CREDENTIALING APPLICATION PACKET INSTRUCTIONS

1) **If you would like to register with CAQH,** please contact your Contract Negotiator or Provider Representative for a CAQH Provider Application and information on CAQH sponsorship.

2) **If you ARE registered with CAQH:**
   a. Complete the enclosed "Provider Data Form" (pages 2 and 3) and upload form to the CAQH website.
   b. Ensure that each of the items on the Checklist (page 4) are uploaded to the CAQH website.
   c. Ensure you authorize CAQH to allow Magnolia Health to view your documents.
   d. CAQH must be re-attested every 120 days. Please make sure you have recently updated your CAQH profile.
   e. If you have a MS Uniform Credentialing application on file with CAQH, you do not need to complete the enclosed MS Uniform Credentialing application.

3) **If no application is on file with CAQH, please complete the enclosed MS Uniform Credentialing application and upload to CAQH website.**
   a. You will need to include the items listed on the "Credentialing Application Checklist" (page 4) and submit all documents. You may fax via secure fax to 866-480-3227 or you may email documents to magnoliacredentialing@centene.com.

Provider Data Form

Date:	Product: ❑MSCAN ❑MSCAN BH ❑Ambetter ❑Ambetter BH ❑Medicare Advantage ❑Medicare Advantage BH	Are you registered with CAQH? ❑Yes ❑No
If Yes, CAQH Provider ID:	Individual NPI:	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security #:	Medicaid ID #:	Medicare ID #:
Provider Type (MD, DO, PhD, LCSW, LPC, NP, etc.):	Are you a hospital based only provider not practicing in an office setting? ❑ Yes ❑ No	
***Primary Office Tax ID:	***Primary Office Group Billing NPI:	
Practice Name:	E-Mail Address:	
Primary Office Street Address:	Suite #:	
Primary Office City:	State:	County:	Zip:
Primary Telephone:	Primary Fax:	
Credentialing Contact Name:	Credentialing Contact Email:	Credentialing Contact Phone:
Primary Specialty:	Applying As: ❑ Specialist ❑ Primary Care Provider (e.g., Primary Care Physician, Mid- level provider)	
If PCP, are you accepting new patients? ❑ Yes ❑ No ❑ Yes, existing patients only	What gender or age restrictions do you have? Gender: ❑ No Restrictions ❑ Female Only ❑ Male Only Age: ❑ No Restrictions ❑ Age Limits: Lowest Age ____ Highest Age ____	
If PCP, please list maximum panel size (default is 1,500):		
Are you board certified? ❑ Yes ❑ No	If Yes, board name:	Exp. Date:
Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.		
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 if you have one.**		
Do you have a CLIA Certificate? ❑ Yes ❑ No	Do you have a CLIA waiver? ❑ Yes ❑ No	Type of Service Provided:
Certificate Number: _____ Certificate Expiration Date:	CLIA Name: _____ Tax ID #:	

*****If provider practices at more than one location, please include those additional locations on the following page (page 3).**

Note: If you have already completed your application with CAQH, please ensure that you have authorized Magnolia Health to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding Magnolia Health to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Magnolia Health.

Additional Practice Locations

Complete the section below if the provider practices at more than one location. Please make additional copies of this page if necessary.

①Location Name	Tax ID Number
Group NPI Number	**Group Medicaid ID Number**
Street Address	**City, State, Zip Code**
Billing Address, if different from Page 2	**City, State, Zip Code**
Location Point of Contact	**Phone Number**
Fax Number	**E-mail Address**

②Location Name	Tax ID Number
Street Address	**City, State, Zip Code**
Group NPI Number	**Group Medicaid ID Number**
Billing Address, if different from Page 2	**City, State, Zip**
Location Point of Contact	**Phone Number**
Fax Number	**E-mail Address**

③ Location Name	Tax ID Number
Street Address	**City, State, Zip**
Group NPI Number	**Group Medicaid ID Number**
Billing Address, if different from Page 2	**City, State, Zip**
Location Point of Contact	**Phone Number**
Fax Number	**E-mail Address**

Credentialing Application Checklist

YOU MUST INCLUDE THE FOLLOWING WITH THE COMPLETED

MISSISSIPPI UNIFORM CREDENTIALING APPLICATION
(Please use this checklist as a guide)

- ☐ Signed and Dated Copy of Practitioner Application, Attestation and Authorization Sheet *(Not to expire within 90 days)*
- ☐ Any gaps of time six (6) months or greater from professional school/training to the present date must be documented.
- ☐ Copy of Collaborative Agreement must be submitted for Physician Assistant, Nurse Practitioner and Nurse Midwife
- ☐ Copy of Hospital Privileges *(All hospital privileges)*
- ☐ Copy of State License(s) *(Not to expire within 90 days)*
- ☐ Copy of DEA Registration *(Not to expire within 90 days)*
- ☐ Copy of State Controlled Dangerous Substance Certificate
- ☐ Copy of Certificate of Professional Liability Policy *(Not to expire within 60 days)*
- ☐ Copy of Board Certification Certificate *(if applicable)*
- ☐ Copy of Certificate or Letter Certifying Formal Post-Graduate Training
- ☐ Copy of Curriculum Vita/Resume
  Chronological order with month/year
  *(**Not accepted as a substitute for completion of application.**)*
- ☐ Copy of ECFMG Certificate *(if applicable)*
- ☐ Copy of Certificates for Conducting X-ray and/or Laboratory Services *(if applicable)*
- ☐ W-9
- ☐ Ownership and Disclosure Form *(For each individual provider)*
- ☐ Page 6 of 12 on CAQH *(Input NPI, Medicare #, and Medicaid #)*

Mississippi Uniform Credentialing Application

Please check one:
☐ ❑ Original Application
☐ ❑ Reappointment

This application is submitted to: _____ , herein, this Managed Care Entity.[1]

SECTION A.

Practice, Educational, Licensure and Work History Information

I. INSTRUCTIONS

This form should be typed or legibly printed in black ink. If more space is needed than provided on original, attached additional sheets and reference the questions being answered. Please do not use abbreviations when completing the application. If an item in the application does not apply to you, write N/A in the box provided.

Current copies of the following documents must be submitted with this application.

- State Medical License(s)
- DEA Certificate
- Board Certification (if applicable)
- Face Sheet of Professional Liability Policy or Certification
- Curriculum Vitae
- ECFMG (if applicable)

II. IDENTIFYING INFORMATION

Last Name:	First:	Middle:
Is there any other name under which you have been known (AKA/Maiden Name)? Name(s):		
Home Mailing Address:	City: State: ZIP:	
Home Telephone Number: Home Fax Number:	E-Mail Address: Pager Number:	
Birthday Date: Birth Place (City/State/Country):	Citizenship (If not a United States citizen, please include a copy of Alien Registration Card).	
Social Security #:	Gender[2]: ☐ Male ☐ Female	
Specialty:	Race/Ethnicity[2] (voluntary):	
Subspecialties:		

III. PRACTICE INFORMATION

Practice Name (if applicable):	Department Name (if Hospital Based):
Primary Office Street Address:	Primary Office Mailing Address if different from Street Address:
City: State: County: Zip:	City: State: County: Zip:
Telephone Number:	FAX Number:
Office Manager/Administrator:	Telephone Number: Fax Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

[1] As used in the information Release/Acknowledgements Section of this application, the term "this Managed Care Entity" shall refer to the entity to which the application is submitted as identified above.

Secondary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number:	
	FAX Number:	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	FAX Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Handicap Access: ☐ Yes ☐ No	24 Hour Coverage: ☐ Yes ☐ No	
Will you accept new patients? ☐ Yes ☐ No	Back office Telephone Number: ( )	

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

Name of Network	**Address**	**Reason for Denial or Deselection**

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc? ☐ Yes ☐ No

If Yes, please list:

Medical Group(s) / IPA(s) Affiliation:

Do you intend to serve as a primary care provider? ☐ Yes ☐ No Do you intend to serve as a specialist? ☐ Yes ☐ No If Yes, please list specialty(s):	Please check all that apply: ☐Solo Practice ☐Single Specialty ☐Group Practice ☐Multi Specialty

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

Name:	Type of Provider:	License Number:

Do you personally employ any physicians? (Do Not include physicians that are employed by the medical group) ☐ Yes ☐No

Name:	Mississippi Medical License Number:

2 This information will be used for consumer information purposes only.

Please list any clinical services you perform that are not typically associated with your specialty:
Please list any clinical services you **do not** perform that are typically associated with your specialty:
Is your practice limited to certain ages? If Yes, specify limitations: ☐ Yes ☐ No

Do you participate in EDI (electronic date interchange)? ☐Yes ☐No If so, which Network**?**	Do you use a practice management system/software: ☐ Yes ☐ No If so, which one?
What type of anesthesia do you provide in your group/office? ☐ Local ☐ Regional ☐Conscious Sedation ☐ General ☐None ☐ Other (please specify):	
Has your office received any of the following accreditation's, certifications, or licensures? ☐American Association for Accreditation of Ambulatory Surgery Facilities (AAASF) ☐ Medicare Certification ☐Mississippi Department of Health Licensure ☐Other:	

IV. BILLING INFORMATION

Billing Company:	
Street Address:	City:
	State**:** ZIP:
Contact:	Telephone Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:

V. OFFICE HOURS – Please indicate the hours your office is open:

Monday 24 HOUR COVERAGE	Tuesday 24 HOUR COVERAGE	Wednesday 24 HOUR COVERAGE	Thursday 24 HOUR COVERAGE	Friday 24 HOUR COVERAGE	Saturday 24 HOUR COVERAGE	Sunday 24 HOUR COVERAGE	Holiday 24 HOUR COVERAGE

VI. COVERAGE OF PRACTICE (List your answering service and covering physicians by name. Attach additional sheets if necessary. Refernce this section number and title)

Answering Service Company:	Telephone Number: ( )	Fax Number: ( )

Mailing Address:	City:	
	State:	ZIP:
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
Covering Physician's Name:	Telephone Number: ( )	
If you do not have hospital privileges, please provide written plan for continuity of care:		

VII. FOREIGN LANGUAGES SPOKEN

Fluently by Physician:	Fluently by Staff:

VIII. LABORATORY SERVICES

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 if you have one**.**

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

IX. MEDICAL/PROFESSIONAL EDUCATION (Attach additional sheets if necessary. Reference this section number and title.)

Medical School**:**	Degree Received:	Date of Graduation (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Medical/Professional School:	Degree Received:	Date of Graduation (mm/yy)
Mailing Address:	City:	
	State & Country	ZIP:

X. INTERNSHIP/PGYI (Attach additional sheets if necessary, Reference this section number and title.)

Institution**:**	Program Director:
Mailing Address:	City:
	State & Country: ZIP**:**
Type of Internship:	

Specialty:	From: (mm/yy)	To: (mm/yy)

XI. RESIDENCES/FELLOWSHIPS (Attach additional sheets if necessary. Reference this section number and title.)

Include residencies, fellowships, preceptorships, teaching appointments (indicate whether clinical or academic). And postgraduate education in chronological order, giving name, address, city, state, country, zip code and dates. Include all programs you attended, whether or not completed.

Institution**:**	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:

Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ☐Yes ☐ No (If "No", please explain on separate sheet.)

Institution:	Program Director:	
Mailing Address:	City:	
	State & Country:	ZIP:

Type of Training (e.g. residency, etc)	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program? ☐Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐ No (If "No", please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training (e.g. residency, etc):	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? ☐Yes ☐ No (If "No", please explain on separate sheet.)			

XII. BOARD CERTIFICATION (Attach copies of documents.)

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 an Accreditation Council for Graduate Medical Education of American Osteopathic Association approved post graduate training that provides complete training in that specialty or subspecialty.

Name of Issuing Board:	**Specialty:**	**Certification Number**:	**Date Certified/ Rectified:**	**Expiration Date (if any):**

Have you applied for board certification other than those indicated above? ☐Yes ☐ No

If so, list board(s) and date(s):

If not certified, describe your intent for certification, if any, and date of admissibility for certification on separate sheet.

Have you taken or failed a board exam? If Yes, Provide details on a separate sheet. ☐Yes ☐ No

XIII. OTHER CERTIFICATIONS (e.g. Fluoroscopy, Radiography, etc.) (Attach additional sheets if necessary. Reference this section number and title.)

Type:	Number:	Expiration Date:
Type:	Number:	Expiration Date:

XIV. MEDICAL LICENSURE/REGISTRATIONS (Attach copies of documents)

Mississippi State Medical License Number:	Issue Date:	Expiration Date:	Active: ☐Yes ☐ No
Drug Enforcement Agency (DEA) Registration Number: Unlimited? ☐Yes ☐ No. If "No", please explain on separate sheet		Expiration Date:	
Controlled Dangerous Substances Certificate (CDS) (if applicable):		Expiration Date:	

ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Visa Number:	Date Issued:	Valid Through:

Medicare UPIN/National Physician Identifier (NPI):	Mississippi Medicare Number:	Mississippi Medicaid Number:

XV. ALL OTHER STATE MEDICAL LICENSES – List all medical licenses now or previously held. (Attach additional sheets if necessary. Reference this section number and title.)

State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No
State:	License Number:	Expiration Date:	Active: ☐ Yes ☐ No

XVI. PROFESSSIONAL ORGANIZATIONS

Please list county, state or national medical societies, or other professional organizations or societies of which you are a member or applicant.

ORGANIZATION NAME	Applicant	Member
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Are you an Officer or Director of any of the professional organizations listed above? If yes, please list: ☐ Yes ☐ No

XVII. PROFESSSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet)

Current Insurance Carrier:	Policy Number:	Original effective date:
Mailing Address:	City:	
	State & Country:	ZIP:
Telephone Number: ( )	Fax Number: ( )	
Per Claim Amount: $	Aggregate Amount: $	Expiration Date**:**

Please explain any surcharges to your professional liability coverage on a separate sheet. Reference this section number and title.

If you have had professional liability carriers in the last five years other than the one listed above, please list them below.

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country::	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State and Country:	ZIP:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

XVII. PROFESSSIONAL LIABILITY (Attach copy of professional liability policy or certification face sheet)

Please list is (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS **(Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc.):	Appointment Date:	
Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
Department/Status (Active, provisional, courtesy, etc)	Appointment Date:	
If you do not have hospital privileges, please explain.		

B. PREVIOUS AFFILIATIONS **(Limit to last ten years. Attach additional sheets if necessary. Reference this Section number and title.)**

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	
Name and Mailing Address of other Hospital/institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

Name and Mailing Address of Other Hospital/Institution:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:	

XIX. PEER REFERNCES

List three professional references, preferably from your specialty area. Do not list 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. Do not include program directors previously listed under post graduate training and education in Section X. NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	Zip:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	Zip:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must be complete. A curriculum vitae is sufficient provided it is current and contains all information requested below. Please explain any gaps in professional work history on a separate page.

Current Practice:	Contact Name:	Telephone Number:	
		Fax Number:	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		
Name of Practice/Employer:	Contact Name:	Telephone Number:	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Name of Practice/Employer:	Contact Name:	Telephone Number: ( )	
		Fax Number: ( )	
Mailing Address:		City:	
		State:	ZIP:
From: (mm/yy)	To: (mm/yy)		

Section B.

Professional Liability Action Explanation

Please complete this section for each pending, settled, or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past five (5) 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 Section B prior to completing, and complete a separate form for each lawsuit.

I. CASE INFORMATION

City, County, and State where lawsuit filed:		Court Case number, if known:	
Date of alleged incident serving as basis for the lawsuit/arbitration:	Date Suit Filed:	Sex of patient:	Age of patient:

Location of Incident: ☐ Hospital ☐My office ☐Other doctor's office ☐Surgery Center ☐Other, (please specify)

Your relationship to Patient (Attending Physician, Surgeon, Assistant, Consulting, etc.):

Allegation:

Is/was there any 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 claim identification number of insurance company 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 to serve as your authorization:

Name: Phone Number:

Name: Phone Number:

II. WHAT IS THE STATUS OF THE LAWSUIT/ARBITRATION DESCRIBED ABOVE? (CIRCLE 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, 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 sheet(s). Include: (1) condition and diagnosis at time of incident. (2) dates and description of treatment rendered, and (3) condition of patient subsequent to treatment. **Please print.**

SUMMARY

SECTION C.
Certification

I certify that the information in Section A and B of this application and any attached documents (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 intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity 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 Mississippi Participating Physician Application. In order for participating Managed Care Entities or 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 Managed Care Entity information 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 attorneys listed in Section B, Page 12, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here:

Physician Signature: Date:

(Stamped Signature Is not Acceptable)

SECTION D.
Attestation Questions

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any 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 public 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 programs), medical society, professional association, medical school faculty position 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), medical society, professional association, medical school faculty position 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. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending? ☐Yes ☐No

7. Have you been denied certification/recertification by a specialty board, or has your admissibility, certification or recertification status changed (other than changing from admissible to certified)? ☐Yes ☐No

8. Have you ever been convicted of any crime (other than a minor traffic violation)? ☐Yes ☐No

9. Are you currently engaged in the illegal use of drugs? ("Illegal use of drugs" means the use of controlled substances, obtained illegally, as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" does not mean on the day of or even the weeks preceding the completion of this application, rather, it means recently enough so that the illegal use may have an impact on one's ability to practice.) ☐Yes ☐ No

10. Have any judgments or claims been entered against you, or settlements been agreed to by you within the last five (5) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitration's against you pending? ☐Yes ☐ No

11. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank? ☐Yes ☐ No

12. 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

13. Are you capable of performing all the services required by your agreement with, or the professional staff bylaws of the Managed Care Entity to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients, yourself, or others? (**A "YES" ANSWER TO THIS QUESTION DOES NOT REQUIRE AN EXPLANATION.)**

☐Yes ☐No

14. Have you ever been reprimanded, censured, excluded, suspended, or disqualified by CLIA, or any other health plan for which you provided services? ☐Yes ☐ No

I hereby affirm that the information submitted in this Section D Attestation Questions, and any addenda thereto is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is Not Acceptable)

Section E. Information
Release/Acknowledgements

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

I am informed and acknowledge that federal and state (3) laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications for participation in this Managed Care Entity 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 Managed Care Entity as may be required by state and federal law and regulation.

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 by any change in the information provided.

In addition to any notice required by any contract with a Managed Care Entity or Healthcare Organization. I agree to notify this Managed Care Entity immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine; (ii) any suspensions, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellations or Nonrenewal of my professional liability insurance coverage.

I further agree to notify this Managed Care Entity in writing, promptly and NO later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Mississippi Board of Medical Licensure taken or pending, including by not limited to, any accusations filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action by me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of 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 Managed Care Entity or 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 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 understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy of facsimile of this document shall be as effective as the original, however, original signatures and current dates are required on pages 13, 14, and 15 of this application.

Print Name Here: _____

Physician Signature: _____ Date _____
(Stamped Signature Is Not Acceptable)

Individual Managed Care Entities may request additional information or attach supplements to this form. Such additions or supplements are not part of the Mississippi Participating Physician Application and have not been endorsed by the organizations below. Questions about supplements shall be addressed to the Managed Care Entity requesting them.

This Application is endorsed by:
· Mississippi Association of Health Plans
· Mississippi State Medical Association
· Mississippi Hospital Association

[3] The intent of this release is to apply at a minimum, protections comparable to those in Mississippi to any action, regardless of where such action is brought.

MAGNOLIA HEALTH PLAN
Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the form by fax to 866-480-3227 or by mail to:

Magnolia Health Plan
Attn: Network Development and Contracting
1020 Highland Colony Parkway, Suite 502
Ridgeland, MS 39157