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Aetna Better Health® of Kansas

sunflower health plan

UnitedHealthcare
Community Plan

Section 12 Attestation / Consent and Release Form

I hereby give permission to Plan/Network, directly and/or through its designee to request information regarding my professional credentials and qualifications from educational facilities, the hospital(s) in which I currently have or formerly privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Plan/Network and its designee, and their respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering or good faith use of the information gathered during the credentialing process.

I hereby authorize the education facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Plan/Network, directly and/or through its designee, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. If applicable, I hereby authorize the Physician Recovery Network or applicable recovery program to release to Plan/Network information regarding my health status and participation status in any treatment program(s). I hereby further release and agree to hold harmless all such entities referenced in the previous sentence, their representatives, employees, and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that the photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection of this application by Plan/Network and may result in denial of my application or termination of my participation in Plan/Network. I further understand that any representation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform Plan/Network in writing within 15 days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, I consent to the inspection of my patient records for Plan Members as necessary for peer review and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by the Plan/Network to evaluate my credentialing application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Plan/Network to allow a provider to review references or recommendations or other information that is peer-review protected.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Plan/Network may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank and /or the Health Care Integrity and Protection Data Bank.

I represent the information provided in or attached to this application is accurate and complete. I attest to either having adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements. I certify that I hold a full, unrestricted license to practice in the state in which I reside or I have indicated on this application the limitations and/or restrictions imposed. I agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to the Plan/Network through its designee. I attest that I will continue to maintain active admitting and staff privileges at a Plan/Network participating hospital or I have otherwise indicated on this application.

This health care organization, and its designee, does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability.

Your signature is required to complete this application. Stamped signatures are not acceptable.

Provider Name (Printed)	Provider Name (Signature)	Date (MMDDYYYY)