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Provider Network Operations
P.O. Box 194247
San Francisco, CA 94119
www.sfhp.org

California Participating Practitioner Application

I. Instructions

This form should be typed. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please refer to cover page for a list of the required documents to be submitted with this application.

II. Identifying Information

☐ Check if there are any changes and update below.

Last Name:	First Name:	Middle:

Is there any other name under which you have been known? Name(s):		
Home Mailing Address:		
City:	State:	Zip Code:

Telephone Number:	Fax Number:	Cell Number:	Pager Number:
Practitioner Email:	Citizenship (If not a U.S. citizen, please provide a copy of Alien Registration Card):		
Birth Date:	Birth Place:	Race/Ethnicity (optional):	
Driver's License State/Number:	Social Security Number:	Gender: ☐ Male ■ Female	

Your intent is to serve as a(n):

☐ Primary Care Provider ☐ Specialist ☐ Urgent Care ☐ Hospitalist ☐ Hospital Based

Specialty:
Subspecialties:

III. Practice Information

☐ Check if there are any changes and update below.

Practice Name (if applicable):	Department Name (if hospital based):	
Primary Office Address:		
City:	State:	Zip Code:
Telephone Number:	Fax:	Website (if applicable):
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:
Federal Tax ID Number:		Name Associated with Tax ID:

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Please identify the physical accessibility of this office: ☐ Basic ☐Limited ☐None

III. Practice Information (Continued)

☐ Check if there are any changes and update below.

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Single Specialty Group ☐ Multi Specialty Group ☐ Urgent Care	
Primary Office Hours of Operation:	Languages spoken by Staff: Languages spoken by Provider:
Group Medicare PTAN/UPIN #:	Group NPI #:

Secondary Practice Information

Practice Name (if applicable):	Department Name (if hospital based):		
Secondary Office Address:			
City:		State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	
Please identify the physical accessibility of this office: ☐ Basic ☐Limited ☐None			
Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Single Specialty Group ☐ Multi Specialty Group ☐ Urgent Care			
Secondary Office Hours of Operation:	Languages spoken by Staff: Languages spoken by Provider:		

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Group Medicare PTAN/UPIN #:	Group NPI #:

Tertiary Practice Information

Practice Name (if applicable):		Department Name (if hospital based):	
Tertiary Office Address:			
City:		State:	Zip Code:
Telephone Number:	Fax Number:	Website (if applicable):	
Office Administrator/Manager:		Office Administrator/Manager Telephone Number:	
Office Administrator/Manager Email:		Office Administrator/Manager Fax Number:	
Federal Tax ID Number:		Name Associated with Tax ID:	
Please identify the physical accessibility of this office: ☐ Basic ☐ Limited ☐None			
Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Single Specialty Group ☐ Multi Specialty Group ☐ Urgent Care			
Tertiary Office Hours of Operation:	Languages spoken by Staff:		
	Languages spoken by Provider:		
Group Medicare PTAN/UPIN #:	Group NPI #:		

Mailing Address

Which of your practices is your primary mailing address? ☐ Primary ☐ Secondary ☐ Tertiary ☐ Other	
If your mailing address is different from your practice address, please provide it:	

IV. Billing Information ☐ Check if there are any changes and update below.

Which of your practices handles your billing? ☐ Primary ☐ Secondary ☐ Tertiary, if none, please provide billing info:		
Billing Company:		
Billing Company Mailing Address:		
City:	State:	Zip Code:

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Contact Person:	Telephone Number:
Federal Tax ID Number:	Name Associated with Tax ID:

V. Practice Description

☐ Check if there are any changes and update below.

Do you employ any allied health professionals (e.g. nurse practitioners, physician assistants, psychologist, etc.)? ☐Yes ☐No
If so, please list:

Name	Type of Provider	License Number
Physician Assistant Supervisor Name:	License Number:	

Do you personally employ any physicians (do not include physicians who are employed by the medical group)? ☐Yes ☐No
If so, please list:

Name	California Medical License Number	Primary/Secondary/Tertiary Practice
		☐ Primary ☐Secondary ☐Tertiary
		☐ Primary ☐Secondary ☐Tertiary
		☐ Primary ☐Secondary ☐Tertiary

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

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

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

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

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

Which offices does this apply to: ☐ Primary ☐ Secondary ☐ Tertiary

Coverage of Practice

List your answering service and covering physicians by name. Attach additional sheets if necessary.

Answering Service Company:		
Answering Service Company Address:		
City:	State: Zip Code:	Email:

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Covering Physician's Name(s) / Phone Number / Which practices does their coverage apply (Primary, Secondary, Tertiary):

VI. Education, Training, and Experience ☐Check if there are any changes and update below.

Medical/Professional Education

Medical School/Professional:	Degree Received:	Graduation Date:
Mailing Address:	Website(if applicable):	
City:	State: Zip Code:	Registrar's Phone Number:

Internship/PGY-1

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Internship:	From (mm/yyyy):	To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

Residencies/Fellowships

Include residencies, fellowships, and postgraduate education in chronological order. Use a separate sheet if necessary.

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:
Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

Institution:	Program Director:	
Address:	City:	State: Zip Code:

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Telephone Number:	Fax Number:	Website(if applicable):
Type of Training:	Specialty:	From (mm/yyyy): To (mm/yyyy):
Did you successfully complete the program? ☐Yes ☐ No (if No, please explain on a separate sheet.)		

VII. Medical Licensure & Certifications ☐ Check if there are any changes and update below.

California State Medical License:	Issue Date:	Expiration Date:
Drug Enforcement Agency (DEA) Registration Number:	Schedules:	Expiration Date:
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:
ECFMG Number (applicable to foreign medical graduates):		Issue Date:
Individual National Physician Identifier (NPI):	Medi-Cal/Medicaid Number:	Individual Medicare PTAN Number:

All Other State Medical Licenses

State	License Number	Issue Date	Expiration Date

Other Certifications (e.g., Fluoroscopy, Radiography, ACLS/BLS/PALS, etc.)

Type of Certification	License Number	Expiration Date

Board Certification(s)

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 California ● a board or association with an 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	Certificate Number	Date Certified/Recertified	Expiration Date (if any)

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Board Certification(s) (Continued)

Have you applied for board certification other than those indicated on the prior page? ☐ 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 below or in a separate sheet.

Specialty:	Describe here:
Board Name:	
Exam Date:	

VIII. Current Hospital and Other Institutional Affiliations ☐ Check if there are any changes and update below.

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). This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s).

A. Current Affiliations

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

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Hospital Name:		Department Name:	
Primary Hospital Address:		Status (active, provisional, courtesy, temporary, etc.):	
City:	State:		Zip Code:
Medical Staff Phone:	Medical Staff Fax:	From (mm/yyyy):	To (mm/yyyy):

A. Current Affiliations (continued)

If you do not have hospital privileges, please explain (physicians without hospital privileges must provide written plan for continuity of care):	

B. Previous Hospital and Other Institutional Affiliations

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

Name and Address of Affiliation:		Department:
		From (mm/yy):
		To (mm/yy):
Reason for leaving:		

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IX. Peer References ☐ Check if there are any changes and update below.

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 where you currently hold privileges.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through close working relations. **At least one reference must be from someone with the same credentials, for example, a MD must list a reference from another MD or a DPM must list one reference from another DPM.**

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

Name of Reference:		Specialty:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Email Address:

X. Work History

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 not sufficient. Please explain any gaps on a separate page.

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

Current Practice:		Contact Name:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	From (mm/yyyy): To (mm/yyyy):

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XI. Professional Liability ☐ Check if there are any changes and update below.

Please list all of your professional liability carriers for the past five years, listing the most recent first. If more space is needed, attach additional sheet(s).

Name of Current Insurance Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

Name of Carrier:		Policy Number:
Address:	City:	State: Zip:
Telephone Number:	Fax Number:	Website(if applicable):
Email Address:	Tail Coverage: ☐ Yes ☐No	Per Claim Amount:
Original Effective Date:	Expiration Date:	Aggregate Amount:

XII. Professional and Practice Services ☐ Check if there are any changes and update below.

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

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

☐ Local ☐Regional ☐ Conscious Sedation ☐General ☐None ☐Other (please specify):

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.

Federal Tax ID:	Type of Service Provided:	Do you have a CLIA certificate? ☐Yes ☐No
Billing Name:		Do you have a waiver? ☐Yes ☐No
CLIA Certificate Number:	CLIA Certificate Expiration Date:	

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XII. Professional and Practice Services (continued)

☐ Check if there are any changes and update below.

Have you or your office received any of the following accreditations, certificates or licensures?

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)

☐ Medicare Certification

☐ Child Health and Disability Prevention Program (CHDP)

☐ California Children Services (CCS)

☐ The Medical Quality Commission (TMQC)

☐ Comprehensive Perinatal Services Program (CPSP)

☐ Family Planning

☐ Other:

Please list international, state and/or national medical societies or other professional organizations or societies of which you are a member or applicant. Use the drop-down list to select your membership status.

Organization Name	Membership Status

Do you participate in electronic data interchange (EDI)? ☐Yes ☐No If so, which Network?

Do you use a practice management system/software? ☐Yes ☐No If so, which one?

Continue to the Next Page for HIV/AIDS Specialist Designation

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HIV/AIDS SPECIALIST DESIGNATION

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) recently defined an HIV/AIDS specialist under Regulation LS - 34 -01.

In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist.

We will use your information for internal referral procedures and for publication listing in the Provider Directory.

☐ No, I do not wish to be designated as an HIV/AIDS specialist.

☐ Yes, I do wish to be designated as an HIV/AIDS specialist based on the below criteria:

☐ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; **OR**

☐ I am board certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; **OR**

☐ I am board certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:

1. In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; **AND**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; **OR**

☐ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; **AND**

1. In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of Infectious Disease from a member board of the American Board of Medical Specialties; **OR**

2. In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients; **OR**

3. In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

Continue to the Next Page for Attestation Questions

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ATTESTATION QUESTIONS

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.

1. Has your license to practice medicine, 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 or involuntarily relinquished any such license or registration or voluntarily or involuntarily accepted any such actions or conditions or have you been fined or received a letter of reprimand or is such action pending?	☐Yes	☐No
2. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily 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 federal program or is any such action pending?	☐Yes	☐No
3. Have your clinical privileges, membership, 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) federal programs, or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?	☐Yes	☐No
4. Have you ever surrendered, allowed to expire, voluntarily or involuntarily 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), 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
5. 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
6. Have you ever been denied certification/recertification by a specialty board?	☐Yes	☐No
7. Have you ever chosen not to recertify or voluntarily surrender your board certification while under investigation?	☐Yes	☐No
8. a. Have you ever been convicted of, or pled guilty to a criminal offense (e.g., felony or misdemeanor) and/or placed on deferred adjudication or probation for a criminal offense other than a misdemeanor traffic offense?	☐Yes	☐No
8. b. Are any such actions pending?	☐Yes	☐No
9. Have any judgments been entered against you, or settlements been agreed to by you within the last ten (10) years, in professional liability cases? If YES, please complete Addendum B.	☐Yes	☐No
10. Are there any professional liability lawsuits/arbitrations against you that have been dismissed or currently pending? If YES, please complete Addendum B.	☐Yes	☐No
11. 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 of any procedures?	☐Yes	☐No

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ATTESTATION QUESTIONS (Continued)

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "**Yes**", please provide full details on a separate sheet of paper.

12. Do you have any physical or mental condition which would prevent or limit your ability to perform the essential functions of the position and/or privileges for which your qualifications are being evaluated in accordance with accepted standards of professional performance, with or without reasonable accommodations? If YES, please describe on a separate sheet any accommodations that could reasonably be made to facilitate your performance of such functions without risk of compromise. ☐Yes ☐No

13. Have you ever rendered professional medical services as an employee of a staff model HMO, an entity insured by the federal government (such as the military or a Federally Qualified Health Center) or an academic institution. If YES, have you, in the past seven (7) years, been named as a defendant in a lawsuit (whether or not you were later dismissed from the matter)? ☐Yes ☐No ☐Yes ☐No

14. Is your current ability to practice impaired by chemical dependency or substance abuse, including present use of illegal drugs? ☐Yes ☐No

15. Within the last three (3) years, has your membership, privileges, participation or affiliation with any healthcare organization (e.g., a hospital or HMO), been terminated, suspended or restricted; or have you taken a leave of absence from a health care organization for reasons related to the abuse of, or dependency on, alcohol or drugs? ☐Yes ☐No

16. Do you have any fines/debts due and owing to any federal, state, or local government that relate to Medicare, Medicaid or any other federal and state health care program? ☐Yes ☐No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and 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.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:**_____

PRINTED NAME: _____

DATE: _____

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INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health care service 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 "Healthcare 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 peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws 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, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.
I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my 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 California; (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 Healthcare Organization in writing, within fourteen (14) 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 California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board 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 any 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 pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) 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.

A photocopy of this document shall be as effective as the original.

APPLICANT SIGNATURE (Stamp is Not Acceptable) **PRINTED NAME** **DATE**

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Addendum A

Practitioner Rights

Right to Review

The practitioner has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that practitioner's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application

Practitioners may request to be informed of the status of their credentialing/recredentialing application. The practitioner may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices.
The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy

Practitioners will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of 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. Practitioners 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.

Correction of Erroneous Information

If a practitioner believes that erroneous information has been supplied to Healthcare Organization by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the practitioner of a discrepancy or within 24 hours of a practitioner's review of his/her credentials file.

Upon receipt of notification from the practitioner, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the practitioner's credentials file. The practitioner will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner via certified letter. The practitioner may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

Healthcare Organization's Credentialing Department Address:

Address: City: State: Zip:

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____
PRINTED NAME: _____
DATE:_____

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California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to San Francisco Health Plan herein, this Healthcare Organization

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.

☐ *Please check here if there are no pending/ settled claims to report (and sign below to attest).*

I: Practitioner Identifying Information		
Last Name:	First Name:	Middle:

II. Case Information			
Patient's Name:	Patient's Gender: ☐ Male ☐ Female		Patient's DOB:
City, County, State where lawsuit filed:	Court Case number, if known:	Date of alleged incident serving as basis for the lawsuit/arbitration:	Date suit filed:

Location of incident: ☐ Hospital ☐ My Office ☐ Other doctor's office ☐ Surgery Center ☐ Other (specify):
Relationship to patient (Attending physician, Surgeon, 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, or other liability protection company or organization.

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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:	Telephone Number:	Fax Number:

III. Status of Lawsuit/Arbitration (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 settled/dismissed, 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 sheets.

Please include:
1. Condition and diagnosis at the time of incident,
2. Dates and description of treatment rendered, and
3. Condition of patient subsequent to treatment.

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 to this 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 California Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Healthcare Organization 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 attorney(s) listed on Page 1 to discuss any information regarding this case with "this Healthcare Organization".

APPLICANT SIGNATURE (Stamp is Not Acceptable) _____
PRINTED NAME: _____
DATE: _____

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California Participating Practitioner Application

Addendum C

DHCS Provider Agreement

Provider Agreement

I declare under penalty of perjury under the laws of the State of California that the foregoing information and the information on all attachments is true, accurate, and complete to the best of my knowledge and belief and that I am authorized to sign this application pursuant to CCR, Title 22, Section 51000.30(a)(2)(B).

I understand that the failure to disclose the required information, or the disclosure of false information, shall, prior to any hearing, result in the denial of the application for enrollment or shall be grounds for termination of enrollment status and suspension from the Medi-Cal program, which shall include deactivation of all provider numbers used to obtain reimbursement from the Medi-Cal program. I understand that I must report changes in the foregoing information within 35 days to the Department of Health Care Services ("DHCS"), Provider Enrollment Division.

I hereby further declare that I will abide by all Medi-Cal laws and regulations and the Medi-Cal program policies and procedures as published in the Medi-Cal Provider Manual, including the requirements for record keeping and the disclosure of information. I understand that compliance with all Medi-Cal laws and regulations is a condition for participation as a provider in the Medi-Cal program.

I agree to make available, during regular business hours, all pertinent financial records, all records of the requisite insurance coverage, and all records concerning the provision of health care services to Medi-Cal beneficiaries to any duly authorized representative of DHCS, the California Attorney General's Medi-Cal Fraud Unit ("AG"), and the Secretary of the United States Centers for Medicare and Medicaid Services. I further agree to provide if requested by any of the above, copies of the records and documentation, and that failure to comply with any request to examine or receive copies of such records shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program. Applicant/Provider will be reimbursed for reasonable copy costs as determined by DHCS or AG.

I also agree that DHCS and/or AG may make unannounced visits to Applicant/Provider, at any of Applicant's/Provider's business locations, before, during or after enrollment, for the purpose of determining whether enrollment, continued enrollment, or certification is warranted, to investigate and prosecute fraud against the Medi-Cal program, to investigate complaints of abuse and neglect of patients in health care facilities receiving payment under the Medi-Cal program, and/or as necessary for the administration of the Medi-Cal program and/or the fulfillment of the AG's powers and duties under Government Code Section 12528. Premises subject to inspection include billing agents, as defined in Welfare and Institutions Code Section 14040.1. Failure to permit inspection by DHCS or AG, or any agent, investigator or auditor thereof, shall be grounds for immediate suspension of Applicant/Provider from participation in the Medi-Cal program.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:** _____
PRINTED NAME: _____
DATE:_____

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Addendum D

DHCS Supplemental Questions

The following questions are additional questions to ensure the applicant supplies information comparable to the applications required to participate in Fee-for-Service Medi-Cal.

INSTRUCTIONS: Please answer the following questions "Yes" or "No". If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper and complete Addendum B.

Have any judgments been entered against you, or settlements been agreed to by you within the last TEN (10) years, in professional liability cases?	☐Yes ☐No
Do you have any fines/debts due and owing to any federal, state, or local government that relate to Medicare, Medicaid or any other federal and state health care program?	☐Yes ☐No

I hereby affirm that the information submitted in this Section, Attestation Questions, Application, and any addenda thereto is current, correct, and complete to the best of my knowledge and belief and 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.

APPLICANT SIGNATURE (Stamp is Not Acceptable)**:**_____

PRINTED NAME: _____

DATE: _____

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EMPLOYEE LANGUAGE SKILLS SELF-ASSESSMENT TOOL

This self-assessment is intended for clinical and non-clinical employees who are bilingual and communicate with a patient in a language other than English.

Employee Name: _____ Department/Job Title_____

Directions: 1) Write any/all languages or dialects you know. 2) Indicate how fluently you speak, read and/or write each language. (See key below) 3) Specify if you currently use the language regularly as part of your job responsibilities.

Language	Dialect, Region, and/or Country	Fluency (See key attached). Circle			As part of your job do you use this language to speak with patients?	As part of your job do you read this language?	As part of your job do you write this language?
		Speaking	Reading	Writing			
1.		N/A	N/A	N/A	Yes ◯ No ⊙	Yes ◯ No ⊙	Yes ◯ No ⊙
2.		N/A	N/A	N/A	Yes ◯ No ⊙	Yes ◯ No ⊙	Yes ◯ No ⊙
3.		N/A	N/A	N/A	Yes ◯ No ⊙	Yes ◯ No ⊙	Yes ◯ No ⊙
4.		N/A	N/A	N/A	Yes ◯ No ⊙	Yes ◯ No ⊙	Yes ◯ No ⊙

Please check off additional qualifications/credentials that support language proficiency level, and attach them to this form. Note: Per state guideline, bilingual providers and staff who communicate with patients in a language other than English must identify and maintain qualifications of their bilingual capabilities on file.

- ☐ Formal language assessment by qualified agency
- ☐ Native speaker with a higher education in language, which demonstrates sufficient accuracy and vocabulary in health care setting.
- ☐ Documentation of successful completion of a specific type of interpreter training
- ☐ Documentation of years employed as an interpreter and/or translator
- ☐ Other (Please specify):

Individuals, who rate themselves with speaking, reading, or writing capabilities below level 3 as defined on the Employee Skills Self-Assessment Key, should not use their bilingual skills or serve as interpreters and/or translators. For assistance, please contact the patient's contracted health plan for immediate telephonic interpreter assistance.

TO BE SIGNED BY THE PERSON COMPLETING THIS FORM

I, _____, attest that the information provided above is accurate.

Date: _____

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Employee Language Skills Self-Assessment Key

Key	Spoken Language
1	Satisfies elementary needs and minimum courtesy requirements. Able to understand and respond to 2-3 word entry-level questions. May require slow speech and repetition.
2	Meets basic conversational needs. Able to understand and respond to simple questions casual conversation about work, school, and family. Has difficulty with vocabulary and grammar.
3	Able to speak the language with sufficient accuracy and vocabulary to have effective for informal conversations on most familiar topics related to health care.
4	Able to use the language fluently and accurately on all levels related to health care work needs. Can understand and participate in any conversation within the range of his/her experience with a high degree of fluency and precision of vocabulary. Unaffected by rate of speech.
5	Speaks proficiently equivalent to that of an educated native speaker. Has complete fluency in the language, including health care topics, such that speech in all levels is fully accepted by educated native speakers in all its features, including breadth of vocabulary and idioms, colloquialisms, and pertinent cultural preferences. Usually has received formal education in target language.

Key	Reading
1	No functional ability to read. Able to understand and read only a few key words.
2	Limited to simple vocabulary and sentence structure.
3	Understands conventional topics, non-technical terms and heath care terms.
4	Understands materials that contain idioms and specialized health care terminology; understands a broad range of literature.
5	Understands sophisticated materials, including those related to academic, medical and technical vocabulary.

Key	Writing
1	No functional ability to write the language and is only able to write single elementary words.
2	Able to write simple sentences. Requires major editing.
3	Writes on conventional and simple health care topics with few errors in spelling and structure.
4	Writes on academic, technical, and most health care and medical topics with few errors in structure and spelling.
5	Writes proficiently equivalent to that of an educated native speaker/writer. Writes with idiomatic ease of expression and feeling for the style of language. Proficient in medical, healthcare, academic and technical vocabulary.

Interpretation VS. Translation	**Interpretation:** Involves spoken communication between two parties, such as between a patient and a pharmacist, or between a family member and doctor. **Translation:** Involves very different skills from interpretation. A translator takes a written document in one language and changes it into a document in another language, preserving the tone and meaning of the original. *Source: University of Washington Center*

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Managed Care Provider Enrollment Disclosure

Background

Beginning January 1, 2018, federal law requires that all managed care network providers must enroll in the Medi-Cal Program if they wish to provide services to Medi-Cal managed care beneficiaries. Managed care providers have two options for enrolling with the Medi-Cal Program. Providers may enroll through (A) a Managed Care Plan (MCP); or (B) DHCS. If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal FFS beneficiaries and contract with MCPs. If the provider enrolls through an MCP, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.

Generally, federal and state laws and regulations that apply to fee-for-service (FFS) providers will also apply to the enrollment process for managed care providers. Regardless of the enrollment option a provider chooses, the provider is required to enter into two separate agreements - the "Plan Provider Agreement" and the "DHCS Provider Enrollment Agreement." The Plan Provider Agreement is the contract between an MCP and a provider defining their contractual relationship. The DHCS Provider Enrollment Agreement is the agreement between DHCS and the provider and is required for all providers enrolled in the Medi-Cal program.

Enrollment Options

A. Enrollment through an MCP. The following provides an overview of the MCP enrollment process:

- The provider will submit a provider enrollment application to the MCP using a process developed by the MCP.
- As part of the application process, the provider will be required to agree that DHCS and the MCP may share information relating to a provider's application and eligibility, including but not limited to issues related to program integrity.
- The MCP will be responsible for gathering all necessary documents and information associated with the MCP application.
- The provider should direct any questions it has regarding its MCP application to the MCP.
- If the provider's application requires fingerprinting, criminal background checks, and/or the denial or termination of enrollment, these functions will be performed by DHCS and the results shared with the MCP.
- While the MCP enrollment process will be substantially similar to the DHCS enrollment process, timelines relating to the processing of the enrollment application may differ. In addition, MCPs will not have the ability to grant provisional provider status nor to authorize FFS reimbursement.
- Providers will not have the right to appeal an MCP's decision to cease the enrollment process.
- The MCP will complete the enrollment process within 120 days of the provider's submission of its application. During this time, the provider may participate in the MCP's network for up to 120 days, pending approval from the MCP.
- Once the enrolling MCP places a provider on the Enrolled Provider List, the provider is eligible to contract with all MCPs. However, an MCP is not required to contract with an enrolled provider.
- Only DHCS is authorized to deny or terminate a provider's enrollment in the Medi-Cal program.

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- Accordingly, if the MCP receives any information that impacts the provider's enrollment, the MCP will suspend processing the provider's enrollment application and refer the provider to DHCS' FFS Provider Enrollment Division (PED) for enrollment where the application process will start over again.
- In order for the provider to participate in the Medi-Cal FFS program, the provider must first enroll through DHCS.

B. Enrollment through DHCS.

- The provider will use DHCS' standardized application form(s) when applying for participation in the Medi-Cal program. (See http://www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx)
- Federal and state laws and regulations that apply to FFS providers will apply to the enrollment process for managed care providers.
- Upon successful enrollment through DHCS, the provider will be eligible to contract with MCPs and provide services to FFS beneficiaries.

There may be other important aspects of the enrollment process that are not set forth in this information bulletin. Please check the DHCS website for provider enrollment updates. Providers should consult with their own legal counsel before determining which enrollment process best suit its needs and objectives.