Hawaii Participating Physician and Health Care Provider Application

This application is submitted to: HHMG , herein this Healthcare Organization[1]

I. INSTRUCTIONS

This form should be typed or legibly printed in black. If more space is need then provide it on original, attach additional sheets and reference the question being answered. **Current copies of the following documents must be submitted with this application:**

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face sheet of professional liability certification
- Current Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known? Name(s)		
Home Mailing Address:	City:	
	State:	ZIP:
Home Fax Number:	Pager Number:	
Birth Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include copy of Alien Registration Card):	
Social Security Number:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if hospital based):	
Primary Office Address:	City:	
	State: HI	ZIP:
Telephone Number:	Fax Number:	
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name affiliated with Tax ID Number:	Federal Tax ID Number:	
Secondary Office Address:	City:	

[1] As used in the Information Release/Acknowledgments Section of this application, the term "this Healthcare Organization" shall refer to the entity to which this application is submitted as identified above.

[2] This information will be used for consumer information purposes only.

	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID number:	
Tertiary Office Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	Fax Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Medical Interests in Practice, Research, etc.:		

IV. PREMEDICAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

V. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference This Section Number and Title)

Medical School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

POSTGRADUATE TRAINING AND EXPERIENCE

VI. INTERNSHIP/PGY1 (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:	Program Director:	Phone Number:
Mailing Address:	City:	
	State:	ZIP:
Type of Internship:		
Specialty:	From (mm/yy):	To (mm/yy):

VII. RESIDENCIES/FELLOWSHIPS (Attach additional sheets if necessary. Reference This Section Number and Title)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic), and postgraduate education in chronological order, giving name, address, city, and ZIP code, and dates. Include **all** programs you attended, whether or not completed.

Institution:	Program Director:		
Mailing Address:	City:		
	State:	ZIP:	
Type of Training (eg. Residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐ Yes ☐ No (if "NO", please explain on separate sheet.)			
Institution:	Program Director:		
Mailing Address:	City:		
	State:	ZIP:	
Type of Training (eg. Residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐ Yes ☐ No (if "NO", please explain on separate sheet.)			
Institution:	Program Director:		
Mailing Address:	City:		
	State:	ZIP:	
Type of Training (eg. Residency, etc.):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐ Yes ☐ No (if "NO", please explain on separate sheet.)			

VIII. BOARD CERTIFICATION

Include certifications by board(s) which are duly organized and recognized by:

- A member board of the American Board of Medical Specialties
- A member board of the American Osteopathic Association
- A board or association with equivalent requirements approved by the Medical Board of Hawaii
- A board or association with Accreditation Council for Graduate Medical Education or American Osteopathic Association approved postgraduate training that provides complete training in that specialty or subspecialty

Name of Issuing Board:	Specialty:	Date Certified/Rectified:	Expiration Date (if any) :

Have you applied for board certification other than those indicated above? ☐ Yes ☐ No

If so, list board(s) and Date(s):

If not certified, describe your intent for certification, if any, and date of eligibility for certification on separate sheet.

IX. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)
(Attach additional sheets if necessary. Reference This Section Number and Title)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

X. MEDICAL LICENSURE/REGISTRATIONS (Remember to attach copies of documents)

HI State Medical License Number:	Issue Date:	Expiration Date:
Drug Enforcement Administration (DEA) Registration Number:		Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Date Issued: Valid Through:
Medicare UPIN/National Physician Identifier (NPI):		Medi-Cal/Medicaid Number:

XI. ALL OTHER STATE MEDICAL LICENSES (List All Medical Licenses Now or Previously Held. Attach additional sheets if necessary. Reference This Section Number and Title)

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

XII. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original Effective Date:	
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount: $	Aggregate Amount: $	Expiration Date:	
Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.			
Please list all of your professional liability carriers within the past seven years, other than the one listed above:			
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

XIII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in reverse chronological order (with the current affiliation(s) first) all institutions where you have current affiliations (A) and have had previous hospital privileges (B) during the past ten years. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Status (active, provisional, courtesy, etc.):	Appointment Date:	
Do you have admitting privileges? ☐ Yes ☐ No	Department:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Status:	Appointment Date:	
Do you have admitting privileges? ☐ Yes ☐ No	Department:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Status:	Appointment Date:	
Do you have admitting privileges? ☐ Yes ☐ No	Department:	

If you do not have hospital privileges, please explain on Addendum A.

B. PREVIOUS AFFILIATIONS During Last Ten Years. (Attach additional sheets if necessary. Reference This Section Number and Title)

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIV. PEER REFERENCES

List three professional references, preferably from your specialty area, not including relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations.

Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:

XV. WORK HISTORY (Attach additional sheets if necessary. Reference This Section Number and Title)

Chronologically list all work history activities since completion of postgraduate training (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice	Contact Name:	Telephone Number:	
		Fax number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Attestation Questions

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide full details on separate sheet.

A. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or an applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily relinquished any such license or registration or voluntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending? Yes ☐ No ☐

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? Yes ☐ No ☐

C. Have you ever been denied, for possible incompetence or improper professional conduct, or breach of contract, clinical privileges, membership, or contractual participation or employment by any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, medical school faculty position or other health delivery entity or system) or have your clinical privileges, membership, contractual participation or employment at any such organization ever been suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed, or is any such action pending? Yes ☐ No ☐

D. Have you ever surrendered, allowed to expire, or voluntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending? Yes ☐ No ☐

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any internship, residency, fellowship, preceptorship, or other clinical education program? Yes ☐ No ☐

F. Has your membership or fellowship in any local, county, state regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? Yes ☐ No ☐

G. Have you been denied certification/recertification by a specialty board, or has your eligibility, certification or recertification status changed (other than changing from eligible to certified)? Yes ☐ No ☐

H. Have you ever been convicted of any crime (other than a minor traffic violation)? Yes ☐ No ☐

I. Do you presently use any drugs illegally? Yes ☐ No ☐

J. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending? Yes ☐ No ☐

K. Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage or any procedure? Yes ☐ No ☐

L. Is there any reason why you are not able to perform all the services required by your agreement with, or the professional staff bylaws of the Healthcare Organization to which you are applying with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes ☐ No ☐

I hereby affirm that the information submitted in this Section XVI, Attestation Questions and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Printed Name: _____

Original Signature: _____ Date: _____
(Stamped or Photocopied Signature Is Not Acceptable)

Information Release/Acknowledgments

I hereby consent to the disclosure, inspection and coping of information and documents relating to my credentials and qualifications ('peer review information') by an between medical organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions training programs, professional liability insurance companies (with respect to certification of coverage and claims history), licensing authorities, and businesses and individuals acting as their agents-collectively "Health Care Organizations") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review records from being further disclosed.

I am informed and acknowledge that federal and state laws[3] provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities engaged in quality assessment, peer review and credentialing on behalf of all persons and entities providing peer review information to such representatives Health Care Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in Health Care Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded fair procedures with respect to my participation in Health Care Organization as may be required by state and federal law and regulation, including but not limited to, Hawaii Business Code Section 435E-34, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of any professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in Hawaii; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (III) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Health Care Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of Hawaii taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition or any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by and Healthcare Organization which has resulted in the filing of a §453-7.5. Report of complaints and information by department with the Medical Board of Hawaii, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or provider participation agreement. A photocopy of this document shall be as effective as the original.

_____

Print Name Here

_____

Signature (Stamped Signature Is Not Acceptable) Date

[3] The intent of this release is to apply at a minimum, protections comparable to those available in Hawaii to any action, regardless of where such action is brought.

Hawaii Participating Physician and Health Care Provider Application

Addendum A

This Addendum submitted to: HHMG, herein, this Healthcare Organization.[4]

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Medical Group(s)/IPA Affiliations:		
Do you intend to serve as a primary care provider? ☐ Yes ☐ No		
Do you intend to serve as a specialist? ☐ Yes ☐ No (If yes, please list specialty(s))		
Please check all that apply: ☐ Solo Practice ☐ Single Specialty ☐ Group Practice ☐ Multi-Specialty		

II. BILLING INFORMATION

Billing Company:		
Street Address:	City:	
	State:	ZIP:
Contact:	Telephone Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	

III. PRACTICE INFORMATION

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologists, etc.)? ☐ Yes ☐ No

If so, please list:

Name: Type of Provider: License Number:

_____
_____
_____
_____
_____

If Physician Assistant Supervisor, please include State License Number: _____

Do you personally employ any providers (do not include providers that are employed by the medical group)? ☐ Yes ☐ No

If so, please list:

Name: Hawaii Medical License Number:

_____
_____

Please list any services you perform that are not typically associated with your specialty:

Please list any services you **do not** perform that are typically associated with your specialty:

[4] As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

Is your practice limited to certain ages? ☐ Yes ☐ No
If yes, specify limitations: _____

Are you a Certified Qualified Medical Examiner (QME) of the State Industrial Medical Council? ☐ Yes ☐ No

Do you participate in EDI (electronic data interchange)? ☐ Yes ☐ No

If so, which Network? _____

Do you use a practice management system/software? ☐ Yes ☐ No

If so, which one? _____

What type of anesthesia do you provide in your group/office?

☐ Local ☐ Regional ☐ Conscious Sedation ☐ General ☐ None ☐ Other: _____

Has your office received any of the following accreditations, certifications, or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ Hawaii Department of Health Services Licensure
☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)
☐ Medicare Certification
☐ The Medical Quality Commission (TMQC)
☐ Other: _____

IV. OFFICE HOURS – Please indicate the hours your office is open:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holiday
Primary Office:							
2nd Office:							

V. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary)

Answering Service Company:	Phone Number:	Fax Number:
Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number:	
Covering Physician's Name:	Telephone Number:	
Covering Physician's Name:	Telephone Number:	
Covering Physician's Name:	Telephone Number:	
If you do not have hospital privileges, please provide written plan for continuity of care:		

VI. FOREIGN LANGUAGES SPOKEN

Fluently by Provider:	Fluently by Staff:

VII. LABORATORY SERVICES

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one.

Tax ID #:	Billing Name:	Type of Service Provided:

Do you have a CLIA certificate? ☐ Yes ☐ No	
Do you have a CLIA waiver? ☐ Yes ☐ No	
Certificate Number:	Certificate Expiration Date:

VIII. PROFESSIONAL ORGANIZATIONS

Please list country, state, or national medical societies, or other professional organizations or societies of which you are member or applicant.

Organization Name:	**Applicant**	**Member**
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

I certify that the information in this document and any attached documents is true and correct.

Print Name: _____

Physician Signature: _____ Date: _____
(Stamped Signature Is Not Acceptable)

Hawaii Participating Physician and Health Care Provider Application

Addendum B

Professional Liability Action Explanation

This Addendum is submitted to: HHMG, herein, this Healthcare Organization.[5]

Please complete this form for each pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven (7) years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital, or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please photocopy this Addendum B prior to completing, and complete a separate form for each lawsuit.

I. IDENTIFYING INFORMATION

Last Name:	First:	Middle:

II. CASE INFORMATION

City, County and State which lawsuit filed:		Court case number, if known:	
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Set of Patient:	Age of Patient:

Location of Incident:

☐ Hospital ☐ My office ☐ Other doctor's office ☐ Surgery Center

☐ Other, (please specify) _____

Your relationship to Patient (Attending Provider, Assistant, Consultant, etc):

Allegation:

Is/was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ☐ Yes ☐ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number of insurance company, or other liability protection company or organization.

_____

_____

If you would like us to contact your attorney regarding any of the above, please provide attorney(s) name(s) and phone number(s). Please fax this document to your attorney as this will serve as your authorization:

Name _____ Phone Number _____

Name _____ Phone Number _____

[5] As used in the Information Release section of this Addendum, the term "this Healthcare Organization" shall refer to the entity to which this Addendum is submitted as identified above.

III. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (Check ONE)

☐ Lawsuit/arbitration still ongoing, unresolved.
☐ Judgment rendered and payment was made on my behalf. Amount paid on my behalf: _____
☐ Judgment rendered and I was found not liable.
☐ Lawsuit/arbitration settled and payment made on my behalf. Amount paid on my behalf: _____
☐ Lawsuit/arbitration dismissed or settled, no judgment rendered, no payment made on my behalf.

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheet(s). Include 1) condition and diagnosis at time of incident, 2) dates and description of treatment rendered, and 3) condition of patient subsequent to treatment.
Please Print.

SUMMARY

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I certify that the information in this document and any attached documents is true and correct. I agree that "this Healthcare organization", its representatives, and any individuals or entities providing information tot his Healthcare Organization in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the Hawaii Participating Physician Application. In order for participating healthcare organizations to evaluate my application for participation in and/or my continued participating in those organizations, I hereby give permission to release to this Healthcare Organization information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization." As used herein, the term " this Healthcare Organization refers to its employees and agents.

_____
Name (please print or type)

_____
Physician Signature (Original Signature Required) Date

Addendum C
To the
Hawaii Participating Physician Application

A. Right of Review

A practitioner has the right to review information obtained for the purpose of evaluating your credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g. malpractice insurance carriers, state-licensing boards, National Practitioner Data Bank), but does not extend to a review of information, references or recommendations protected by law from disclosure.

You request to review such information at any time by sending a written request via letter or fax to Compliance Officer at 1110 Nuuanu Ave, 1112 Honolulu, HI 96816. Fax number 888-847-8215. The Credentialing Director will notify you within 72 hours of receiving the request of the date and time when such information will be available for review at the Credentialing Department.

B. Notification of Discrepancy

You will be notified in writing via letter or fax, when information obtained by primary sources varies substantially from information provided on your application. Examples of information at substantial variance include reports of a practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Your will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

C. Correction of Erroneous Information

If you believe that erroneous information has been supplied by a primary source, you may correct such information by submitting a written detailed explanation (via letter or fax) to the Compliance Officer at 1110 Nuuanu Ave, 1112 Honolulu, HI 96816. Fax number 888-847-8215. This notification must occur within 48 hours of the notification of a discrepancy as provided in Section B or within 24 hours of a your review of your credentials file as provided in Section A.

Upon receipt of this notification, primary source information in dispute will be reverified. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file and you will be notified in writing, via letter or fax that the correction has been made to your credentials file. If, upon re-review, primary source information remains inconsistent with your notification, the Credentialing Department will notify you via letter or fax. You may then provide proof of correction by the primary source body to the Credentialing Department via letter or fax at the address above within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided. If, after 10 working days, primary source information remains in dispute, you may be subject to administrative action up to administrative denial/termination.

D. Physician Signature_____ Date_____
(Stamped Signature is not acceptable)

Ohana Health Plan Addendum D

1. Are you CPSP (Comprehensive Prenatal Services Program) certified?	Yes ☐	No ☐	NA ☐
2. Are you CS (Children's Services) certified?	Yes ☐	No ☐	NA ☐
3. Are you CHDP (Child Health & Disability Prevention) certified?	Yes ☐	No ☐	NA ☐
4. In the last 5 years, have you had a history of chemical dependency or substance abuse that might adversely affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? If yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your abstinence prospectively and your Adherence to prevailing standards of professional performance.	Yes ☐	No ☐	

_____ _____

Provider Name Date

_____

Signature

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 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)*

M M D D Y Y Y Y

DATE SIGNED*

3094