ("Recipient(s)"). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

I. THE PROVIDER AGREES:

A. To comply with all standards of practice, professional standards and levels of Service as set forth in all applicable federal and state laws, statues, rules and regulations, as well as all administrative policies, procedures, transmittals, and guidelines issued by the Department, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of providers. The Provider acknowledges his, her or its responsibility to become familiar with those requirements as they may differ significantly from those of other third party payor programs;

B. To maintain adequate medical, financial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Recipients for a minimum of six years from the date of payment or longer if required by law. The Provider agrees to provide access upon request to its business or facility and all related Recipient information and records, including claims records, to the Department, the Medicaid Fraud Control Unit (MFCU) of the Maryland Attorney General's Office, the U.S. Department of Health and Human Services, and/or any of their respective employees, designees or authorized representatives. This requirement does not proscribe record requirements by other laws, regulations, or agreements. It is the Provider's responsibility to obtain any Recipient consent required to provide the Department, its designee, the MFCU, federal employees, and/or designees or authorized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medical Assistance provider.

1. Original records must be made available upon request during on-site visits by Department personnel or personnel of the Department's designee.

2. Copies of records must be timely forwarded to the Department upon written request;

C. To protect the confidentiality of all Recipient information in accordance with the terms, conditions and requirements of the health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and regulations adopted thereunder contained in 45 CFR 160, 162 and 164, and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq*.);

D. To provide services on a non-discriminatory basis and to hold harmless, indemnify and defend the Department from all negligent or intentionally detrimental acts of the Provider, its agents and employees. The Provider will not discriminate on the basis of race, color, national origin, age, religion, sex, disabilities, or sexual orientation;

E. To provide Services in compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and their respective accompanying regulations, and ensure that qualified individuals with disabilities are given an opportunity to participate in and benefit from its Services, including providing interpretive services for the deaf and hard of hearing when required;

F. To check the Federal List of Excluded Individuals/Entities on the Health and Human Services (HHS) Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors. To check the Federal System for Award Management (SAM) prior to hiring or contracting with individuals or entities and periodically check the SAM website to determine the participation/exclusion status of current employees and contractors. To check the Maryland Medicaid List of Excluded Providers and Entities prior to hiring or contracting with individuals or entities and periodically check the website to determine the participation/exclusion status of current employees and contractors. The Provider further agrees to not knowingly employ, or contract with a person, partnership, company, corporation or any other entity or individual that has been disqualified from providing or supplying services to Medical Assistance Recipients unless the Provider receives prior written approval from the Department;

G. To accept the Department's payments as payment in full for covered Services rendered to a Recipient. The Provider agrees not to bill, retain, or accept any additional payment from any Recipient. If the Department denies payment or requests payment from the Recipient, or if the Department denies payment or requests repayment because an otherwise covered Service was not medically necessary or was not preauthorized (if required), the Provider agrees not to seek payment from the Recipient for that Service. The Provider further agrees to immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department;

H. With the exception of prenatal care or preventive pediatric care, to seek payment from a Recipient's other insurances and resources of payment before submitting claims to the Department, which includes but is not limited to seeking payment from Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance. If payment is made by both the Department and the Recipient's other insurance, the Provider shall refund the Department, within 60 days of receipt, the amount paid by the Department;

I. To accept responsibility for the validity and accuracy of all claims submitted to the Department, whether submitted on paper, electronically or through a billing service;

J. That all claims submitted under his, her or its provider number shall be for medically necessary Services that were actually provided as described in the claim. The Provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions. This may include his, her or its expulsion from the Maryland Medical Assistance Program and/or referrals by the Department to the HHS OIG for expulsion from the Medicare program;

K. That if Provider is a physician, he or she will, upon request, submit the name and applicable licensure for each physician extender in his or her employment. The Provider is responsible for knowing and complying with the Maryland Medical Assistance Program's definition of an eligible physician extender and for providing supervision as required by the Maryland Medical Assistance Program;

L. That in case of a group provider, the individual Provider rendering the service shall include his or her own provider number, as well as the group provider number, on any claim;

M. To furnish the Department, within 35 days of the Department's request, full and complete information about:

1. The ownership of any subcontractor with who the Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request;

2. Any significant business transaction between the Provider and any wholly-owned supplier, or between the Provider and any subcontractor, during the 5-year period ending on the date of the request; and

3. Any ownership interest exceeding 5 percent held by the Provider in any other Medical Assistance Provider;

N. That before the Department enters into or renews this Agreement, the Provider agrees to disclose the identity of any person who:

1. Has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and

2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs;

O. To exhaust all administrative remedies prior to initiating any litigation against the Department;

P. Upon receipt of notification that the Provider is disqualified through any federal, state and/or Medicaid administrative action, to not submit claims for payment to the Department for Services performed after the disqualification date;

Q. Any excessive payments to a Provider may be immediately deducted from future Department payments to any payee with the Provider's tax identification number, at the discretion of the Department;

R. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State legislature and/or federal sources. The Department may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therin) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;

S. To comply with the Deficit Reduction Act of 2005 (DRA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least $5,000,000.

T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual (s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

U. To notify the Department within five (5) working days of any of the following:

1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;

2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or

3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership this Agreement is automatically assigned to the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

II. THE DEPARTMENT AGREES:

A. To reimburse the Provider for medically necessary Services provided to Recipients that are covered by the Maryland Medical Assistance Program. Services will be reimbursed in accordance with all Program regulations and fee schedules as reflected in the Code of Maryland Regulations or other rules, action transmittals or guidance issued by the Department; and

B. To provide notice of changes in Program regulations through publication in the Maryland Register.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this Agreement by giving thirty (30) days notice in writing to the other party. After termination, the Provider shall notify Recipients, before rendering additional Services, that he or she is no longer a Maryland Medical Assistance participating Provider;

B. That the effective date of this Agreement shall be _____, provided that the Department verifies the information in the Provider's application. This Agreement shall remain in effect until either party terminates the Agreement (as described in Section III A). Following termination of this Agreement, the Provider must continue to retain records and reimburse the Maryland Medical Assistance Program for overpayments as described in this Agreement and as required by law, including but not limited to Maryland Health-General § 4-403;

C. That no employee of the State of Maryland, whose duties include matters relating to this Provider's Agreement, shall at the same time become an employee of the Provider without the written permission of the Department;

D. That this Agreement is not transferable or assignable;

E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

Provider Signature (No stamps)	Date	Department Authorization	Date
Provider Name (Type or Print)	Date	Assistant Attorney General	Date

Provider Address (Type or Print)

SCION DENTAL, INC
A SKYGEN USA COMPANY

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

To **enroll in Scion Dental's EFT payment program, please fill out this form and you must return this form with a voided check or the agreement will not be valid.**

PART I – REASON FOR SUBMISSION

Reason for Submission: ☐ New EFT Authorization ❑ Revision to Current EFT setup (e.g. account or bank changes)

PART II – PROVIDER OR SUPPLIER INFORMATION

Name of Payee:

Tax Identification Number: (Designate SSN ☐ or EIN ☐) .

Address of Payee (City, State, Zip):

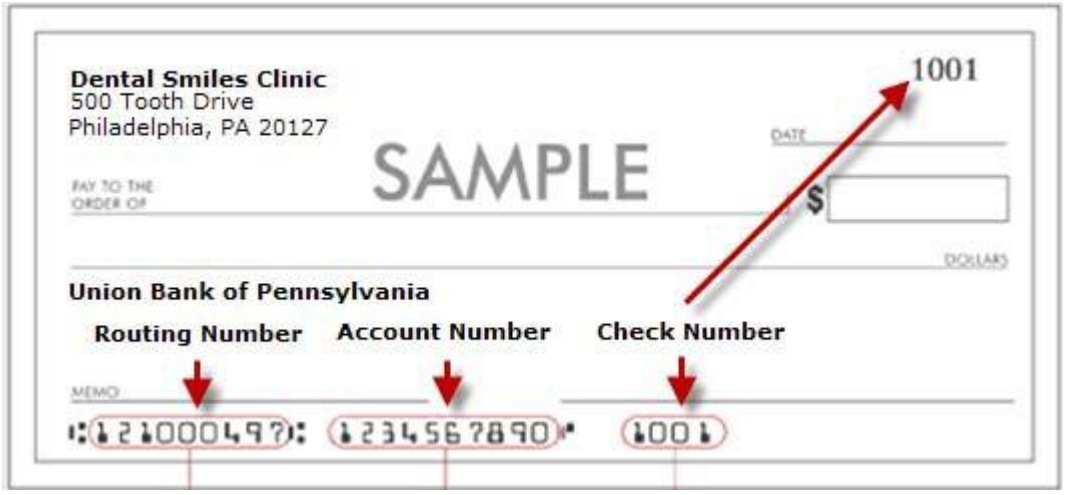
PART III – DEPOSITORY INFORMATION (Financial Institution)

Bank/Depository Name

Depository Routing Transit Number (nine digits – include any leading zeros)

Depositor Account Number (up to 10 digits – include any leading zeros)

Type of Account (check one) ☐ Checking Account ☐ Savings Account



PART IV – CONTACT INFORMATION

Name of Billing Contact:

Phone Number of Billing Contact:

Email Address of Billing Contact:

PART V – AUTHORIZATION

I hereby authorize Scion Dental on to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of Authorized Billing Contact:_____Date:

ELECTRONIC FUNDS TRANSFER (EFT)

Terms of Use

The following terms and conditions, as amended from time to time, ("Agreement") apply to all use of the Scion Dental, Inc.'s ("Scion") Electronic Funds Transfer solution, and the use of any service provided in connection therewith (collectively the "EFT Services"). In this Agreement, the words "you", "your" and "yours" means the individual(s) entity or entities identified on the attached Electronic Fund Transfer (EFT) Authorization Agreement, and the words "we," "our," "us" refers to Scion affiliates and designees. Your enrollment or use of the EFT Services signifies your agreement to be legally bound by the terms and conditions set forth herein.

ACH and Wire Transfers. This Agreement is subject to Article 4A of the Uniform Commercial Code -- Funds Transfer. By signing this Agreement, you authorize Scion, acting directly or indirectly on behalf of or through, any third party administrator, health care coalition, or health plan carrier, or other third party carrier or payer (each a "Carrier") that participates in the EFT Services, to credit or debit the account(s) listed on your Enrollment Form (the "Account" or "Accounts") in connection with processing transactions between you and the Carrier. We may rely upon all Account information and identifying numbers provided by you on the Authorization Agreement to receive payment. We may rely on the routing and account numbers you provided even if they identify a financial institution, person or account other than the one named on the Enrollment Form. You agree to be bound by all applicable law, rules and guidelines related to electronic funds transfers, including, without limitation, 31 CFR Part 210, Article 4A of the UCC and the Automated Clearing House (ACH) Association Rules. The ACH rules provide, among other things, that payments made to you, or originated by you, are provisional until final settlement is made through a Federal Reserve Bank or payment is otherwise made as provided in Article 4A-403(a) of the UCC. If we do not receive such payment, we are entitled to a refund from you in the amount credited to your Account and the Carrier that originated or instructed such payment will not be considered to have paid the amount so credited. We are not required to give you any notice of debits or credits to your Accounts. We may make adjustments to your Accounts whenever a correction or change is required. For example, if we make an error with respect to your Account, you agree that we may correct such error immediately and without notice to you. Such errors may include, but are not limited to, reversing an improper credit to your Account, making adjustments for returned items, and correcting calculation and input errors. Our right to make adjustments shall not be subject to any limitations or time constraints, except as required by law.

Accounts. You represent and warrant that (a) you are the owner of each of the Accounts and (b) none of the Accounts is used primarily for personal, family or household purposes.

Disclosures of Account Information to Others. We may disclose information to third parties about you and your Account(s) and transactions as follows: (i) pursuant to agreements with third parties that assist us in the provision of EFT Services; (ii) to verify the existence and condition of an Account; and (iii) as otherwise necessary for us to provide services or facilitate payments to you.

Amendments and Termination. Scion may add, remove, change or otherwise modify any term of this Agreement at any time. We may also terminate or discontinue some or all of the EFT Services at any time without notice to you.

Governing Law and Venue. The laws of the State of Wisconsin shall govern this Agreement and all disputes arising hereunder. You hereby consent that jurisdiction and venue are proper in the State of Wisconsin for the resolution of any dispute arising under this Agreement.

Severability. If any provision of this Agreement is found to be unenforceable according to its terms, all remaining provisions will continue in full force and effect.

Cooperation. You agree to cooperate fully with us in furnishing any information, documentation or performing any action requested by us. You shall furnish us, upon forty-eight (48) hours' notice, with true, accurate and complete copies of such records, documentation or any other information we or our authorized employees, representatives, agents and any regulatory agencies may request; provided, however, that you shall not be required to divulge any records to the extent prohibited by applicable law.

Ownership. Except as provided in this Agreement, Scion shall have and own all rights, title and interests in the EFT Services and any information arising from or in connection therewith. You hereby acknowledge the specific ownership interests of Scion as set forth herein and you shall not acquire any ownership rights by virtue of this Agreement.

Relationship of the Parties. The relationship between both parties under this Agreement is that of independent parties contracting at an arm's-length with each other. Nothing herein contained shall be construed as constituting a partnership, joint venture or agency between the parties hereto.

Entire Agreement. This Agreement constitutes the only agreement between the parties hereto relating to the subject matter hereof, except where expressly noted herein, and all prior negotiations, agreements and understandings relating to the subject matter hereof, whether oral or written, are superseded or canceled hereby.

Force Majeure. Scion shall not be liable for a delay in performance or failure to perform any obligation under this Agreement to the extent such delay is due to causes beyond our control, including, but not limited to, governmental requests, regulations or orders, utility or communications failure, delays in transportation, national emergency, war, civil commotion or disturbance, war conditions, fires, floods, storms, earthquakes, tidal waves, failure or delay in receiving electronic data, equipment or systems failure or communication failures.

Warranties, Indemnification and Limitation of Liability. SCION HEREBY DISCLAIMS ALL WARRANTIES WITH RESPECT TO THE SERVICES AND PRODUCTS PROVIDED HEREUNDER, WHETHER EXPRESS, IMPLIED, STATUTORY OR OTHERWISE, INCLUDING, WITHOUT LIMITATION, ANY WARRANTY OF MERCHANTABILITY OR FITNESS FOR USE FOR A PARTICULAR PURPOSE. Scion is entering into this agreement as an accommodation and convenience to you, and you will indemnify and hold Scion free and harmless from and against any and all claims, demands, actions, suits damages and costs, whether groundless or otherwise, whether based on contract, negligence or otherwise, and as may arise out of any act or failure to act on the part of Scion. Scion shall incur no liability to you or any other person in the event the intended party does not receive the funds if Scion shall have acted reasonably in transmitting the funds in accordance with your instructions. Scion shall not be held liable or responsible for failures, delays, errors, claims or damages in the execution or effectuation of any transfer occasioned by the fault or negligence of any correspondent bank, agent, or agency for purposes of making or completing transfer of funds. IN NO EVENT SHALL SCION, ITS PARENT, AFFILIATES, SUBSIDIARIES, DIRECTORS, OFFICERS, EMPLOYEES, AGENTS OR REPRESENTATIVES BE LIABLE FOR SPECIAL, INCIDENTAL OR CONSEQUENTIAL DAMAGES OR CLAIMS BY YOU OR ANY THIRD PARTY RELATIVE TO THE TRANSACTIONS HERE UNDER.

Application for Participation in Maryland Medical Assistance Program
GROUP DENTAL ADDENDUM

If you have a CAQH number, please provide it here:

If you do not have a CAQH number, please complete the following addendum.

Office Information

Office Hours

(USE HHMM FORMAT AND ROUND TO THE NEAREST HALF-HOUR)

	START	A=AM P=PM	END	A=AM P=PM		START	A=AM P=PM	END	A=AM P=PM
MONDAY					FRIDAY				
TUESDAY					SATURDAY				
WEDNESDAY					SUNDAY				
THURSDAY									

NOTE:
After hours back office telephone will be used only by the health plan and will not be published under any circumstances.

24/7 PHONE COVERAGE?* ☐ YES ☐ NO

IF YES ☐ ANSWERING SERVICE ☐ VOICE MAIL WITH INSTRUCTIONS TO CALL ANSWERING SERVICE ☐ VOICE MAIL WITH OTHER INSTRUCTIONS

AFTER HOURS BACK OFFICE TELEPHONE

Open Practice Status

ACCEPT NEW PATIENTS INTO THIS PRACTICE?* ☐ YES ☐ NO

ACCEPT ALL NEW PATIENTS?* ☐ YES ☐ NO

ACCEPT EXISTING PATIENTS WITH CHANGE OF PAYOR?* ☐ YES ☐ NO

ACCEPT NEW MEDICARE PATIENTS?* ☐ YES ☐ NO

ACCEPT NEW PATIENTS WITH PHYSICIAN REFERRAL?* ☐ YES ☐ NO

ACCEPT NEW MEDICAID PATIENTS?* ☐ YES ☐ NO

IF ANY OF THE ABOVE INFORMATION VARIES BY PLAN, EXPLAIN (USE BOTH LINES IF REQUIRED)

ARE THERE ANY PRACTICE LIMITATIONS?* ☐ YES ☐ NO

IF YES

GENDER LIMITATIONS ☐ MALE ONLY ☐ NONE ☐ FEMALE ONLY

AGE LIMITATIONS MINIMUM AGE MAXIMUM AGE

LIST OTHER LIMITATIONS

Application for Participation in Maryland Medical Assistance Program
INDIVIDUAL DENTAL ADDENDUM

Practice Location Information (Continued)

Languages

LANGUAGES

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

INTERPRETERS AVAILABLE?* ☐ YES ☐ NO

LANGUAGES INTERPRETED

LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE | LANGUAGE CODE

Accessibilities

DOES THIS OFFICE MEET ADA ACCESSIBILITY REQUIREMENTS?* ☐ YES ☐ NO

DOES THIS SITE OFFER HANDICAPPED ACCESS FOR THE FOLLOWING

- BUILDING?* ☐ YES ☐ NO
- PARKING?* ☐ YES ☐ NO
- RESTROOM?* ☐ YES ☐ NO

OTHER HANDICAPPED ACCESS

DOES THIS SITE OFFER OTHER SERVICES FOR THE DISABLED?* ☐ YES ☐ NO

- TEXT TELEPHONY (TTY)* ☐ YES ☐ NO
- AMERICAN SIGN LANGUAGE* ☐ YES ☐ NO
- MENTAL/PHYSICAL IMPAIRMENT SERVICES* ☐ YES ☐ NO

OTHER DISABILITY SERVICES

ACCESSIBLE BY PUBLIC TRANSPORTATION?* ☐ YES ☐ NO

- BUS* ☐ YES ☐ NO
- SUBWAY* ☐ YES ☐ NO
- REGIONAL TRAIN* ☐ YES ☐ NO

OTHER TRANSPORTATION ACCESS

Services

Does this location provide any of the following services?

LABORATORY SERVICES? ☐ YES ☐ NO — IF YES, PROVIDE ACCREDITING/ CERTIFYING PROGRAM (E.G., CLIA, COLA, MLE)

RADIOLOGY SERVICES? ☐ YES ☐ NO — IF YES, PROVIDE X-RAY CERTIFICATION TYPE

EKGS? ☐ YES ☐ NO	ALLERGY INJECTIONS? ☐ YES ☐ NO	ALLERGY SKIN TESTING? ☐ YES ☐ NO	ROUTINE OFFICE GYNECOLOGY (PELVIC/PAP)? ☐ YES ☐ NO
DRAWING BLOOD? ☐ YES ☐ NO	AGE APPROPRIATE IMMUNIZATIONS? ☐ YES ☐ NO	FLEXIBLE SIGMOIDOSCOPY? ☐ YES ☐ NO	TYMPANOMETRY/ AUDIOMETRY SCREENING? ☐ YES ☐ NO
ASTHMA TREATMENT? ☐ YES ☐ NO	OSTEOPATHIC MANIPULATION? ☐ YES ☐ NO	IV HYDRATION/ TREATMENT? ☐ YES ☐ NO	CARDIAC STRESS TEST? ☐ YES ☐ NO
PULMONARY FUNCTION TESTING? ☐ YES ☐ NO	PHYSICAL THERAPY? ☐ YES ☐ NO	CARE OF MINOR LACERATIONS? ☐ YES ☐ NO	

IS ANESTHESIA ADMINISTERED IN YOUR OFFICE? ☐ YES ☐ NO — IF YES, WHAT CLASS/CATEGORY DO YOU USE?

IF YES, WHO ADMINISTERS IT?

LAST NAME | FIRST NAME

TYPE OF PRACTICE (SELECT ONE ONLY)* ☐ SOLO PRACTICE ☐ SINGLE SPECIALTY GROUP ☐ MULTI-SPECIALTY GROUP

ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

Application for Participation in Maryland Medical Assistance Program
GROUP DENTAL ADDENDUM

Professional Liability Insurance Carrier

Professional Liability Insurance Carrier

SELF-INSURED?* ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME*

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER?* ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE

$ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Professional Liability Insurance Carrier

List other current, future, or previous carrier(s) if current carrier is less than ten (10) years.

NOTE: A longer period may be required by your healthcare entity.

SELF-INSURED? ☐ YES ☐ NO

CARRIER OR SELF-INSURED NAME

NUMBER* STREET* SUITE/BUILDING

CITY* STATE* ZIP CODE*

TYPE OF COVERAGE?* ☐ INDIVIDUAL ☐ SHARED

ORIGINAL EFFECTIVE DATE* EFFECTIVE DATE* EXPIRATION DATE

DO YOU HAVE UNLIMITED COVERAGE WITH THIS INSURANCE CARRIER? ☐ YES ☐ NO

$ AMOUNT OF COVERAGE PER OCCURRENCE

$ AMOUNT OF COVERAGE AGGREGATE

POLICY INCLUDES TAIL COVERAGE? ☐ YES ☐ NO

POLICY NUMBER*

Application for Participation in Maryland Medical Assistance Program GROUP DENTAL ADDENDUM

Standard Authorization, Attestation and Release

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 regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

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)*

DATE SIGNED*