RELYMD MEDICAL GROUP CREDENTIALING APPLICATION

Please print clearly or type.

Personal / Practice Information	
Name:	U S. Citizen: ☐Yes ☐No
Social Security Number:	Place of Birth:
Specialty:	MD ☐ DO ☐
Home Street Address:	Home phone:
Home City, State, Zip:	Cell phone:
Email:	Cell Provider (required for consult alerts)
Languages (other than English) in which you are fluent and would like conduct consults in that language:	
Medicare Number:	NPI Number:

Are you registered as a provider with Medicaid? ☐Yes ☐No
If yes, please provide a list of all Medicaid registration numbers and corresponding state(s) of registration.

Medicaid #: _____ **State of Registration:** _____
Medicaid #: _____ **State of Registration:** _____
Medicaid #: _____ **State of Registration:** _____
Medicaid #: _____ **State of Registration:** _____
Attach a separate sheet, if necessary.

Are you a provider for any Health Plans? ☐Yes ☐No

If yes, please list:
☐UHC/OPT ☐Aetna ☐BCBS ☐Cigna ☐Amerigroup ☐Humana ☐MultiPlan ☐Other:_____

Education and Training (Please provide a copy of diploma / certificate of completion)	
College or University:	Address:
Degree:	Major:
Dates of Attendance: From: To:	Program successfully completed? ☐Yes ☐No
Post-Graduate Education (Institution):	Address:
Degree:	Major:
Attendance Dates: From: To:	Program successfully completed? ☐Yes ☐No
Post-Graduate Education (Institution):	Address:
Degree:	Major:
Dates of Attendance: From: To:	Program successfully completed? ☐Yes ☐No
Post-Graduate Education (Institution):	Address:
Degree:	Major:
Dates of Attendance: From: To:	Program successfully completed? ☐Yes ☐No

Professional License/Certification (Please provide copies of current Medical/Professional license certificates)		
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:
State of Licensure:		Date of issue:
Number:	Type:	Date of expiration:

Professional License/Certification continued			
DEA Certificate (if applicable)	Schedules	Issue Date	Expiration
DPS Certificate (if applicable)	Schedules	Issue Date	Expiration
ACLS Certification: (attach copy of verification)	Expiration Date:		
ATLS Certification: (attach copy of verification)	Expiration Date:		
PALS Certification: (attach copy of verification)	Expiration Date:		
BCLS Certification: (attach copy of verification)	Expiration Date:		
ABMS Board Certification: (**RelyMD Medical Group REQUIRES either ABMS or AOA Board Certification**	Expiration Date:		
Have you ever failed a professional certification exam? ☐ Yes ☐ No *If you answered yes, please attach a detailed narrative.*			
Military Service			
Are you currently on Active or Reserve Military Duty? ☐ Yes ☐ No			
Professional Reference Information: PLEASE WRITE LEGIBLY and Please Provide Reference email address or fax when possible Please list the name, address, phone, and fax numbers of two (2) professional references **(must be MD or DO)** of the same discipline as yourself who can attest to your current clinical competency, ethical character, and health status.			
Peer Reference:	Relationship: Years Associated:		
Address:	Phone:	**Fax**:	
Email:			
Peer Reference:	Relationship: Years Associated:		
Address:	Phone:	**Fax**:	
Email:			

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Work History (Please provide at least 5 Years of work history and please write legibly) *You must address all work history since completing your training, including Military History. Attach a separate page if necessary. NOTE: All gaps of greater than one hundred and eighty (180) days MUST have a written explanation.*		
Current Employer:	Job Title:	
Address:	Phone:	Fax:
Dates of Affiliation: (mm/yyyy) From: To:	Supervisor:	
Employer:	Job Title:	
Address:	Phone:	Fax:
Dates of Affiliation: (mm/yyyy) From: To:	Supervisor:	
Employer:	Job Title:	
Address:	Phone:	Fax:
Dates of Affiliation: (mm/yyyy) From: To:	Supervisor:	
Employer:	Job Title:	
Address:	Phone:	Fax:
Dates of Affiliation: (mm/yyyy) From: To:	Supervisor:	
Employer:	Job Title:	
Address:	Phone:	Fax:
Dates of Affiliation: (mm/yyyy) From: To:	Supervisor:	
Employer:	Job Title:	
Address:	Phone:	Fax:
Dates of Affiliation: (mm/yyyy) From: To:	Supervisor:	

Professional Information *Please answer each of the following questions either "Yes" or "No" – DO NOT LEAVE ANY QUESTIONS UNANSWERED. Provide documentation/additional information for each "Yes" answer (i.e. elaboration and details of all malpractice claims history, elaboration and details of any sanction activity, details and circumstances of denials, etc).*	
	Answer
Licensure 1. Has your license, registration or certification to practice in this state or any other state or region been denied, restricted, limited, suspended or revoked? Have you been reprimanded by any state licensing agency; or, are any of these actions pending with respect to your license?	
2. Have you ever received a reprimand or been fined by any state licensing board?	
Hospital Privileges and Other Affiliations 3. Have your clinical privileges or hospital staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by hospital or healthcare institution, medical staff or committee, or governing board?	
4. Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?	
5. Have you ever been required to obtain additional education or training as a result of peer review or quality assurance activities?	
6. Have your privileges or membership with any Professional Provider Organization, insurance company, Health Maintenance Organization or any other third party payer, network, or delivery system been denied, restricted, limited, suspended, or revoked?	
7. Have any complaints been filed against you in a Medical or other Professional Society?	
Education, Training and Certification 8. Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during a clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	
9. Has your certification(s) or eligibility ever been revoked?	
10. Have you ever practiced in a different geographic area other than the one in which you are now practicing?	
DEA or DPS 11. Has your Federal DEA and/or CDS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?	
Medicare, Medicaid or other Governmental Program Participation 12. Has your participation in Medicare, Medicaid, TriCare, Railroad Medicare or any other government program been denied, suspended or revoked; or have you been, or are you currently under investigation by these or any other regulatory agency?	
Other Sanctions or Investigations or Criminal 13. Are you currently, or have you ever been, the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?	

Physician Signature Date

Professional Information continued	
	Answer
14. Have you ever been convicted of to, pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional.	
15. Have you ever been convicted of, pled nolo contendere to any felony including an act of violence, child abuse or sexual offence?	
16. Have you been court-martialed for actions related to your duties as a medical professional?	
17. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	
18. Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?	
Malpractice Claims History and Professional Liability 19. Are you now, or have you EVER been involved in any malpractice action(s) including litigation, arbitration, or mediation, regardless of the method or amount of the outcome resulted; or, have you received any notice of claim or complaint against you?	
20. Have any professional liability claim settlements, not involving litigation or arbitration, been paid by you or on your behalf?	
21. Do you currently have medical malpractice insurance? Carrier Name: _____ Amounts:_____ Effective Date:_____ Expiration Date:_____	
22. Have you been denied malpractice coverage or has your coverage ever been limited, reduced or cancelled?	
23. Have you ever been the subject of any administrative, civil or criminal investigation involving sexual misconduct or child abuse?	
24. Have you been court-martialed for actions related to your duties as a medical professional?	
Ability to Perform Job 25. Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	
26. Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?	
27. Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you?	
28. Are you currently under the care of a physician or psychologist, or have you participated in any recovery program established pursuant to a state statue?	
29. Are you currently using illegal drugs or illegally abusing legal drugs (a controlled substance as defined in Schedules I through V of Section 202 of the controlled Substances Act, 21 U.S.C. 812.22?	
30. Are you currently taking any medications that may affect either your clinical judgment or motor skills?	
31. Which of the following best describes your current health status: (If you status is fair or poor, please provide a written explanation on a separate sheet or below.)	☐Good ☐Fair ☐Poor

_____

Physician Signature Date

Explanation for questions with derogatory “yes” answers:

Physician Signature Date

RelyMD Medical Group Authorization, Attestation and Release Form

By completing an Application to qualify to provide Medical Services through the RelyMD Network, I:

- Signify my willingness for interviews concerning this application;
- Fully understand and agree that I have the burden of producing adequate information for the proper evaluation of my professional current competence, character, ethics and other qualifications and for resolving any doubts about such qualifications. I hereby reaffirm that I will abide by the Credentialing Policies and Procedures/Rules and Regulations;
- Consent to the inspection and copying of all records and documents that may be relevant to my pending credentialing/employment review and decision;
- Release RelyMD Medical Group, its officers, directors, employees, representatives, agents, and the Credentialing staff from any liability for acts performed in connection with the processing and evaluation of this application and from any and all consequences resulting from the disclosure of the information;
- Unless otherwise prohibited by state or federal law, release the Credentialing staff and RelyMD Medical Group employees or representatives and authorize them/consent to provide other hospitals, licensing boards, and organizations concerned with my performance and the quality of patient care, relevant information that RelyMD Medical Group may have concerning my performance or quality of patient care;
- Consent to the confirmation of current physical and mental health status to perform the duties necessary in the manner as required by RelyMD Medical Group and as stated in the Credentialing Plan/Policies and Procedures. (A copy of these documents is available for review upon written request made to the Credentialing office of RelyMD Medical Group.)
- I authorize any third party including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care services, medical credentialing and accreditation agencies, professional medical societies, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to RelyMD Medical Group and/or its Agent(s), information including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualification for participation in, or with, RelyMD Medical Group. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release;
- I release from all liability and hold harmless any entity, its agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of RelyMD Medical Group, its agent(s), or other third parties in connection with the gathering, release and exchange of, and/or reliance upon, information used in accordance with this Authorization, Attestation and Release, I further agree not to sue any entity, any agent(s) or any other third-party for any claims based on

statements not to sue any Entity, any Agent(s) or any other Third-Party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by laws for peer review and credentialing activities;

- In this Authorization, Attestation and Release, all references to RelyMD Medical Group, its Agent(s), and/or other Third-Party include their respective employees, directors, officers, advisors, counsel, and agents. RelyMD Medical Group, any of its affiliates, agents or managed service organizations retain the right to allow access to the information contained herein for purposes of a credentialing audit conducted by any Third-Party to the extent required for any commercially-reasonable purposes as long as the auditing agency executes an appropriate confidentiality agreement.

- I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant to become an Approved Participant, a member of RelyMD Medical Group's healthcare staff, or a Provider of the RelyMD Network. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination of my relationship with RelyMD Medical Group. I agree that information obtained in accordance with the provisions of the Authorization, Attestation and Release is not and will not be a violation of my privacy.

- I certify that all information provided by me in my Application is true, correct, and complete to the best of my knowledge and belief, and that I will notify RelyMD Medical Group and/or its Agent(s) within thirty (30) days of any material changes to the information I have provided in my Application or authorized to the release pursuant to the credentialing process. I understand that corrections to this Application are permitted at any time prior to a determination by RelyMD Medical Group of my approval to be considered qualified as an Approved Participant and/or Provider for the RelyMD Network, must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in my Application may constitute grounds for withdrawal of my Application from consideration; denial or revocation of my qualification and/or approval to participate on the RelyMD Network; and/or immediate suspension or termination.

- I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

I acknowledge and attest that the information contained in this application, and all enclosed attached documents I agree to provide to support this application, are complete and accurate. I agree to notify RelyMD Medical Group of any change in the information contained in this application and any attached documents within thirty (30) days of the date that I am, or should be, made aware of the change.

_____ _____

Physician Signature Date

_____

Printed name of Applicant