1600 Green Hills Road, Ste. 101
Scotts Valley, CA 95066-4981
831-430-5560

950 East Blanco Road, Ste. 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Ste. B
Merced, CA 95340-4710
209-381-5300

Dear Sir or Madam:

Thank you for your interest in joining the Central California Alliance for Health (the Alliance) provider network. We greatly value your partnership in better serving our community. Enclosed is the California Participating Physician application and additional documents required to begin the credentialing process.

The following document copies ***must* accompany the enclosed application form:**

- Addendum A, B & C (enclosed)
- Declaration of Confidentiality (enclosed)
- Certification Regarding Debarment (enclosed)
- Taxpayer Identification Form (W-9) (enclosed)
- Copy of current Medical License
- Copy of current DEA license
- Copy of current NPI number
- Copy of professional liability coverage with limits of $1,000,000/claim and $3,000,000/aggregate
- Copy of Clinical Laboratory Improvement Amendments (CLIA) or Waiver (if applicable)
- Curriculum vitae (with dates in MM/YYYY format)
- Hospital Privileges Status or Admitting Agreement

Medi-Cal Certification is required
Beginning January 1, 2018, federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program. Providers have the right to be screened and enrolled directly through DHCS, but still need to complete the Alliance credentialing process which is separate from DHCS screening and enrollment. See the next page for additional information.

If you are the supervising physician for non-physician medical practitioner(s) (NPMP), please also include:

- Copy(ies) of NPMP Agreement(s) (enclosed)
- NPMP Application and accompanying documents that can be found at http://www.ccah- alliance.org/credentialing.html

All provider applications are reviewed by the Alliance Peer Review and Credentialing Committee or a Medical Director. Credentialing applications and supplemental documentation must be completed and signed within 180 days. Forms may be submitted in the following ways:

Mail: 1600 Green Hills Road, Scotts Valley, CA 95066 Attn: Credentialing
Email: credentialing@ccah-alliance.org
Fax: 831-430-5528

We appreciate your cooperation in the credentialing process.

Sincerely,
CCAH – Credentialing Department

DHCS Medi-Cal Provider Screening and Enrollment Requirement

Beginning January 1, 2018, federal law requires that all Alliance-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program. If you are already screened and enrolled through DHCS, you have successfully met this requirement.

Alliance providers have two options for enrolling with the Medi-Cal Fee-for-Service Program. Providers may enroll through (1) DHCS; or (2) through a Managed Care Plan that has a screening and enrollment process substantially equivalent to that of the Department of Health Care Services (DHCS).

- If a provider enrolls through DHCS, the provider is eligible to provide services to Medi-Cal Fee for Service (FFS) beneficiaries and contract with the Alliance.
- If the provider enrolls through a Managed Care Plan, the provider may only provide services to Medi-Cal managed care beneficiaries and may not provide services to Medi-Cal FFS beneficiaries.
- The Alliance is working to implement a screening and enrollment process, which we anticipate will go live no later than 2019. Until such time as the Alliance screening and enrollment process is implemented, providers contracted with the Alliance are required to enroll directly with DHCS.

Enrollment through DHCS

- Providers will use the DHCS standardized application form(s) when applying for participation in the DHCS Medi-Cal Program. The application forms are available on the DHCS website at www.dhcs.ca.gov/provgovpart/Pages/ApplicationPackagesAlphabeticalbyProviderType.aspx. DHCS also has a new online portal for enrollment, available at pave.dhcs.ca.gov/sso/login.do. To create an account, click on the "Sign Up" button at the top right corner of the page.

Upon successful enrollment through DHCS, providers will have satisfied the Alliance screening and enrollment requirement. Please note that absent successful screening and enrollment through DHCS, a contracted provider's status with the Alliance may change after January 1, 2018.

If you have questions about these new requirements, please contact Alliance Provider Services at 800-700-3874 ext. 5504.

For more information contact your Alliance Provider Services Representative at 800-700-3874 ext. 5504

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

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:

Home Phone 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: Social Security Number:

Birth Place: Gender Male Female

Driver's License State/Number: Race/Ethnicity (optional):

Your intent is to serve as a(n):

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

Specialty:

Subspecialties:

III. Practice Information

Practice Name (if applicable): Department Name (if hospital based):

Primary 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:

III. Practice Information (Continued)

Please identify the physical accessibility of this office. ○ Basic ○ Limited ○ None

Type of practice (check all that apply): ☐ Solo Practice ☐ Group Practice ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

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 ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

Secondary Office Hours of Operation

Languages spoken by Staff:

Languages spoken by Provider:

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 ☐ Urgent Care

☐ Single Specialty Group

☐ Multi Specialty Group

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

Which of your practices handles your billing? ◯ Primary ◯ Secondary ◯ Tertiary If none, please provide billing information:

Billing Company

Billing Company Mailing Address:

City: State: Zip Code:

Contact Person: Telephone Number:

Federal Tax ID Number: Name Associated with Tax ID:

V. Practice Description

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
		☐ Primary ☐ Secondary ☐ Tertiary

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

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

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

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

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

Which offices does this applies 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 Mailing Address:

City: State: Zip Code: Email:

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

VI. Education, Training and Experience

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 ______

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 ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Training: ______ Specialty: ______ From (mm/yy): ______

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) To(mm/yy): ______

Institution: ______ Program Director: ______

Address ______ City ______ State ______ Zip ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Training: ______ Specialty: ______ From (mm/yy): ______

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) To(mm/yy): ______

Institution: ______ Program Director: ______

Address ______ City ______ State ______ Zip ______

Telephone Number: ______ Fax Number: ______ Website (if applicable): ______

Type of Training: ______ Specialty: ______ From (mm/yy): ______

Did you successfully complete the program? ◯ Yes ◯ No (Please explain on a separate sheet.) To(mm/yy): ______

VII. Medical Licensure & Certifications

California State Medical License Number	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)

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:

Board Name:

Exam Date:

Describe here:

VIII. 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). 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 : Status (active, provisional, courtesy, temporary, etc.):

Primary Hospital Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Secondary Hospital Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

Hospital Name: Department Name : Status (active, provisional, courtesy, temporary, etc.):

Other Institution Address:

City: State: Zip Code: From (mm/yy):

Medical Staff Phone: Medical Staff Fax: To (mm/yy):

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 Institution 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:

Name and Address of Affiliation:

Department:

From (mm/yy):

To (mm/yy):

Reason for leaving:

IX. 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. **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. Curriculum vitae are <u>not</u> sufficient. Please explain any gaps on a separate page.

Current Practice: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

Name of Practice/Employer: Contact Name:

Address City State Zip

Telephone Number: Fax Number: From (mm/yy): To (mm/yy):

XI. Professional Liability

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

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 CLIA waiver? Yes No

CLIA Certificate Number: CLIA Certificate Expiration Date:

XII. Professional and Practice Services (continued)

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
- ☐ The Medical Quality Commission (TMQC)
- ☐ Child Health and Disability Prevention Program (CHDP)
- ☐ Comprehensive Perinatal Services Program (CPSP)
- ☐ California Children Services (CCS)
- ☐ 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

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.

As always, if information about your practice changes, please notify us promptly.

☐ 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 Medicine 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

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
   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 seven (7) 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

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

Continue to the Next Page for Additional Attestation Questions

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.

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. ○ Yes ○ No

    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

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 two (2) 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

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**

Continue to the Next Page for Information Release/Acknowledgements

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** _____

Addenda Submitting :

☐ Addendum B: Professional Liability Action Explanation

This application and Addenda A and B were created and are endorsed by:
- California Association of Health Plans (916) 552-2910
- California Association of Physician Groups (916) 443-2274

Print Form

The CPPA has been completed. Please be sure you have signed the last two pages (pages 15 and 16) before submission.

California Participating Practitioner Application

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:

California Participating Practitioner Application

Addendum B

Professional Liability Action Explained

This Addendum is submitted to _____ herein, this Healthcare Organization

Please complete this form for each pending, settled or otherwise conclude 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 Gender ◯ Male ◯ Female Patient 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.

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**

Print Form

Addendum C to California Participating Physician Application

1. Credentialing Contact Information:

Name: _____

Phone: _____ Fax: _____

Address: _____

Email: _____

2.

Program / Specialty Participation:	Yes	No	Effective Date
Comprehensive Perinatal Services Provider (CPSP)	❒	❒	
Child Health and Disability Prevention Program (CHDP)	❒	❒	
California Children's Services (CCS)	❒	❒	
Medi-Cal Certified	❒	❒	

3. Does this provider supervise Non- Physician Medical Practitioners? (e.g. NP,PA,CNM)

❑ Yes ❑ No **If yes, please complete list below and the attached agreement.*

NPMP Name	NPMP Title	# of hours / week	Supervising Physician Name

New Provider Training

As a new provider joining the Alliance, you are required to complete the Alliance new provider training.

After reviewing the information in the New Provider Training, please sign below to acknowledge that you have received these training materials and the date of your review.

New Provider Training for PCP

New Provider Training Non-PCP

I have completed my review of the new provider training materials from the Central California Alliance for Health.

_____

Signature of Provider

_____

Date

1600 Green Hills Road, Suite 101
Scotts Valley, CA 95066-4981
831-430-5500

950 East Blanco Road, Suite 101
Salinas, CA 93901-4487
831-755-6000

530 West 16th Street, Suite B
Merced, CA 95340-4710
209-381-5300

In Lieu of Hospital Privileges Statement

In order to provide continuing quality of care for our members, Central California Alliance for Health's Credentialing Policy and Procedure states that each provider needs to have admitting privileges at a local in-network hospital. Should the providers seeking to be credentialed not have appropriate privileges; any of the following situations can apply and satisfy the requirement. ***Please check any that apply.***

I, _____
(Print name)

Do not have local in-network hospital privileges. However, in order to comply with Central California Alliance for Health's requirement of providing quality continuing care for all members I have the following plan:

☐ *The following named physician who is a member of the Central California Alliance for Health provider network and who has local in-network privileges will admit the member needing care. (May name more than one)*

_____ _____
(Name of admitting physician) *(Name of in-network hospital)*

☐ *I would refer the patient to*

_____*in-network hospital to*

be admitted by a hospitalist.

Signature: _____ Date: _____

Please return this form to credentialing@ccah-alliance.org, or by fax at (831) 430-5528. Thank you.

SUMMARY OF NON-PHYSICIAN MEDICAL PRACTITIONERS REQUIREMENTS

Non-physician medical practitioners (NPMP) are defined as nurse practitioners, physician assistants and nurse midwives. When providing services under the supervision of a physician, nurse practitioners should be supervised according to California Code of Regulations, the Nurse Practice Act, and the California Business and Professions Code. Physician assistants may provide medical services under a Delegation of Services Agreement (DSA) entered into with the supervising physician, in accordance with the California Code of Regulations and the California Business and Professions Code.

Central California Alliance for Health will perform credentialing and ongoing monitoring activities for all NPMPs who operate under a supervisory agreement with a contracted, credentialed supervising physician. Each physician/NPMP team will sign an agreement, and keep it on file, stating that the NPMP will follow the protocols developed for practice by the supervising physician. The protocols may be revised with the approval of the supervising physician and a new agreement should then be signed. A sample agreement is attached.

NON-PHYSICIAN MEDICAL PRACTITIONER (NPMP) AGREEMENT*

The following is an agreement between _____ and _____ .
NPMP Name Supervising Physician

I agree to follow the protocols established by _____ for NPMPs.
Name of Practice or Group

I agree to consult with my supervising physician for all cases as outlined in the protocol and for any case that I am unsure about the diagnosis or management.

I understand that a physician will be available either on-site or by electronic communication at all times.

I understand that I am expected to stabilize clients during life-threatening emergencies and to contact a physician as soon as possible and/or arrange for emergency transport to the nearest hospital.

I understand that my charts will be reviewed by the supervising physician who will discuss cases with me on a regular basis.

I understand that medications must be ordered as per California Business and Professional Codes relating to the practice of NPMPs.

This agreement is effective until the supervising physician(s), or the NPMP requests a change in writing.

I understand that failure to follow these protocols may result in disciplinary action.

Non-Physician Medical Practitioner	Supervising Physician
_____	_____
Signature	Signature
_____	_____
Type or Print Name	Type or Print Name
_____	_____
Date	Date

***This document may be substituted with a standard written agreement if one already exists.**

The form below is a requirement of our Medi-Cal contract with the State. Please review and sign below where indicated.

LETTER OF AUTHORIZATION PROCEDURES RELEASE/ACCESS OF DHS COMPUTER FILES FOR THE MEDI-CAL PROGRAM DECLARATION OF CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized / maintained by the Department of Health Services, I, _____ , agree not to divulge
(Provider name)
any information obtained in the course of my assignment to unauthorized persons, and agree not to publish or otherwise make public any information regarding persons receiving Medi-Cal services such that the persons who receive such services are identifiable.

Access to such data shall be limited to the Plan, myself, my employees, fiscal agents, State and federal personnel who require the information in the performance of their duties, and to such others as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signature of Provider

_____
Date

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION - LOWER TIERED COVERED TRANSACTIONS

Instructions for Certification

1. By signing and submitting this certification as part of this proposal, the prospective lower tier participant is providing the certification set out below.

2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective lower tier participant knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

3. The prospective lower tier participant shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective lower tier participant learns that its certification was erroneous when submitted or had become erroneous by reason of changed circumstances, including but not limited to suspension, debarment, or exclusion from participation in any federally-funded health care program following its
previous certification.

4. The terms covered transaction, debarred, suspended, ineligible, lower tier covered transaction, participant, person, primary covered transaction, principal, proposal, and voluntarily excluded, as used in this clause, have the meaning set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.

5. The prospective lower tier participant agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the department or agency with which this transaction originated.

6. The prospective lower tier participant further agrees by submitting this proposal that it will include this clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion-Lower Tier Covered Transaction," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that is not proposed for debarment under 48 CFR part 9, subpart 9.4, debarred, suspended, ineligible, or voluntarily excluded from covered transactions, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may, but is not required to check the List of Parties Excluded from Federal Procurement and No procurement Programs.

8. Nothing contained in the foregoing shall be construed to require establishment of a system or records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is proposed for debarment under 48 CFR part 9, subpart 9.4, suspended, debarred, ineligible or voluntarily excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the department or agency with which this transaction originated may pursue available remedies, including suspension and/or debarment.

(1) The prospective lower tier participant certifies, by submitting this proposal and signing below, that neither it or its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency, or is excluded as the result of state or federal action from participation in any federally-funded health care program.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

_____

Signature

_____

Printed Name

_____

Date

Form **W-9**
(Rev. October 2007)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See **Specific Instructions** on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/Sole proprietor ☐ Corporation ☐ Partnership
☐ Limited liability company. Enter the tax classification (D=disregarded entity, C=corporation, P=partnership) ▶ _____
☐ Other (see instructions) ▶

☐ Exempt payee

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. citizen or other U.S. person (defined below).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. See the instructions on page 4.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Purpose of Form

A person who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States,
- An estate (other than a foreign estate), or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,