Individual Provider Application - SCS MCCW Program

Dear Provider:

In order to comply with state, federal and accreditation requirements for the South Carolina Solutions (SCS) Medically Complex Children's Waiver Program (MCCW), SCS must collect certain demographic and credentialing information on providers applying for network participation. All information requested on the enclosed application is essential to the contracting and credentialing process. For timely processing of your application, please complete all questions and provide all documentation. If all necessary information is not completed, the application will be returned to you for completion, which will delay processing time.

- All blanks must be filled in with the appropriate information. Stating "See CV or See Resume" is NOT ACCEPTABLE. Please mark all non-applicable sections with N/A.
- The application and attachments should be TYPED or LEGIBLY PRINTED IN BLACK INK.
- If more space is needed than is provided on the application, please attach additional sheets and reference the question being answered.
- Please do not use abbreviations when completing the application.

NOTE: Providers are selected to participate in our network based on the credentialing assessment and our ongoing determination of the network's needs. Completion and submission of the application and the required documentation does not guarantee inclusion in the SCS MCCW network.

Thank you for your cooperation in completing this application. If you have any questions while completing this application, please call the Credentialing Department at (855) 530-4941.

Current copies of the following documents MUST be submitted with this application.
Please use this checklist to avoid exclusion of necessary documentation.

1. Completed Provider Application (pages 1-2) ☐
2. Signed and dated Confidential Practice History and Info Form (page 5) ☐
3. Signed and dated Attestation (page 6) ☐
4. Copy of current Malpractice Face Sheet (Binder) or JUA Documentation ☐
5. Signed and dated Malpractice Claims/Suit History Form (page 7) ☐
6. Copy of current Medical License ☐
7. Copy of current DEA Certificate ☐
8. Copy of Medical School Diploma, Internship Certificate, Residency Certificate, Fellowship Certificate and American Board Certificate, if applicable ☐
9. Completed and signed and dated W9 Form ☐
10. Copy of current Curriculum Vitae or Resume ☐
11. Hospital Privileges or Hospitalist Agreement ☐

Application Preparer / Credentialing Contact Information

Name ____

Address ____

City ______________________________ State __________ Zip ______________

Phone Number ______________________________ Fax Number ______________________________

Email ____

Please Print Provider Name: ____

Individual Provider Application - SCS MCCW Program

Individual Provider Information

1) Provider Name: ____________________________ __________________________ ___________________ ______
Last First Middle Jr, Sr,

2) Professional Degree: ☐ MD ☐ DO ☐ Other

3) Medicaid ID: ____

4) NPI: ____

5) Maiden/Former Names/Aliases: ____

6) DOB: MM ______ DD _____ YYYY __________ 7) SS#: ____

8) Gender: ☐ Male ☐ Female

9) If you are not a U.S. Citizen, do you have authorization to work in the U.S.? ☐ Yes ☐ No

10) Are you associated only with a County Health Department? ☐ Yes ☐ No

11) List any foreign languages you speak fluently: ____

12) Please list the specialties for which you are applying to be credentialed:

Primary Specialty: ____

Secondary Specialty: ____

Tertiary Specialty: ____

13) Do you object to providing any services for moral or religious reasons? ☐ Yes ☐ No

If Yes, please specify: ____

Credentialing Information

14) Current Professional Licenses:

State	License Number	Issue Date	Expiration Date

15) History of Previous Licensure in all jurisdictions: ☐ NA

State	License Number	Issue Date	Expiration Date	Status

16) DEA Registration: ☐ NA
Registration Number: _________________________________ Issue Date: ___________ Expiration Date: _________

Individual Provider Application - SCS MCCW Program

Credentialing Information - Continued

17) Professional Liability Coverage:
Type of Coverage: ☐ JUA ☐ Malpractice Insurance

Address: ____

City: ________________________ State: __________ Zip: __________

Phone Number: ____________________ Fax Number: ____________________

Amount of Coverage: ____________________ ____________________
Aggregate Single event/per episode

Policy Number: ______________________ Expiration Date: __________

18) Work History:
Please attach your CV or Resume and explain any gaps in employment of more than 6 months:

____
____
____

19) How many years have you been in active clinical practice? ____________________
20) How many years have you provided medical care for medically complex children (MCC)? __________

Please provide the following employment history for the past 5 years:

Facility Name	Employed From – Employed to	Contact Name for Verification	Phone #	Care for MCC?
____________	________	______________	________	☐ Yes ☐ No
____________	________	______________	________	☐ Yes ☐ No
____________	________	______________	________	☐ Yes ☐ No
____________	________	______________	________	☐ Yes ☐ No
____________	________	______________	________	☐ Yes ☐ No

21) Board Certifications: ☐ NA

Name of Certifying Board	Area of Certification	Date Certified	Date Expires
____________	____________	________	________
____________	____________	________	________
____________	____________	________	________

Education - Please attach additional sheets as necessary:

22) Medical School Name: ____

Address: ______________________________ Country: __________

City: ________________________ State: __________ Zip: __________

From: __________ To: __________ Degree: ____________________

Individual Provider Application - SCS MCCW Program

23) Internship Institution's Name: ____

Address: ______________________________________ Country: ____________

City: ________________________________ State: _________ Zip: ___________

From: ___________ To: ___________ Completed? ☐ Yes ☐ No

24) Residency Institution's Name: ____

Address: ______________________________________ Country: ____________

City: ________________________________ State: _________ Zip: ___________

From: ___________ To: ___________ Completed? ☐ Yes ☐ No

25) Fellowship Institution's Name: ____

Address: ______________________________________ Country: ____________

City: ________________________________ State: _________ Zip: ___________

From: ___________ To: ___________ Completed? ☐ Yes ☐ No

Hospital Privileges - Please attach additional sheets as necessary:

26) Primary Admitting Hospital
Name: ____
Address: ____ Tel #: ____________
City: _____________________________ State: ___________ Zip: ___________
Expiration: ____
Status of Privileges ☐ Active ☐ Provisional ☐ Courtesy ☐ Other: __________________

27) Additional Hospital
Name: ____
Address: ____ Tel #: ____________
City: _____________________________ State: ___________ Zip: ___________
Expiration: ____
Status of Privileges ☐ Active ☐ Provisional ☐ Courtesy ☐ Other: __________________

28) Additional Hospital
Name: ____
Address: ____ Tel #: ____________
City: _____________________________ State: ___________ Zip: ___________
Expiration: ____
Status of Privileges ☐ Active ☐ Provisional ☐ Courtesy ☐ Other: __________________

Individual Provider Application - SCS MCCW Program

Confidential Practice History and Information

29) Have you ever been involved in a professional liability suit and/or arbitration, or have any other proceedings been instituted against you? ☐ Yes ☐ No

30) Have there ever been any settlements or judgments, involving litigation or arbitration, involving your professional practice? ☐ Yes ☐ No

(If the answer to either of the above questions is "Yes", please complete the attached Claims/Suit History Information Addendum for each suit or settlement.)

31) Has your license to practice, in your profession, ever been denied, suspended, restricted or voluntarily surrendered while under investigation, or have you ever been subject to Consent Order, probation or any conditions or limitations by any State Licensing Board? ☐ Yes ☐ No

32) Have you ever voluntarily surrendered your professional license in order to avoid suspension, revocation, disciplinary action, or for any other reason? ☐ Yes ☐ No

33) Have you ever received a reprimand or been fined by any State Licensing Board? ☐ Yes ☐ No

34) Has any hospital or managed care organization ever denied your application for privileges? ☐ Yes ☐ No

35) Has your staff membership or clinical privileges ever been voluntarily or involuntarily limited, reduced, suspended, relinquished, or terminated? ☐ Yes ☐ No

36) Have you ever voluntarily or involuntarily resigned from a medical or professional staff or professional organization to avoid suspension, dismissal, or other disciplinary action? ☐ Yes ☐ No

37) Has your DEA Registration Number ever been limited, denied, suspended, revoked, restricted, denied renewal, voluntarily or involuntarily relinquished? ☐ Yes ☐ No

38) Have you ever been expelled or suspended from receiving payment under the Medicare or Medicaid Program in any jurisdiction? ☐ Yes ☐ No

39) Have you ever been convicted of a felony crime or do you have any felony or misdemeanor charges pending other than minor traffic offenses? ☐ Yes ☐ No

40) Have you ever been the subject of adverse action reports to a State or Federal databank, including being sanctioned by a Peer Review Organization? ☐ Yes ☐ No

41) Do you have any medical or mental illness that may impair your ability to fully and safely function within your professional capacity or to provide care according to accepted standards of professional performance, or that may pose a threat to the health or safety of patients? ☐ Yes ☐ No

42) Do you currently engage in the illegal use of drugs, including prescription drugs, without the direct supervision of a licensed health care professional? ☐ Yes ☐ No

43) Has your professional liability coverage ever been denied or terminated by action of any insurance company? ☐ Yes ☐ No

If you answered Yes to any of the above questions (#29 - #43), a written explanation is required. Please explain in an attachment.

Individual Provider Application - SCS MCCW Program

<u>Provider Attestation and Authorization Release Form</u>

I agree to notify Community Health Solutions of America, LLC (CHS) within two (2) business days, in writing, should events occur during the course of my participation that would change any of the information on this application.

I hereby authorize CHS and their representatives to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present liability carriers, who may have information bearing on my professional competence, character, and ethical qualifications, and authorize release of said information to CHS. I hereby release all individuals, organizations, previous or current employers, and institutions of learning from all liability for any damages which may result from issuing such information.

I understand that my continued participation in the SCS MCCW network is contingent upon my acceptance by CHS and upon my continuing to positively maintain appropriate credentials, including satisfactorily completing the recredentialing process at least every three (3) years.

I further understand that potential quality of care issues identified during the initial credentialing or recredentialing processes, or at any time during my participation in the SCS MCCW network, may be subject to peer review and that subsequent adverse findings may affect my network privileges.

I acknowledge that and agree to this application and all statements herein becoming a part of my agreement with CHS. I understand that CHS will use this information in confidence and in association with my application and that discovery of any significant deviations in the information I have provided is grounds for denial of the application or immediate termination from the SCS MCCW network at any time.

I understand that if my application for privileges is denied by CHS, I have the right to appeal the decision to the CHS Credentialing Appeal Panel.

All information, including supporting documentation, submitted by me in connection with this application is true and complete to the best of my knowledge and belief. I agree to update this application while it is being processed, should there be any change in the information provided that could affect the application or its outcome. I understand that I have the right to review information (excluding information protected by peer review statutes) submitted in support of this credentialing application and to correct erroneous information submitted by any other party.

All information submitted by me in this application is true to the best of my knowledge and belief. I fully understand that any significant misstatement in, or omission from, this application may constitute cause for denial of participation or cause for summary dismissal from the SCS MCCW network.

44) Provider Name: ___________________________________ _________________________ ___________________
Last First Degree

45) Provider Signature: ____ Date: ____________

Thank you for taking the time to apply for participation in the CHS network.
If you have any questions, please call the Credentialing Department at 855-530-4941.
Please mail your completed application to:
Credentialing Department
P.O. Box 23500
St. Petersburg, FL 33742

Please be sure to enclose all items listed in the Credentialing Checklist (Page 1)
in addition to any forms or attachments required with your Application.

Individual Provider Application - SCS MCCW Program

Claim/Suit History Information Addendum

All applicants are required to provide information on any professional liability claims, complaints or causes of action that have been filed against him/her and the status of such issues. Your application process will be delayed until this information is received. If this page is not applicable, please mark as such and sign and date bottom of page.

Please complete an individual form for each incident in which you have been involved.

A. Name(s) of Plaintiff(s): ____

B. Name(s) of Defendant(s): ____

C. Month/Year of Incident: ____ D. Date Claim Filed: __________________

E. Where Incident Occurred: ____

F. Identify your professional relationship to the alleged injured party:
☐ Primary (attending) physician ☐ Consulting ☐ Secondary physician (i.e., surgeon) ☐ Other: ______________

G. Describe the nature of the incident (complaint, allegation):
____
____
____
____

H. Provide a narrative description of your participation/level of care:
____
____
____
____

I. Complete the following indicating the outcome, the date of the decision, and any monies paid:

Outcome of Incident	Date	Amount	Outcome of Incident	Date	Amount
☐ Pending	__________	__________	☐ Dropped	__________	__________
☐ Settled	__________	__________	☐ Closed	__________	__________
☐ Dismissed with prejudice	__________	__________	☐ Dismissed without prejudice	__________	__________
☐ Verdict for plaintiff	__________	__________	☐ Verdict for you	__________	__________

Note: If you have a pending claim at the time of credentialing, CHS will routinely request an update on the status until the claim is closed.

J. Provider Name: __________________________________ ____________________________ ___________________
Last First Degree

K. Provider Signature: ____ Date: ______________________