PRACTITIONER CREDENTIALING APPLICATION

University of Maryland Medical System Health Plans (UMMSHP) utilizes the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource as part of our credentialing process. UMMSHP encourages physicians to apply using the CAQH online process.

Please update your information on CAQH to give permission for UMMSHP to access your CAQH application.

Physician Name: ______________________________________ Date of Application: _________
CAQH Provider ID: ____________________________________

Credentialing Questions:

1. If you are applying for participation as a primary care physician (PCP), are you EPSDT certified? Y / N

2. Do you use Complementary or Alternative Medicine (Integrative Medicine) in your practice? Y / N

3. Do you have any physical or mental health problems that affect your current ability to provide health care? Y / N

4. Do you hold a waiver to prescribe or dispense buprenorphine under the Drug Addiction Treatment Act of 2000 (DATA 2000) Y / N

5. Do you currently provide services to patients with special needs? Y / N

   Please check if you work with individuals in the following populations and have specific education, special training, and experience for providing services to each population checked:

   __ Children with Special Health Care Needs
   __ Physical disabilities
   __ Developmental disability
   __ HIV/AIDS
   __ Pregnant and postpartum women
   __ Children in State supervised care
   __ Homeless
   __ Substance Abuse

Billing Information:

(Please enter the following box 33 in the manner that you will be submitting claims with the correct billing entity name, group NPI and address information.)

Billing Contact: ____________________Billing Phone:__________________

Billing Contact Email: _______________________Billing Fax:_____________

33. BILLING PROVIDER INFO & PH # ( )	
a. NPI	b.

ATTESTATION AND INFORMATION RELEASE AUTHORIZATION

I authorize University of Maryland Medical System Health Plans (UMMSHP), its representatives, affiliated entities, employees, agents, and/or its 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 UMMSHP and its Agents in inspect and copy all records and documents relating to such an investigation.

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, 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 UMMSHP and/or its Agents 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, UMMSHP. I authorize my current and past liability carriers to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any individuals or entities who provide information based upon this Authorization, Attestation and Release.

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 UMMSHP and/or its Agents. I hereby further authorize the Agents 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.

I release from all liability and hold harmless UMMSHP and its Agents, as well as 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 UMMSHP, its Agents, or other third parties 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 UMMSHP or its Agents, 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 UMMSHP, its Agents, or any third parties in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provide by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to UMMSHP, its Agents, and/or third parties include their respective employees, directors, officers, advisors, counsel, and agents. UMMSHP and its Affiliates retain 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 its 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 UMMSHP or a participating provider with UMMSHP. 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 UMMSHP in accordance with the applicable bylaws, rules, regulations, and requirements of UMMSHP. 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 UMMSHP and/or its Agents within ten (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 release pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of participation by UMMSHP, and must be submitted online or in writing, and must be dated and signed by me. I acknowledge that UMMSHP will not process an application until it deems it to be complete 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 misstatements or omission in the application may constitute ground 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 UMMSHP and/or its Agents. 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 those 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: **Print Name:** **Date:**