



# LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

## DIRECTIONS

Please type or print in black ink when completing this form. If you need more space or have more than four locations, attach additional sheets and reference the question being answered. Please see page 9 for a list of required documents.

**\*\* All sections must be completed in their entirety. "See C.V.", not acceptable\*\***

## GENERAL INFORMATION

LAST NAME	SUFFIX	FIRST	MIDDLE	GENDER <input type="radio"/> MALE <input type="radio"/> FEMALE
DEGREE: <input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> DC <input type="checkbox"/> DDS <input type="checkbox"/> DMD <input type="checkbox"/> OTHER _____				
Any other name under which you have been known? (AKA) LIST		ECFMG NUMBER		UPIN NUMBER
HOME STREET ADDRESS		CITY	STATE	ZIP CODE
HOME PHONE NUMBER	PAGER NUMBER/ANSWERING SERVICE		HOME E-MAIL ADDRESS (Optional)	
SOCIAL SECURITY NUMBER	DATE OF BIRTH	BIRTH PLACE (CITY, STATE)	RACE/ETHNICITY (Voluntary)	
NPI - INDIVIDUAL	NPI - GROUP	MEDICAID PROVIDER NUMBER	MEDICARE PROVIDER NUMBER	

## PRIMARY PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)			OFFICE MANAGER				
STREET ADDRESS		CITY	STATE	ZIP CODE			
PHONE NUMBER	FAX NUMBER	OFFICE E-MAIL					
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER		TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION					
Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)							
<b>BILLING ADDRESS</b> (Address to which you want payments sent)		CONTACT PERSON		TELEPHONE NUMBER			
CITY	STATE	ZIP CODE	<b>BILLING E-MAIL</b>	FAX NUMBER			
OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify) _____					<input type="checkbox"/> Provider <input type="checkbox"/> Other		
Languages spoken at this location: (other than English) _____							
Accepting Patients? <input type="checkbox"/> New <input type="checkbox"/> Existing Only		<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify) _____					
Age group(s) treated: <input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65		<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages		<input type="checkbox"/> 12-18 years <input type="checkbox"/> Other (Specify): _____		<input type="checkbox"/> 19-65 years	
Are PAs and/or nurse/paraprofessional practitioners used? <input type="radio"/> Yes <input type="radio"/> No			Is this facility handicapped accessible? <input type="radio"/> Yes <input type="radio"/> No				
Emergency After Hours Number		Arrangements for 24 hour / 7 day a week coverage (Specify)					

Group or Covering Physicians: \_\_\_\_\_

**SECOND PRACTICE LOCATION**

INSTITUTION/GROUP/CLINIC NAME (If applicable)					OFFICE MANAGER		
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
OFFICE HOURS		MON	TUES	WED	THUR	FRI	SAT SUN
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____							<input type="checkbox"/> Provider <input type="checkbox"/> Other
Accepting Patients?		<input type="checkbox"/> New <input type="checkbox"/> Existing Only		<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____			
Age group(s) treated:		<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65	<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages	<input type="checkbox"/> 12-18 years	<input type="checkbox"/> 19-65 years <input type="checkbox"/> Other (Specify): _____		
Are PAs and/or nurse/paraprofessional practitioners used? <input type="radio"/> Yes <input type="radio"/> No				Is this facility handicapped Accessible? <input type="radio"/> Yes <input type="radio"/> No			
Emergency After Hours Number			Arrangements for 24 hour / 7 day a week coverage (Specify)				
Group or Covering Physicians:							

**THIRD PRACTICE LOCATION**

INSTITUTION/GROUP/CLINIC NAME (If applicable)					OFFICE MANAGER		
STREET ADDRESS				CITY		STATE	ZIP CODE
PHONE NUMBER		FAX NUMBER		OFFICE E-MAIL			
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED							
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER				TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION			
Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)							
BILLING ADDRESS (Address to which you want payments sent)				CONTACT PERSON		TELEPHONE NUMBER	
CITY		STATE		ZIP CODE		BILLING E-MAIL	
OFFICE HOURS		MON	TUES	WED	THUR	FRI	SAT SUN
Do you practice at this location: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Other (Specify): _____							
Languages spoken at this location: (other than English) _____							<input type="checkbox"/> Provider <input type="checkbox"/> Other

**THIRD PRACTICE LOCATION CONTINUED**

Accepting Patients?	<input type="checkbox"/> New <input type="checkbox"/> Existing Only	<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____		
Age group(s) treated:	<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65	<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages	<input type="checkbox"/> 12-18 years <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> 19-65 years
Are PAs and/or nurse/paraprofessional practitioners used?	<input type="radio"/> Yes <input type="radio"/> No	Is this facility handicapped Accessible?	<input type="radio"/> Yes <input type="radio"/> No	
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)			

Group or Covering Physicians: \_\_\_\_\_

**FOURTH PRACTICE LOCATION**

If you have more than four locations, attach additional sheets with the following information

INSTITUTION/GROUP/CLINIC NAME (If applicable)			OFFICE MANAGER		
STREET ADDRESS		CITY		STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER		<b>OFFICE E-MAIL</b>		
TYPE OF PRACTICE: <input type="checkbox"/> SOLO <input type="checkbox"/> MULTISPECIALTY GROUP <input type="checkbox"/> SINGLE SPECIALTY GROUP <input type="checkbox"/> HOSPITAL-BASED					
TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - PROVIDER			TAX IDENTIFICATION NUMBER/ DATE TAX ID # EFFECTIVE - LOCATION		

Name to which tax ID number is registered with the IRS (Important: must match the name given on IRS information given)

<b>BILLING ADDRESS</b> (Address to which you want payments sent)			CONTACT PERSON		TELEPHONE NUMBER		
CITY	STATE	ZIP CODE	<b>BILLING E-MAIL</b>		FAX NUMBER		
OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN

Do you practice at this location:  Full-time  Part-time  Other (Specify): \_\_\_\_\_Languages spoken at this location: (other than English) \_\_\_\_\_  Provider  Other

Accepting Patients?	<input type="checkbox"/> New <input type="checkbox"/> Existing Only	<input type="checkbox"/> Only family members of existing patients <input type="checkbox"/> Other (Specify): _____		
Age group(s) treated:	<input type="checkbox"/> 0-6 years <input type="checkbox"/> Over 65	<input type="checkbox"/> 7-11 years <input type="checkbox"/> All Ages	<input type="checkbox"/> 12-18 years <input type="checkbox"/> Other (Specify): _____	<input type="checkbox"/> 19-65 years
Are PAs and/or nurse/paraprofessional practitioners used?	<input type="radio"/> Yes <input type="radio"/> No	Is this facility handicapped Accessible?	<input type="radio"/> Yes <input type="radio"/> No	
Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)			

Group or Covering Physicians: \_\_\_\_\_

**CORRESPONDENCE**

Please check location where you would like correspondence sent.				
<input type="checkbox"/> Primary	<input type="checkbox"/> Second	<input type="checkbox"/> Third	<input type="checkbox"/> Fourth	<input type="checkbox"/> All
<input type="checkbox"/> Other Address _____				

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER	FAX NUMBER	<b>E-MAIL</b>
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**MEDICAL RECORDS**

Please check location where you would like medical records requests sent.  
 Primary     Second     Third     Fourth     Correspondence  
 Other address \_\_\_\_\_

If different from practice or correspondence located checked above

PHONE NUMBER	FAX NUMBER	EMAIL
_____	_____	_____

**SPECIALTY**

TYPE OF PROVIDER:    PRIMARY CARE PHYSICIAN    PHYSICIAN SPECIALIST    BOTH    OTHER SPECIALTY: \_\_\_\_\_

**PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)**                      **BOARD CERTIFIED (ABMS)**

Specialty: \_\_\_\_\_                       Yes    No

Sub-Specialty: \_\_\_\_\_                       Yes    No

Sub-Specialty: \_\_\_\_\_                       Yes    No

**BOARD CERTIFICATION**  
 (as recognized by American Board of Medical Specialties)  
 (Please attach a copy of current certification(s).)

PRIMARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
_____	_____	_____	_____
SECONDARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
_____	_____	_____	_____
THIRD SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
_____	_____	_____	_____

**DIRECTORY INFORMATION**

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by health care organization**

Primary Location	Second Location	Third Location	Fourth Location
<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty	<input type="checkbox"/> Specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory
<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory
<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty	<input type="checkbox"/> Sub-specialty
<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory	<input type="checkbox"/> Directory

IF DIFFERENT FROM PRACTICE LOCATIONS:

PHONE NUMBER	FAX NUMBER	E-MAIL
_____	_____	_____

**PHO / IPA AFFILIATIONS\***

List any other PHO's, IPA's, which you participate in and dates of participation:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\* The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.

## CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: .....

List in **chronological** order from oldest to most current all hospitals at which you currently have privileges:

HOSPITAL	LOCATION/ADDRESS	TYPE OF PRIVILEGES	EFFECTIVE DATE MO/YR
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHO ADMITS FOR YOU AND TO WHAT HOSPITAL? PLEASE LIST PROVIDER'S NAME, SPECIALTY AND HOSPITAL.

.....

## EDUCATION

**IF ADDITIONAL TRAINING HAS BEEN COMPLETED, PLEASE ATTACH ON A SEPARATE FORM.**

**MEDICAL/PROFESSIONAL SCHOOL:** .....

CITY	STATE	ZIP
------	-------	-----

DEGREE	YEAR OF GRADUATION	DATES ATTENDED (MO/YR) From ..... To .....
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INTERNSHIP: INSTITUTION NAME	TYPE OF TRAINING
------------------------------	------------------

CITY	STATE
------	-------

UNIVERSITY AFFILIATION	COMPLETED <input type="radio"/> YES <input type="radio"/> NO	DATES ATTENDED (MO/YR) From ..... To .....
------------------------	---	---

RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
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CITY	STATE	DATES ATTENDED (MO/YR) From ..... To .....
------	-------	---

UNIVERSITY AFFILIATION	COMPLETED <input type="radio"/> YES <input type="radio"/> NO	
------------------------	---	--

RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
-----------------------------	-------------------	--

CITY	STATE	DATES ATTENDED (MO/YR) From ..... To .....
------	-------	---

UNIVERSITY AFFILIATION	COMPLETED <input type="radio"/> YES <input type="radio"/> NO	
------------------------	---	--

FELLOWSHIP: INSTITUTION NAME	SPECIALTY FIELD	DATES ATTENDED (MO/YR) From ..... To .....
------------------------------	-----------------	---

CITY	STATE	COMPLETED <input type="radio"/> YES <input type="radio"/> NO
------	-------	---

	TYPE OF FELLOWSHIP	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
--	--------------------	--

FELLOWSHIP: INSTITUTION NAME	SUBSPECIALTY FIELDS	DATES ATTENDED (MO/YR) From ..... To .....
------------------------------	---------------------	---

CITY	STATE	COMPLETED <input type="radio"/> YES <input type="radio"/> NO
------	-------	---

	TYPE OF FELLOWSHIP	<input type="checkbox"/> Clinical <input type="checkbox"/> Research
--	--------------------	--

## WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the month and year for each entity listed.**  
**Work history is critical. Failure to provide this information may delay your credentialing.**

**CODE:**

**C** = Clinic/Group   **S** = Solo Practice   **A** = Academic (Paid Teaching Appointments)   **H** = Civilian Hospital Medical Staff Appointment  
**M** = Military Service (Including Hospital Staff Appointments)   **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE (From MO/YR to MO/YR)
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....
.....	..... ..... .....	.....

**In the following section, please explain any gaps of two months or more in your education,  
post-graduate training or work history:**

**PROFESSIONAL LICENSES**

<b>PROFESSIONAL LICENSES</b>	<b>LICENSE NUMBER</b>	<b>DATE OBTAINED</b>	<b>EXPIRATION DATE</b>
STATE LICENSE	.....	.....	.....
FEDERAL DEA REG NUMBER	.....	.....	.....
STATE CDS LICENSE NUMBER	.....	.....	.....
CLIA CERTIFICATE	.....	.....	.....

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen?

Yes  No **If yes, a current copy of your CLIA Registration must accompany this application.**

**FOR DENTISTS ONLY** - Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?)

Yes  No **If yes, a copy of your Anesthesia Permit must accompany this application.**

**Have you been or are you currently licensed in any other state? If YES, please complete the following:**

.....	.....	.....	.....
LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE
.....	.....	.....	.....
LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE
.....	.....	.....	.....
LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE

**(Please attach a copy of all licenses listed above and additional ones in other states not listed.)**

**REFERENCES**

**List, as professional references, three or more peers (Physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years.  
(References should not be relatives or current partners.)**

.....	.....	.....
NAME	SPECIALTY	PHONE NUMBER

.....	.....	.....	.....
STREET ADDRESS	CITY	STATE	ZIP

.....	.....	.....
NAME	SPECIALTY	PHONE NUMBER

.....	.....	.....	.....
STREET ADDRESS	CITY	STATE	ZIP

.....	.....	.....
NAME	SPECIALTY	PHONE NUMBER

.....	.....	.....	.....
STREET ADDRESS	CITY	STATE	ZIP

**PROFESSIONAL LIABILITY INSURANCE COVERAGE**

NAME OF CARRIER .....	POLICY NUMBER .....
ADDRESS AND PHONE NUMBER OF CARRIER .....	
AMOUNTS PER OCCURRENCE/AGGREGATE .....	DATES OF COVERAGE .....
Do you participate in the Louisiana Patients' Compensation Fund?	<input type="radio"/> YES <input type="radio"/> NO
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation)	<input type="radio"/> YES <input type="radio"/> NO
Are you self-insured in accordance with the Louisiana Medical Malpractice Act?	<input type="radio"/> YES <input type="radio"/> NO
<b>Please attach a copy of the current Certificates of Insurance.</b>	

**GENERAL QUESTIONS**

**Please check the appropriate response to the following questions:**

**If you answered YES to any of the questions below, please attach a full explanation on a separate page.**

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have your clinical privileges at any hospital or health care institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you engaged in the illegal use of drugs within the past two years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you presently a named defendant in a pending professional liability lawsuit?  If YES, please enter the number of cases ..... and attach a full explanation of each.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. During the past 5 years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action?  If YES, please enter the number of cases ..... and attach a full explanation of each.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**REQUIRED ATTACHMENTS**

- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Professional Liability Insurance
- ✓ History of Malpractice suits in past 5 years, regardless of whether judgments or settlements paid.
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 8.
- ✓ Current Employer Identification Number (EIN) Letter, W-9 Form or Federal Tax Deposit Coupon
- ✓ Education Certificate for Foreign Medical Graduates (ECFMG) (If applicable)
- ✓ Health Plan Agreement (If applicable)

**STATEMENT TO APPLICANTS**

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:11.1.A (8) an adverse medical review panel opinion is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:11.1, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

**PROVIDER STATEMENT TO RELEASE INFORMATION**

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

**X**

NAME (Please Print)

SIGNATURE

ORIGINAL ATTESTATION DATE

SECOND ATTESTATION DATE

THIRD ATTESTATION DATE

*Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.*