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*

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

Explanation of Claims, Suits, or Judgments

(Complete one sheet for each case)

1. Name of the individual involved in the claim: _____
2. Name of the Claimant: _____
   Sex: _____ Age: _____
   Was claim or suit:
   _____ Merely threatened, or
   _____ Limited to Claimant's attorney contact (e.g. request of medical records), or
   _____ Actually filed against you?

3. Date of the alleged error: ____/__/__
   Date of the claim: ____/__/__

Additional defendants: _____

4. Disposition of claim: _____ DISMISSED
   _____ ABANDONED (no activity for over 3 years)
   _____ WON by defense
   _____ WON by claimant
   Total paid $_____
   Amount paid on your behalf $_____
   Indicate whether:
   Court judgment _____
   Out of court settlement _____
   If OPEN
   Provide the following information:
   Claimant's settlement demand? $_____
   Defendant's offer for settlement? $_____
   Insurer's loss reserve $_____

5. Name of the insurer: _____
6. Description of claim (provide enough information to allow appropriate evaluation):
7. Describe the alleged act, error, or omission upon which Claimant bases claim:

_____
_____
_____
_____

8. Description of the case and events:
9. _____
_____
_____
_____
_____
_____

10. Type of injury claimed:
    _____ Emotional only
    _____ Temporary disability
    _____ Death
    _____ Cosmetic
    _____ Permanent Disability
    _____ Other (describe)

Provider's Name: _____ Date: ____ / ___ / ____

_____

Signature

EVOLUTIONS HEALTHCARE SYSTEMS, INC. and its authorized representatives upon request and receipt of a copy of the consent and release form.

The term EVOLUTIONS HEALTHCARE SYSTEMS, INC. and its authorized representatives means the corporation (s) with which I have applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating my credentials, or acting upon my application: the members of EVOLUTIONS HEALTHCARE SYSTEMS, INC. Board and their appointed representatives, the Chief Executive Officer or his designees, the Credentials Committee members, other EVOLUTIONS HEALTHCARE SYSTEMS, INC. employees, consultants to EVOLUTIONS HEALTHCARE SYSTEMS, INC., EVOLUTIONS HEALTHCARE SYSTEMS, INC. Attorney and his/her partners, associates or designees. The term third parties means all individuals, including appointees to EVOLUTIONS HEALTHCARE SYSTEMS, INC. medical staffs or hospital or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether hospitals, health care facilities or not, from whom information has been requested by EVOLUTIONS HEALTHCARE SYSTEMS, INC. or its authorized representatives or who have requested such information from EVOLUTIONS HEALTHCARE SYSTEMS, INC. and its authorized representatives.

_____

Applicant's Signature

_____

Print Applicant's Name

__/__/____

Date

Hospital Privileges Questionnaire

Do you currently hold staff privileges in a hospital? Yes or No (Please circle)

If no, do you utilize a hospitalist group to admit on your behalf? Yes or No (Please circle)

Hospitalist Group(s):_____

Signature: _____ Date:_____

Print Name: _____

Molina Healthcare of Florida, Inc.
CAQH Credentialing

Please review and complete the information requested below. It is required that all providers are credentialed every three years to maintain participating provider status.

Provider Last Name: _____ **Provider First Name:** _____

Provider Specialty: _____ **Provider Date of Birth:** _____

Group Name: _____ **PCP/SPC/Ancillary:** _____

Medicaid #: _____ **Group Medicaid #:** _____ **Medicare #:** _____

NPI #: _____ **Group NPI #:** _____ **Last four SS #:** _____

CAQH I.D. #: _____

Providers State License #: _____ **Issue Date:** _____

Covering Physician: _____ **Age Range:** _____

Credentialing Contact Person: _____ **E-Mail Address:** _____

Supervising Physician (ARNP/ NP/ Midwife – Only): _____

Hospital Privileges: _____

ASC Privileges: _____

Does provider have Electronic Medical Records ☐ or Paper Medical Records ☐

Demographics:

Practice Location 1:

Address: _____

City: _____

State: _____

Zip: _____

Phone #: _____

Fax #: _____

Office Hours: _____

PCMH Recognition: ____ Y ____ N

PCSP Recognition: ____ Y ____ N

Practice Location 2:

Address: _____

City: _____

State: _____

Zip: _____

Phone #: _____

Fax #: _____

Office Hours: _____

PCMH Recognition: ____ Y ____ N

PCSP Recognition: ____ Y ____ N

*If so, please provide a copy of the PCMH certificate(s)

Are you currently participating in the MMA Physician Incentive Program (MPIP) with another Health Plan? _____ Y _____ N

*If so, please provide a copy of the notification letter regarding your qualification for the MPIP