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

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

Fingerprinting Information

(Please Print Clearly)

Name:_____ Social Security Number: _____

Aliases:_____

Date of Birth: _____ Place of Birth: _____
(MM/DD/YYYY)

Citizenship: _____ Race: _____ (W-White/Latino(a); B-Black; A-Asian; NA-Native American; U-Unknown)

Sex: _____ Weight: _____ Height: _____
(M=Male; F=Female)

Eye Color:_____ Hair Color: _____

Address: _____ Apt. Number: _____

City:_____ State: _____ Zip Code: _____

Tampa General Medical Group

P.O. Box 1289
Tampa, FL 33609-1289
Tel: (813) 844-4578 Fax: (813) 844-4705

Attestation of Total Patient Load

2025

Dear Primary Care Physician:

The Agency for Health Care Administration requires that each Primary Care Physician shall not exceed a patient load of 3,000 active patients from all plans or services, including commercial insurances.

> *Active patients are defined as patients who have been seen by the Primary Care Physician at least three times per year.*

In order to meet contractual obligations, we ask that you provide the information requested below. Please check the box, sign and return via email to jfeierab@tgh.org or fax to (813) 844-4705.

Should you have any questions, please contact the Jennifer Feierabend at (813) 844-8927.

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☐ I ***do not*** have more than 3,000 ***active*** patients.

_____

Signature of Primary Care Physician

_____

Please Print Name

A PCP with 3000 active patients would see in excess of 4 "active" patients every hour for 8 hours a day, 5 days a week, 52 weeks of the year.

3000 patients X 3 visits a year = 9000 visits a year

9000 ÷ 52 = 173 visits per week

173 ÷ 5 = 35 visits per day

35 ÷ 8 = 4+ visits per hour

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): USF Physicians Group

Signature: _____ Date:_____

Print Name: _____

Attention Contracted Payors:

The Physician Applicant referenced below currently does not have admitting privileges at a participating local hospital. Said Applicant has arranged for inpatient admissions at Tampa General Hospital, an in-network hospital, by a participating physician. Please note that Applicant has applied for membership and privileges to the Medical Staff of Tampa General Hospital and is currently in the application/verification process.

Physician Applicant:

Signature

Print Name

Specialty

Date

Admitting Participating Physician:

Signature

Print Name

Specialty

Date

If you have any questions regarding this notice, please contact Jennifer Feierabend at (813) 844-8927 or jfeierab@tgh.org.

Sincerely,

Jennifer Feierabend

Jennifer Feierabend
Data Management Coordinator

2025

Florida Health Sciences Center, Inc d/b/a Tampa General Hospital (TGH) Compliance Program Guidelines Attestation for Subcontractors & Downstream Entities

As required by the Centers for Medicare & Medicaid Services (CMS), First Tier, Downstream, and Related Entities that provide administrative and/or health care services for Medicare Part C and D plans, must meet specific CMS compliance program expectations††.

_____ is considered a Downstream or Related Entity of TGH, and this attestation is intended to provide evidence that the requirements listed below were met by your organization.

The following training is provided to all employees assigned to work on TGH business within 30 days of hire and annually thereafter. Records will be/are retained for 10 years.

1. **General Compliance Training**
2. **Fraud, Waste, and Abuse (FWA) Training**
3. **Cultural Competency and Health, Safety, and Welfare Education (Abuse, Neglect and Exploitation)**
4. **Code of Conduct and Compliance Policies**

A review of the Federal HealthCare Program Exclusion list for every employee assigned to work on TGH business prior to hire/contract and then monthly thereafter. Records should be maintained for 10 years.

- Department of HHS, Office of Inspector General (OIG)
- System for Award Management (SAM)

No TGH related business is sent offshore without the express written consent of an authorized TGH representative, if it involves the receipt, viewing, processing, transferring, handling, storing, or accessing of PHI. TGH has been notified of any offshore arrangements as may be needed.

I certify, as an authorized representative of a Downstream or Related Entity that has a written agreement with TGH that the statements made above are true and correct to the best of my knowledge. Also, my organization agrees to maintain documentation supporting the statements made above. We'll maintain this documentation in accordance with federal regulations and our contract with TGH, which is no less than ten (10) years. My organization will produce evidence of the above to TGH, or CMS upon request. My organization understands that the inability to produce this evidence may result in a request for a Corrective Action Plan (CAP) or other contractual remedies such as contract termination.

_____ _____

Signature of Organization's Authorized Representative | Organization's Authorized Representative Printed Name and Title

_____ _____

Organization Name Printed | Date

††These requirements are further described within CMS's updated guidance on the compliance program requirements and related provisions for Sponsors ("Guidelines"), published in both Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 9 and Pub. 100-16, Medicare Managed Care Manual, Chapter 21.

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

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

By submitting this authorization and release of information form, I understand and agree as follows:

I understand and acknowledge that, as an applicant for participating status with Molina Healthcare of Florida, Inc. for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

I further understand and acknowledge that Molina Healthcare of Florida, Inc. or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Molina Healthcare of Florida, Inc. as part of the verification and credentialing process.

I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to Molina Healthcare of Florida, Inc., their staffs and agents.

I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Molina Healthcare of Florida, Inc. or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies of Molina Healthcare of Florida, Inc.

I agree to abide by the policies, procedures, and or contractual agreements of Molina Healthcare of Florida, Inc. from whom I am seeking initial or recredentialing.

I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Molina Healthcare of Florida, Inc. where I have membership and/or participation status before initiating judicial action.

I understand that completion and submission of this application/Attestation/Authorization and Release does not automatically grant me membership or participating status with Molina Healthcare of Florida, Inc.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

1.	**Do you have more than 3,000 patients (defined as seen a minimum of (3) times per year) in your practice, including all populations; Medicaid FFS, MSM Network, MHO, Health Plan, Medicare and commercial.**	**YES** ☐	**NO** ☐
2.	**Are you eligible to become Medicaid provider?**	**YES** ☐	**NO** ☐

ATTESTATION/RELEASE FORM

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: ----------

(Stamped signature is not acceptable)

Date: _____

CAQH # : _____

Modification to the wording or format of the Practitioner Application may invalidate the application.