WPPA, INC.
PROVIDRS CARE

I. CREDENTIALING PLAN

A. INTRODUCTION

WPPA, Inc. dba ProviDRs Care (Network) is a for-profit organization established to contract with various providers and facilities for the members of our contracting Groups. Network is responsible for recruiting, contracting and the credentialing of physician members, and is committed to continuously improving the quality of patient care and serving the community in an efficient and cost-effective manner.

In order to assure that high quality and cost effective providers are in Network, and to ensure that health care facilities meet industry standards, expert credentialing and recredentialing processes are necessary and will include recredentialing at least every three years for professional providers. This document outlines the authorized documented policy that specifies the standards and practices of Network.

B. GOVERNANCE STRUCTURE

The Network Board of Directors (Network Board) has ultimate authority on matters of credentialing policy. The Board has charged the Membership and Peer Review Committee (Membership Committee) with the development of policies and procedures that are consistent with Board policy, that are sensitive to consumer needs and that maintain strict confidentiality. These policies and procedures will be used by the Membership and Peer Review Committee in making credentialing decisions regarding providers for Network's provider panel.

C. PURPOSE OF THE CREDENTIALING PLAN

The purpose of this Credentialing Plan is to assure a systematic approach to the non-discriminatory selection, evaluation, monitoring, disciplining and separation of members of the Network.

Together the screening and credentialing activities will allow the Network to:

Screen applicants to determine if the applicant meets the pre-application requirements, if the applicant is needed for the network, and if the provider should be invited to apply to the Network for membership.

Invite applicants to apply as panel participants if screening criteria are met.

Obtain and maintain provider professional information (all information received or discovered during credentialing or recredentialing will be maintained with strict confidentiality at all times).

Approve qualified physicians including MD's, DO's, DPM's, DDS's. Approve qualified allied health professionals to be listed in the directory.

To ensure providers are provided the opportunity to review and correct information used in the credentialing process.

Enable due process of those providers who do not meet criteria. Establish membership disciplinary procedures. Assist in the continuous quality improvement of the provider Network.

The following practitioners are not subject to credentialing requirements when practicing solely as the following:

- Emergency Room providers
- Radiologists (excluding Oncology and Interventional Radiologists)
- Anesthesia Providers (excluding Pain Management)
- Pathologists
- Hospitalists
- Locum Tenens

D. CONFIDENTIALITY, DISCRIMINATION, AND CONFLICT OF INTEREST

The Network requires that all members of the Membership and Peer Review Committee maintain the strictest of confidence regarding information presented and discussed during the credentialing procedures. Credentialing decisions will be conducted in a non-discriminatory manner. Decisions will not be based on race, ethnic/national identity, gender, age, sexual orientation, patient type (e.g. Medicaid), type of practice, etc. Additionally, the Membership and Peer Review Committee on an annual basis will monitor and avoid any discrimination or conflict of interest issues. If Committee Chair observes behavior that may potentially be considered discriminatory or a conflict of interest, they will discuss this with the Committee Member and determine resolution, which may include a report submitted to the Network Board.

The Membership and Peer Review Committee members will be required to sign a Confidentiality/ Discrimination Conflict of Interest Agreement annually. (see Attachment V.)

All credentialing information will be kept stored in the Managed Care Department in a locked and secure environment.

E. MEMBERSHIP AND PEER REVIEW COMMITTEE

The Network Board of Directors has delegated the credentialing and peer review function to the Membership and Peer Review Committee. The purpose, committee membership, and committee rules which address the credentialing function are as follows:

PURPOSE

The purposes of the Membership and Peer Review Committee are to:

1. Conduct peer review of providers applying or reapplying for membership in the Network, using information that is no more than one hundred eighty (180) days old.
2. Recommend to the Board acceptance or rejection of provider applications based on minimum professional standards and peer review.
3. Provide reconsideration and/or appeal opportunity for invited providers who have been denied participation or continuation in the Network.
4. Recommend to the Board actions/discipline for continuation in Network for providers who:
    a. breach contract provisions;
    b. exhibit inappropriate utilization;
    c. demonstrate quality of care inconsistent with community standards; or
    d. have excessive complaints and grievances; or
    e. have more than two (2) sanctions in a given year.
5. Advise the Board of Directors on credentialing policy issues; and
6. Review annually and recommend needed revisions of the Credentialing Plan to the Network Board of Directors.

COMMITTEE MEMBERSHIP

Membership and Peer Review Committee members shall be comprised of at least six (6) voting members (composed of physicians representing multiple specialties) appointed by the Network Board President, and up to two (2) representatives of the Network Managed Care Department.

COMMITTEE RULES

The Network Membership and Peer Review Committee conducts meetings using the following rules of order in performing the credentialing function. The Committee will be chaired by a physician who is responsible for carrying out the duties of the Membership Committee and will act as a liaison for Board of Directors. In addition, such physician will lead the implementation of the credentialing program according to the Credentialing Plan and its associated policies and procedures:

1. Not more than four (4) physician members from the Board of Directors.
2. Remainder, Non-Board member physicians.
3. Peer Review is conducted by physicians.
4. The Committee will meet at least monthly for a total of no less than twelve (12) meetings per year. Meetings may be scheduled more frequently, if necessary.
5. Procedures are voted on by the Committee.
6. Policy changes in the Credentialing Plan must be approved by the Network Board.
7. A simple majority of voting committee members present (at least three) is required for approval of participation status, policy and procedure changes.
8. Confidential minutes are taken.
9. Every applicant is reviewed by the Membership and Peer Review Committee, using information that is no more than one hundred eighty (180) days old.
10. All Committee members must execute confidentiality/conflict of interest agreements (see V. Attachment A).
11. Committee may vote by unanimous consent in writing or by phone.
12. Members receive indemnification by Network.
13. Additional rules to be developed as needed.

F. PRACTITIONER RIGHTS

The practitioner has the right to review information submitted to support their credentialing application. The practitioner will be notified in writing within thirty (30) days of any information obtained during the credentialing process that varies substantially from information provided to the organization by the practitioner. The practitioner will then have thirty (30) days to submit corrections or explanations of discrepancies to WPPA, Inc., dba ProviDRs Care via email, fax or mail prior to Membership Committee review of the file. The practitioner has the right to request status during the credentialing process and receive a written response within thirty (30) days. The applicant will be notified of these rights as described in the Application Cover Letter (see Section IV – Letter B). Each practitioner shall be entitled, upon request, to information obtained by WPPA, ProviDRs Care to evaluate the practitioner's credentialing application from outside sources such as state licensing boards and malpractice carriers. WPPA, ProviDRs Care may at its discretion, provide redacted copies or summaries of information if required to protect an individual's confidentiality. If a practitioner believes, upon review of the information, that any information contained therein is misleading and/or erroneous, the practitioner may submit a corrective statement, which WPPA, ProviDRs Care shall place in the practitioner's credentialing file. The foregoing does not require WPPA, ProviDRs Care to alter or delete any information contained in the practitioner's credentialing file, nor does it require WPPA, ProviDRs Care to disclose to a practitioner references, decisions, or other peer review protected information.

G. PEER REVIEW AND USE OF CRITERIA

Peer Review is the review of an applicant's professional behavior, educational background and experience as a physician.

The use of explicit criteria during peer review is to avoid discrimination during the selection process, to approve physicians who have demonstrated their commitment to quality and who have the requisite background for Network's needs. Criteria are to be used in conjunction with the judgment and experience of the Membership Committee. The committee may waive any criteria when in the best interest of Network and patient care, except criteria regarding current licensure, DEA, liability limits and an attested application.

H. APPEALS BOARD/FAIR HEARING PROCEDURES

MEMBERSHIP of the Appeals Board

A panel of at least five (5) physicians (with no more than one on the Membership and Peer Review Committee), one of whom is designated as chairman, is appointed by the Network Board of Directors. The purpose, membership rules and appeal procedures are as follows:

PURPOSE

The purposes of the Appeals Board/ Fair Hearing Process are to:

1. Provide a fair hearing for providers with the purpose of addressing adverse decisions regarding disciplinary action and/or termination resulting from a credentialing or recredentialing review.
2. Review all information submitted by the Membership Committee, Board of Directors and the Appellant.
3. Render a decision which is supported by all rules and regulations regarding educational background and training, experience, professional behavior and appropriate utilization of resources in providing high quality patient care.

APPEALS BOARD RULES

The Network Appeals Board follows the following rules of order:

1. The Appeals Board has ultimate authority to hear and respond to appeals.
2. Any physician in direct competition with an applicant may render clinical opinion, but shall be excused from the meeting for voting.
3. The Board will notify the physician of the Appeals Board review process.
4. Within two weeks after receiving an appeal, the Appeals Board will schedule a hearing at a time and place mutually agreed on by both parties.
5. The right to a hearing is forfeited if the provider fails, without good cause, to appear for the Appeals Board hearing.
6. The physician may be represented by an attorney or other person of the physician's choice.
7. The physician is entitled to the following rights:
    a. To have a record made of the proceedings;
    b. To call, examine and cross-examine witnesses;
    c. To present evidence determined to be relevant by the Appeals Board, regardless of its admissibility in a court of law;
    d. To submit a written statement at the close of the hearing;
    e. To receive the written recommendation of the Appeals Board, including a statement of the basis for the recommendations; and

f. To receive a written decision from Network, including a statement of the basis for the decision.

8. The Appeals Board will submit a written response to the appeal within 60 days after receiving the appeal, specifying the findings and the decision.

II. CREDENTIALING – RECREDENTIALING CRITERIA

A. PHYSICIAN PRE-APPLICATION SCREENING CRITERIA

License	MD, D.O., D.P.M., D.D.S. with current, unrestricted license to practice medicine in state in which the network is established.
Hospital Privileges	Has or is applying for privileges at a Network Hospital or meets acceptable exception criteria (rural area, non-hospital based specialty, etc.).
Malpractice	Current professional liability coverage with no history of denial or cancellation.
Recommendations	From one peer, non-economic relationship.
Network Panel Status	Meets specific Network panel membership need as documented in the current board resolution on panel status.

B. GENERAL PRACTITIONER SELECTION CRITERIA

Application and Attestation	Application with attestation as to completeness and correctness. Incomplete applications will be returned. Complete applications will include name; degree; date of birth; specialty; board certifications; address and phone; TIN; work history for the past five years; license state, number and expiration date; answers to all professional questions and health status questions; education institution, degree and graduation date; training institution(s), specialty(s), and dates; certificate of insurance with a current expiration date; hospital privileges; DEA for state(s) in which the applicant is currently practicing, Bureau of Narcotics and Dangerous Drugs (BNDD) number and expiration date; original application signature and original release signature no more than 180 days prior to receipt of application.
State License	Verified, current and unrestricted license in the states in which network is established. Providers with a Federal Active License will be reviewed by the Membership Committee for consideration to participate or continue participation in the network.
Education	1. MDs and DOs: Graduation from medical school. Successful completion of a residency except: a. General Practitioners who graduated from medical school prior to 1985 or b. The lack of a panel physician would create a public health hardship in a specific community. 2. DDSs: Graduation from dental school and completion of specialty training as applicable. 3. DPMs: Graduation from podiatry school and completion of a residency, as applicable.

DEA	Verified, Current Federal Drug Enforcement Administration Certificate (DEA #) for state(s) in which the applicant is currently practicing or a valid explanation of the lack thereof for practitioners practicing in a non-prescribing specialty (e.g. optometry, pathology, radiology).
State BNDD	Verified, Current state BNDD if applicable
Current Liability Coverage	Maintain at least the minimal amount of professional liability insurance as required by the state law with no history of denial or cancellation.
Malpractice History	1. No pattern of suits over a five-year period of time based on incident date, or 2. No more than two lawsuits filed with incident dates during one calendar year, or 3. No more than two payments or settlements of $30,000 or more per suit with incident dates in one calendar year, or 4. No cases resulting in permanent disability or death, in which payment of over $30,000 was made, or 5. No pending cases, which in the view of the Committee, could result in failure to meet malpractice history criteria.
Privileges	1. Current unrestricted admitting privileges consistent with the licensure in a Network hospital, or 2. Physician is in a specialty which does not traditionally admit patients and has courtesy or consulting privileges at a network hospital, e.g., Anesthesiology, Dermatology, Pathology, DPM or Radiology. 3. Physician is in a specialty or subspecialty frequently used as a consultant, and has consulting privileges at a Network hospital, e.g. Psychiatrist or 4. Physician has a transfer agreement with a physician/hospitalist or direct referral with admitting privileges at a Network hospital, or 5. The lack of a panel physician would create a public health hardship in a specific community.
Impairment	Absence of any condition that impairs judgment or performance of essential functions of practice with or without accommodation (including mental, substance abuse, or other health problems) currently or over the past 5 years.
Suspension or Probation	Absence of or valid justification of: 1. Probation or suspension from professional medical societies, or 2. Loss or limitations of hospital privileges, or 3. History of loss of license, or 4. Medicare or Medicaid Sanctions.
Work History	Included with the application, five (5) consecutive years history or length of practice if less than 5 years, with no gaps of six (6) months or more, or, in the case of a gap, an explanation via email, fax or mail from the provider regarding that time period.
Criminal Indictment	No felony conviction or indictment including a plea of no lo contendre.
NPDB	Satisfactory report.

C. ADDITIONAL CRITERIA FOR NON PHYSICIAN BEHAVIORAL HEALTH PROVIDERS

State License or Certification	Verified and current license as a psychologist, social worker, professional counselor, or clinical nurse specialist/psychiatric and mental health nurse practitioner in the state in which network is established or certified as a substance abuse counselor in the state in which the network is established or possessing a master's degree in the health sciences field along with three (3) years experience in providing substance abuse services. Each provider licensure must meet the requirements of the state regulatory board.
Education	Provider must have degree in appropriate fields from an accredited university program recognized by the appropriate certifying body: 1. Licensed Clinical Social Worker (LSCSW) –Masters or doctoral degree in social work with emphasis in clinical social work. 2. Licensed Professional Counselor (LPC) – Masters or doctoral degree in counseling or education with counseling field of study (doctoral in Divinity does not meet criteria). 3. Licensed Clinical Professional Counselor (LCPC) - Masters degree in counseling or meet same qualifications. 4. Licensed Clinical Psychotherapist (LCP) – Masters degree in psychology. Licensed as an LMLP, or meet same qualifications. 5. Licensed Psychologist (LP) - Doctorate degree in field of psychology 2 years of supervised work experience. 6. Licensed Master Level Psychologist (LMLP) - Master degree in field of psychology. 7. Licensed Marriage & Family Therapist (LCFMT) – Masters or doctoral degree in Marriage and Family Therapy or related field of study 8. Licensed Marriage Family Therapist (LMFT) - Masters or Doctorate degree in Marriage and Family Therapy OR a related field which contained coursework considered to be equivalent to the Marriage and Family therapy program 9. Clinical Nurse Specialist/Psychiatric and Mental Health Nurse Practitioner – Masters degree in nursing with specialization in psychiatric and mental health nursing and certified by American Nurses Association (ANA) in psychiatric nursing. 10. Clinical Psychologist – Doctoral degree 11. Licensed Addiction Counselor (LAC) - Baccalaureate degree in addiction counseling or a related field. 12. Licensed Clinical Addiction Counselor (LCAC) - Masters degree in addiction counseling or a masters degree in a related field. 13. Behavior Analyst (BA) - Bachelor's or graduate degree and completed course work for licensure as a behavior analyst.

Experience	Provider must comply with state guidelines regarding clinical experience in each counseling specialty. The experience must be completed in an appropriate mental health or chemical dependency treatment facility.
Practice Patterns	Emphasis on the following: 1. Outpatient therapy. 2. Short-Term problem focused therapy instead of long-term insight-oriented therapy. 3. Availability of 24-hour crisis intervention. 4. Willingness to participate in utilization management, quality assurance, credentialing and sanctioning processes.

D. CREDENTIALING CRITERIA FOR APRN (NP, CNM) AND PA

State License APRN	Valid and current RN license by the state in which the provider practices. Valid and current document of recognition (certification type) as required by the state in which the provider practices.
State License PA	Valid and current PA license by the state in which the provider practices.
DEA	Verified, Current Federal Drug Enforcement Administration Certificate (DEA #) for state(s) in which the applicant is currently practicing or a valid explanation of the lack thereof for practitioners practicing in a non-prescribing specialty (e.g. optometry, pathology, radiology).
Education and Certification	Graduation from a training program and appropriate post-graduate training program resulting in licensure and certification (current or expired): 1. NP – certification program accredited by The National Commission for Certifying Agencies (NCCA) such as ANCC, PNCB, AANP. 2. CNM – certification by the National Certification Corporation of OB/GYN and Neonatal Nursing, American College of Nurse Midwives, or American Midwifery Certification Board. 3. NP must be certified by National Psychiatric and Mental Health Nursing Practice if performing psychotherapy. 4. PA – certification by the National Commission of Certification of Physician's Assistants in the applicable specialty. 5. If the lack of a panel NP or PA would create a public health hardship in a specific community as determined by the Board, the Board may waive the certification requirement. 6. The ProviDRs Care Board of Directors waives the certification requirement for the NP or PA based on information provided by the applicant or knowledge of the applicant's medical skills. If either of these measures is unavailable, the Committee may request additional information from known and reputable resources.
Grandfather Clause	1. Current participating APRN providers that have chosen not to obtain certification will be considered for continuing participation if the provider graduated before 1976. In addition to standard recredentialing process,

	providers are required to submit two letters of reference from peer with non-economic relationship. All letters of reference will be reviewed to determine network eligibility. 2. Current participating P.A. providers will be considered for continuing participation. In addition to standard recredentialing process, providers are required to submit two letters of reference from peer with non-economic relationship. All letters of reference will be reviewed to determine network eligibility.
Privileges	May be required to have Allied privileges with a Network hospital.
Supervision Agreement	Must be supervised and employed by at least one (1) Network Physician who abides by the APRN Supervision Policy, works under a written Network approved protocol and is currently licensed as a physician in the states in which network is established and practices in a specialty appropriate to the NP or CMN. In accordance with KSBHA Statutes and Regulations Chapter 65 Article 28b (65-28b02), a certified nurse midwife may provide clinical services without the requirement of a Collaborative Practice Agreement with a person licensed to practice medicine and surgery when such clinical services are limited to those associated with a normal uncomplicated pregnancy and delivery, including: (1) the prescription of drugs and diagnostic tests; (2) the performance of episiotomy or repair of a minor vaginal laceration; (3) the initial care of the normal newborn; and (4) family planning services, including treatment or referral of male partners for sexually-transmitted infections.
Controlled Substance Form	Controlled substance form completed and signed by PA/APRN and supervising Network Physician, if applicable.

E. CREDENTIALING CRITERIA FOR AuD, SLP, RD AND RDNs

State License	Valid and current license by the state in which the provider practices. Valid and current document of recognition (certification type) as required by the state in which the provider practices.
Education and Certification	Graduation from a training program and appropriate post-graduate training program resulting in licensure and certification (current or expired): 1. AuD– Master's degree or equivalent from an educational institution with standards consistent with those of the state universities or accredited by ASHA. For providers who possess at least a doctorate degree or equivalent in audiology from an educational institution won or after January 1, 2012 and any individual who possesses at least a master's degree or equivalent in audiology prior to January 1, 2012, shall be deemed to have met the educational requirement.

	2. SLP- Master's degree or equivalent from an educational institution with standards consistent with those of accredited state universities or accredited by ASHA. 3. RD – Baccalaureate degree or equivalent from an educational institution with standards with those of accredited state universities or approved by the Academy of Nutrition and Dietetics. 4. RDN - Bachelor's degree with course work approved by the Academy of Nutrition and Dietetics' Accreditation Council for Education in Nutrition and Dietetics

III. FACILITY REQUIRED CREDENTIALING CRITERIA

ProviDRs Care requires hospitals, home health agencies, skilled nursing facilities, DME suppliers, long term care facilities, ambulatory surgical centers, behavioral health care facilities providing mental health or substance abuse services in an inpatient, residential, ambulatory facility based outpatient and laboratories to be qualified, competent and meet the standards for performance and delivery of high quality clinical care and service.

All facilities requesting participation with ProviDRs Care must complete the credentialing process and be approved for participation before entering into a contractual agreement.

ProviDRs Care confirms network facilities are in good standing with state and federal regulatory and/or accrediting bodies at least every three years thereafter (excluding DME suppliers and laboratories).

ProviDRs Care facility credentialing guidelines are based on the standards set by the National Committee for Quality Assurance (NCQA).

Facility applicants must provide the following in order to be considered for network participation:

1. Active, unencumbered state license to operate if applicable
2. A CMS or state review less than three years old at the time of application. The report from the institution must show evidence of substantial compliance or an acceptable corrective action plan with current state regulatory requirements or;
3. Accreditation by one of the following accrediting bodies:

Facility Type	Acceptable Accrediting Bodies
Hospitals, Behavioral Health Facilities	JCAHO, AOA, AAAHC, CMS or State Agency review or certification
Skilled Nursing Facility, Nursing Home	CARF, CHAPS, JCAHO, CMS or State Agency review of certification
Home Health Care Agencies	CHAPS, JCAHO, ACHC, CMS or State Agency review or certification
Ambulatory Surgery Centers	AAAASF, AOA, AAAHC, JCAHO, CMS or State Agency review or certification
Laboratories	CLIA and State Agency review or certification

Maintain at least the minimal amount of professional liability insurance as required by the state law with no history of denial or cancellation.

Organizations Not Accredited or Certified: If the Organization is not accredited or certified by an agency listed above, a site visit of the organization by the credentialing staff is required before making a recommendation for participation to the Board of Directors. A Site visit will include assessment of environment, policies, medical records, safety issues and access. Credentialing staff will present results and recommendations to the Board of Directors for decision and action.

Verification of Credentials Process: ProviDRs Care completes primary verification of credentials using recognized sources in the following areas:

1. Current state license in the state where the facility provides care to WPPA, ProviDRs Care members via the state's department of health and human services website or a current copy of the facility license as displayed to the public included in the application.

2. Copy of professional liability insurance coverage current at the time of committee decision, with minimal amount of professional liability insurance as required by the state law with no history of denial or cancellation, or, evidence of federal or state tort immunity included in the application.
3. Verification Review of sanctions or exclusions from Medicare/Medicaid, or other Federal Healthcare Programs via query of The Office of the Inspector General (OIG) and NPDB online.
4. Copy of accreditation by an approved Accredited bodies included in the application.

IV. POLICIES AND PROCEDURES

A. PROFESSIONAL PROVIDER CREDENTIALING PROCEDURE

Once a provider has completed the application, credentialing is begun. The following outline represents the credentialing procedure. (Primary Source Verification (PSV) is performed by Network or its designee.)

Responsibility	**Action**
Network Staff	Sends physician/provider an application including a Consent/Release Authorization form as well as a cover letter.
Provider	Returns completed application, signed attestation or release and requested additional documentation to Network. Attestation includes providers' response to all professional questions, health status questions and any limitation of privileges or disciplinary action.
PSV	Receives the completed application from the Provider/Network, checks the package for completeness, including documentation and additional explanations as requested on the application and signed attestation. Obtains any missing information and/or clarification of discrepancies or returns the application to the provider for completion. Performs Primary Source Verification (PSV) or Network may perform PSV services.
PSV	Inquires with the following for primary source verification of information provided by the applicant: 1. State Board of Medical Examiners in state(s) in which the applicant is currently practicing. 2. National Technical Information Services tapes or Verify a copy of the DEA or controlled dangerous substance certification is valid and current in state(s) in which the applicant is currently practicing. Registration Certificate provided by the applicant for verification. Acceptable verification sources: - DEA or CDS agency - DEA or CDA certificate - Documented visual inspection of the original DEA or CDS certificate - Confirmation from NTIS database - Confirmation from the AMA physician Masterfile (DEA only) - Confirmation from the state pharmaceutical licensing agency (where applicable) 3. For providers outside of Kansas; a copy of the state's BNDD Certificate for verification. 4. Educational institution for Residency or highest level of education or training, or in the case of a foreign graduate who has not completed a U.S. residency program, ECFMG.

	5. AMA Profile or by phone/fax/internet to the specialty board, American Osteopathic Association Directory or by phone/fax/internet to the specialty board, American Board of Oral and Maxillofacial Surgery or by phone/fax/internet, American Board of Podiatric Medicine or by phone/fax/internet, American Board of Foot and Ankle Surgery or by phone/fax/internet. ABMS verification of Board Certification in the practicing specialty precludes the necessity of verifying education. 6. Hospital designated on application at which applicant is privileged. 7. Work history within medical specialty for past five years, not verified, documented in writing as provided by the applicant. 8. National Practitioner Data Bank report for verification of five years malpractice and disciplinary Medicare/Medicaid sanction history or exclusion. 9. Kansas Board of Healing Arts or appropriate state licensing board and the NPDB for verification of license sanctions.
PSV	Performs secondary source verification of information provided and attested by the applicant: 1. Copy of the Certificate of Insurance provided by the applicant for verification of required professional liability coverage. 2. Certification, as applicable. 3. Reasons for any inability to perform the essential functions of the position, with or without accommodation. 4. Lack of present illegal drug use. 5. History of loss of license and felony convictions. 6. Correctness and completeness of the application.
PSV	Makes 3 primary source attempts over a 60-day period. If no response is received, the Network Staff is advised.
PSV	Advises Network of failure to obtain required verifications and/or send profile to Network, within 90 days.
Network Staff	Determines whether enough information exists to present the file to the Membership Committee.
PSV	Prepares a file summary for all providers for whom complete documentation and verification exist for the Membership Committee. Verification information presented must be no more than 180 days old at the time of review.
PSV	Maintains the original file consisting of the application, file summary and all supporting documentation, including primary source verifications.
Network Staff	Will notify the practitioner in writing of any information received as result of the credentialing process which varies substantially from the process which was provided by the practitioner. The practitioner will then be given two weeks in which to correct erroneous information before the file is reviewed by the Membership Committee.
Membership Committee	Reviews file and makes a recommendation of the provider's status to the Board of Directors.

Network Board	Approves or denies participation.
Network Staff	Notifies provider within 60 days of the Membership Committee determination and documents basis for failure to meet criteria, if any.
Provider	May request a reconsideration or appeal from the Membership Committee within 30 days of negative decision.
Membership Committee	May reverse denial decision based on additional information or may uphold the denial decision.
Network Staff	Notifies provider of Membership Committee's decision.
Network Staff	Notifies payors, employers and TPAs by providing needed information from provider profile in provider database.
Provider	If denial decision is upheld, the applicant's next step is to appeal to the Appeals Board (see Section IV. J).

B. CREDENTIALING STATUS DEFINITIONS

During the peer review process, the Membership Committee may elect to use one of four credentialing status definitions. The four status definitions are:

1. **Routine/Standard-Active Status** - successful achievement by provider of criteria established by the Network Board of Directors necessary to remain a full Active member of Network for three (3) years or for a shorter designated time.
2. **Deferred/Tabled Status** - action on the application of the provider for membership in Network is deferred for additional information and the application is considered at a later date. Network will seek additional information to be reviewed by the Membership Committee.
3. **Termination Status** - provider has failed to meet criteria required for continued membership in Network.
4. **Provisional Credentialing Status** – provider who has not achieved or satisfied all the criteria established by Network Board of Directors necessary to become an Active member of the network, but has successfully completed a preliminary review by the CVO and network staff, can be admitted/retained to the network for a temporary period of sixty (60) days or less, provider may also be limited to current medical group practice.
5. **Watch Status** – successful achievement by provider of criteria established by the Network Board of Directors necessary to remain a full Active member of Network for one (1) year or for a shorter designated time.

C. RE-CREDENTIALING PROCEDURE FOR PROFESSIONAL PROVIDER

Once a provider has become a member of the Network, he or she is re-credentialed at least every three (3) years or earlier as determined by the Membership Committee during initial credentialing. Providers with watch status are recredentialed annually or sooner depending on the decision of Membership Committee. The following outline represents the recredentialing procedure.

Responsibility	**Action**

Network Staff	Produces a list of providers due for recredentialing.
PSV	Produces a recredentialing profile (application), attestation or a release and mails, faxes or emails to provider for update.
Provider	Returns updated recredentialing profile, signed attestation or release to PSV for update to provider file. Attestation includes providers' response to all professional questions, health status questions and any limitation of privileges or disciplinary action.
PSV	Inquires with the following for primary source verification of information provided by the applicant: 1. State Board of Medical Examiners in state(s) in which the applicant is currently practicing. 2. National Technical Information Services tapes or Verify a copy of the DEA or controlled dangerous substance certification is valid and current in state(s) in which the applicant is currently practicing. Registration Certificate provided by the applicant for verification. Acceptable verification sources: - DEA or CDS agency - DEA or CDA certificate - Documented visual inspection of the original DEA or CDS certificate - Confirmation from NTIS database - Confirmation from the AMA physician Masterfile (DEA only) - Confirmation from the state pharmaceutical licensing agency (where applicable) 3. For providers outside of Kansas; a copy of the state's BNDD Certificate for verification. 4. Educational institution for Residency or highest level of education or training, or in the case of a foreign graduate who has not completed a U.S. residency program, ECFMG. 5. AMA Profile or by phone/fax/internet to the specialty board, American Osteopathic Association Directory or by phone/fax/internet to the specialty board, American Board of Oral and Maxillofacial Surgery or by phone/fax/internet, American Board of Podiatric Medicine or by phone/fax/internet, American Board of Foot and Ankle Surgery or by phone/fax/internet. ABMS verification of Board Certification in the practicing specialty precludes the necessity of verifying education. 6. Hospital designated on application at which applicant is privileged. 7. Work history within medical specialty for past five years, not verified, documented in writing as provided by the applicant. 8. National Practitioner Data Bank report for verification of five years malpractice and disciplinary Medicare/Medicaid sanction history or exclusion. 9. Kansas Board of Healing Arts or appropriate state licensing board and the NPDB for verification of license sanctions.
PSV	Performs secondary source verification of information provided and attested by the applicant:

	1. Copy of the Certificate of Insurance provided by the applicant for verification of required professional liability coverage. 2. Reasons for any inability to perform the essential functions of the position, with or without accommodation. 3. Lack of present illegal drug use. 4. History of loss of license and felony convictions. 5. Correctness and completeness of the application.
Network Staff	Determines whether enough information exists to present the file to the Membership Committee.
PSV	Prepares a file summary for all providers for whom complete documentation and verification exist. Information included in the file may be no more than 180 days old at the time of review.
Membership Committee	Reviews file and makes a recommendation of the provider's status to the Board of Directors.
Network Board	Approves or denies participation.
Provider	May request a reconsideration or appeal from the Membership Committee within 30 days of negative decision.
Membership Committee	May reverse denial decision based on additional information or may uphold the denial decision.
Network Staff	Notifies provider of Membership Committee's decision.
Provider	If denial decision is upheld, the applicant's next step is to appeal to the Appeals Board (see Section IV. J).

D. ONGOING MONITORING OF SANCTIONS, COMPLAINTS, AND ADVERSE EVENTS

POLICY

Ongoing Monitoring of Sanctions, Complaint, and Adverse Events will be performed on participating providers, and, when appropriate, action on important safety, care or service issues will be taken according to the Disciplinary Procedures outlined in Section I. Reports from the following sources shall be reviewed for the presence of any providers participating in the Network within thirty (30) calendar days of its release:

1. Medicare and Medicaid sanction reports
2. Licensing boards
3. Complaints
4. Adverse Events

PROCEDURE

Responsibility	**Action**
Network Staff	Review State Board Actions/Medicare/Medicaid sanction reports every month.

Network Staff	Maintain and review physician service complaints or reports of adverse events on a monthly basis.
Network Staff	Present to the Membership Committee for review any sanction or license action taken within (30) days of receipt.
Network Staff	Investigate all service complaints or adverse events and present to the Membership Committee any significant findings regarding quality of care within (30) days of receipt.
Membership Committee	Review sanction or complaint and make recommendations to the Network Board.
Network Board	Review Membership Committee recommendation within (30) days and determine proper action as defined in Section IV, I, Disciplinary Procedures.
Network Staff	Document all Committee or Board reviewed information and action in provider's credentials file.

E. MALPRACTICE HISTORY DEVELOPMENT

POLICY

Network will review the past five years of malpractice history provided by the applicant and obtained through the National Practitioner Data Bank to assist in the decision to grant or continue participation status to providers. Refer to Network Credentialing Criteria for details regarding satisfactory malpractice history.

PROCEDURE

If additional information is needed for malpractice cases that are "pending" the Network Staff or Membership Chairman will contact physician or office for additional information.

F. IMPAIRED PROVIDERS (due to chemical dependency)

POLICY

Network shall not grant participation status or will revoke existing status if there is evidence of impaired judgment or performance due to chemical dependency.

Applicants with a history of chemical dependency within the past five (5) years must meet the advocacy requirements of the appropriate medical association.

PROCEDURE

When chemical dependency problems are noted on the application or should a member of the Membership Committee suspect a history of chemical dependency, each case will be investigated by Network Staff prior to presenting the application to the Membership Committee.

Responsibility	**Action**

Network Staff	Case is discovered.
Network Staff	Case is referred to Membership Chairman
Network Staff	Letters are sent to: 1. Applicant to determine the nature of the condition and/or the treating facility/providers. 2. Treating facility or provider to determine if the program was completed and to determine the after care arrangements. 3. Appropriate medical association to determine if the applicant has been in the program and if there was successful completion.

G. IMPAIRED PROVIDERS (due to physical and manual health)

POLICY

Applicants with documented impairment over the age of 70 will submit an annual written report from their physician confirming their mental and physical health.

Network shall not grant participation status or will revoke existing status if there is evidence of impaired judgment or performance due to a physical or psychiatric health condition.

PROCEDURE

When physical or psychiatric health problems are noted on the application or should a member of the Membership Committee suspect a history of physical or psychiatric health problems, each case will be investigated by the Network Staff prior to presenting the application to the Network Membership Committee.

Responsibility	**Action**
Network Staff	Case is discovered.
Network Staff	Case is referred to the Medical Director
Medical Director	Letters are sent to: 1. Applicant to determine the nature of the condition and the identification of necessary on-going treatment for the condition. 2. Treating facility/provider to determine if applicant can safely perform duties without impairment of judgment or performance.

H. PROVIDER PRACTICING WITHOUT BOARD CERTIFICATION

POLICY

Network providers are to meet the Board Certification requirements in Section II-B. Exceptions to this policy are identified for two categories of providers:

1. Board Certified providers, who are practicing in a subspecialty without subspecialty Board Certification. (Ex. Oncologist practicing pediatric oncology.)

Procedure: Under the direction of the Chairman of the Membership and Peer Review Committee, the Network Staff will send current hospital letter requesting privileging information regarding the applicant.

If the privileging is granted by the hospitals, the applicant will be recommended for participation status.

If the privileging is not granted by the hospitals, the applicant will not be granted participation status for the subspecialty.

2. Board Certified providers, whose practice is in a different primary specialty without Board Certification. (Surgeon practicing Emergency Medicine).

Procedure: Applicant must meet requirements stated in Section II-B.

I. DISCIPLINARY PROCEDURES

Providers who provide medically unnecessary care, who are not accountable for pre-certification review, who engage in inappropriate utilization of health care resources, are in breach of contract provisions, or who demonstrate poor judgment, quality of care, unprofessional conduct, questionable competence or other inappropriate actions as determined by the Board of Directors, may lose their participation status with the Network.

The following Table illustrates the categories and the disciplinary process applied to each level of infraction:

DISCIPLINARY PROCEDURES				
Category	1st	2nd	3rd	4th
Failure to participate with UR	Warning by phone	Warning by phone	Warning in writing	QAC review
Unnecessary Care	Warning by phone	Warning by phone	Warning in writing	QAC review
Cont. Breach	Warning by phone	Warning by phone	QAC review	NA
Quality Breach	Warning in writing	Warning in writing	QAC review	NA

Infractions are noted in writing in the provider credentials record and are reviewed on a twelve-month basis. The Network presents the record of infractions to the Membership Committee as specified in the Table. If, in the opinion of the Membership Committee, a provider does not meet minimal criteria or accumulates excessive warnings, the Network's Board of Directors will notify the provider by registered mail of the decision to place on probation for a designated period of time, restrict privileges or terminate the Network participation contract. The right and procedures to appeal the decision are provided in the notification. Flagrant violations may be reviewed by the committee immediately and appropriate action taken.

The Appeal process for this action is the same as for denial or termination as a result of credentialing/recredentialing.

Any action to restrict, suspend or terminate a provider's clinical privileges or plan participation, which is based on professional competence or professional conduct, for more than 30 days will be reported to the state licensing board and/or National Practitioner's Data Bank.

Within 15 calendar days of the effective date of the final action, the Manager responsible for credentialing reports the action to the following authorities:

- All appropriate state licensing agencies
- National Practitioner Data Bank (NPDB)

A letter is then written to the appropriate state licensing boards describing the adverse action taken, the practitioner it was taken against and a copy of the NPDB report is attached to the letter. This letter is sent certified to the appropriate state licensing boards within 24-hours of receiving the final NPDB report. A copy of this letter is filed into the Practitioner's credentials file.

Actions that are not reportable to the NPDB or licensing board are those that, in general, do not reduce, restrict, suspend, revoke, deny, or fail to renew clinical privileges or membership. Furthermore, actions that are not based on a physician's professional competence or behavior do not have to be reported.

The following are not reportable to the state licensing board and/or NPDB:

1. Censures, reprimands, or admonishments that do not adversely affect a physician's clinical practice or privileges.
2. A requirement that a physician have consultations on certain cases, retrain, receive additional training or attend continuing education classes.
3. Any withdrawal of an application for appointment or participation before the board takes final action.
4. Administrative suspensions such as those given to physicians for failing to meet reporting and other administrative requirements.
5. A voluntary relinquishing of participation as long as the physician is not under investigation for professional competence or conduct (but not if participation is relinquished in return for canceling an investigation).
6. Leaves of absence to enter a drug, alcohol, or psychiatric rehabilitation.

J. APPEALS/DUE PROCESS

If an invited provider has been denied participation with Network, reconsideration and an appeal process are available to the provider. In the event an applicant pursues legal recourse, and the case is decided in favor of Network, the applicant is responsible for all attorney fees. The following outline represents these processes.

Responsibility	**Action**
Network Staff	Notifies provider in writing reasons of denied participation decision including a summary of the appeals process.
Network Staff	Action will be reported within 30 days of the Membership Committee to the NPDB and to the Kansas Board of Healing Arts or the appropriate licensing board.
Provider	May request reconsideration from the CC within 30 days. Provider must provide clarification of or additional, new information.

Membership Committee	May recommend a reversal of the non-participation decision based on additional information, or may uphold the non-participation decision.
Network Board	Approves or denies a reversal.
Network Staff	Notifies provider in writing of Membership Committee's decision to uphold or Board decision regarding reversal.
Provider	If non-participation decision is upheld, the applicant may appeal to the Board of Directors within 30 days of the denial.
Network Board	Notifies applicant of the Appeals Board review process.
Appeals Board	Conducts the Appeals Board hearing and makes a final determination.
Appeals Board	Notifies provider in writing of final status within 60 days.
Network Staff	Updates system and produces a revised delegated provider profile.

K. DELEGATED CREDENTIALING TO OTHER ENTITIES

The credentialing process may be delegated by contract to a contracted IPA or group medical practice. The Network Staff and/or Membership Committee will perform a pre-audit review of the external entity's provider application and credentialing plan to ensure compliance with NCQA standards and Network's application, criteria, policies and procedures. The pre-audit will include a review of credentialing and recredentialing files. If the delegate is NCQA Accredited, a file review is not required. The external entity's plan must conform to the Network credentialing plan and the credentialing criteria must meet or exceed the Network credentialing criteria in order to be approved by the Membership Committee. The entity's Credentials Committee must be constructed to meet state and federal requirements for Peer Review. The entity must agree to permit Network and NCQA access to credentialing files and Credentials Committee minutes, or a written summary of such minutes.

Network's Membership Committee will provide the criteria to the external entity and will assist the entity in developing a satisfactory credentialing plan.

Network's Membership Committee has the ultimate authority for credentialing providers. The Network retains the right to approve new providers and to terminate or suspend individual providers. The Membership Committee, at its discretion, will review any credentialed provider as well as all exceptions granted by the external entity. The entity must notify the Network within 5 working days of any changes in status of the providers, including but not limited to termination, resignation, changes in privileges, probation, or other disciplinary action.

The Network Membership Committee will review the entity's credentialing and reappointment or recertification processes at least annually. This will include a review of the credentialing plan, including criteria, using the 8/30 methodology.

Review of the provider files will include the following to determine file adequacy: Orderly, consistent format and organization

1. Completed, legible application
2. Signed attestation
3. 3.Copies of Primary Source verification of the following:
    a. board certification
    b. education, if not Board Certified
    c. appropriate license(s)
    d. malpractice claims history

e. copies of DEA certificate, BNDD certificate, privilege status at primary admitting facility, and malpractice coverage.

4. Copies of Provider Authorization/Release and Delegation Release.
5. Report of work history.
6. Documentation of adverse professional actions, e.g. Hospital suspensions or limitations, Medicare/ Medicaid suspension, DEA investigations/actions, state licensing investigations/ actions.
7. Documentation and appropriateness of disciplinary actions.
8. Documentation of Recredentialing conducted at least every three years with Primary Source verification as prescribed and QA/QI information provided by NETWORK Quality Management.
9. Evidence of Peer Review and due process.
10. Review of Credentialing Plan and Credentials Committee minutes.

If audit findings indicate discrepancies of credentialing criteria, the Membership Committee may rescind the delegation and conduct internal credentialing. The committee will routinely monitor and evaluate the delegated credentialing process.

If deficiencies are found during the audit, WPPA, ProviDRs Care may develop a corrective action plan for the delegated entity, to correct deficiencies in its credentialing process. WPPA, ProviDRs Care may conduct an independent investigation into the credentials and/or professional conduct of any applicant or participating provider. Delegated entity shall permit WPPA, ProviDRs Care timely and reasonable access to all credentialing documents and related files.

L. DELEGATED CREDENTIALING FOR OTHER ENTITIES

The credentialing process may be delegated to the Network by a Managed Care Organization or other entity. The Network Staff will review the external entity's provider application and credentialing requirements for variances with the Network's application, criteria, policies and procedures. If there are variances, the CC will determine whether the required changes are acceptable. If not acceptable, the CC or its representative will notify the entity representative and make an attempt to resolve the differences. The CC will present its recommendations to the Board.

If an agreement is signed with the entity, the Network will agree to allow the entity and NCQA access to credentialing files and credentials committee minutes (or a written summary of such minutes).

As part of the application process, the Network providers will sign a "Delegated Credentialing Release" which allows the plan to provide information obtained during credentialing which is required by the external entity.

This is in addition to the Network release the provider must sign.

The external entity must provide full disclosure of the basis for a decision not to credential a provider or to take disciplinary action, including termination. The entity must have an appeals process, which is offered to the provider.

V. SAMPLE LETTERS

A. APPLICATION NON-ACCEPTANCE LETTER

Dear Dr._____:

Thank you for your interest in the WPPA, INC. dba ProviDRs Care (Network). The Network Board of Directors met and your application was reviewed for possible exceptions to our closed panel status. They did not find that your situation satisfied our exception criteria and decline to process your application at this time

The health care needs of our communities and medical staffing are dynamic. Your interest in the Network has been noted and should the need arise for an addition in your specialty, we may contact you.

Sincerely,

WPPA, INC. dba ProviDRs Care

B. APPLICATION ACCEPTANCE LETTER, SEND APPLICATION

Dear Dr. _____:

WPPA, INC. dba ProviDRs Care (Network) Board of Directors met this week and agreed to extend you an application for Network membership.

Credentialing begins with the completion of the enclosed application, two authorization/release forms, and the attachment of the supporting documents identified on page one of the application. Additionally, we will need a copy of a current Certificate of Insurance (COI), your Kansas or Missouri License, DEA and BNDD. Please make sure the application is carefully and thoroughly completed using information pertinent to your practice.

The practitioner will then have thirty (30) days to submit corrections or explanations of discrepancies to WPPA, Inc., dba ProviDRs Care via email, fax or mail prior to Membership Committee review of the file. The practitioner has the right to request status during the credentialing process and receive a written response within thirty (30) days. The applicant will be notified of these rights as described in the Application Cover Letter. Each practitioner shall be entitled, upon request, to information obtained by WPPA, ProviDRs Care to evaluate the practitioner's credentialing application from outside sources such as state licensing boards and malpractice carriers. WPPA, ProviDRs Care may at its discretion, provide redacted copies or summaries of information if required to protect an individual's confidentiality. If a practitioner believes, upon review of the information, that any information contained therein is misleading and/or erroneous, the practitioner may submit a corrective statement, which WPPA, ProviDRs Care shall place in the practitioner's credentialing file. The foregoing does not require WPPA, ProviDRs Care to alter or delete any information contained in the practitioner's credentialing file, nor does it require WPPA, ProviDRs Care to disclose to a practitioner references, decisions, or other peer review protected information.

The enclosed packet will give you some information about the Network, our contracting Groups and panel size. Please call (316-683-4111) if you have any questions about the organization or the application process. We look forward to working with you!

Sincerely,

WPPA, INC. dba ProviDRs Care

To be included when appropriate
(One of the Network credentialing standards is Board Certification of its members. There are a few exceptions to this requirement, but it is the hope of the Network that you complete Board Certification as soon as possible within your specialty.)

C. APPROVED CREDENTIAL STATUS

Dear Dr.

We are pleased to inform you that the WPPA, INC. dba ProviDRs Care Membership and Peer Review Committee approved your application for Active Membership. Enclosed for your file and reference is a copy of the WPPA Physician Provider Agreement and your fully executed Declaration of Agreement.

Currently, over 62,000 persons are covered under health plans, which participate in ProviDRs Care Network. All eligible participants have either WPPA or ProviDRs Care Network on their ID cards. I have enclosed a list as to where the claims are to be filed for each contracting Group.

As a contracting provider, you are required to obtain precertification prior to an elective admission, to include obstetrical admissions. Urgent and emergency admissions require notification within 48 hours. You are urged to collect applicable copayments at the time of service (applicable copayment amounts are on the patient's ID card). Your office is required to file claims for WPPA, Inc. ProviDRs Care Network patients. Each ID card states where claims are to be filed.

Questions regarding the overall operation of WPPA, INC. dba ProviDRs Care Network should be addressed to Josette Donaldson at (316) 683-411 ext. 229. We appreciate your interest and participation in the Network and look forward to working with you.

Sincerely,

WPPA, INC. dba ProviDRs Care

To be included when appropriate
(One of the Network credentialing standards is Board Certification of its members. There are a few exceptions to this requirement, but it is the hope of the Network that you complete Board Certification as soon as possible within your specialty.)

D. DENIED CREDENTIAL STATUS

Dear Dr.

We regret to inform you that at this time the Membership Peer Review Committee did not approve your application for participation with the WPPA, Inc. dba ProviDRs Care (Network). Below is a summary of the reasons:

_____.

You may re-submit your application after one year or, if you wish to submit additional information at this time you must notify the Network in writing within thirty days of this letter. The Network will permit appeals from adverse credentialing decision only to the extent required by law, NCQA requirements or if applicable, the Physician Contract.

Sincerely,

WPPA, Inc. dba ProviDRs Care

E. RE-CREDENTIAL APPLICATION LETTER

REQUIRES IMMEDIATE RESPONSE

Dear Dr.

The WPPA ProviDRs Care Network Board of Directors, in keeping with the NCQA guidelines, has implemented a structured process for recredentialing physicians in the WPPA ProviDRs Care Network.

To simplify and coordinate this recredentialing effort, which will be carried out every three years, ProviDRs Care Network has entered into a relationship with Medical Provider Resources (MPR), for the recredentialing of physicians in the WPPA ProviDRs Care Network.

Your past participation is much appreciated and on behalf of the board we hope you will continue participating in this physician owned and managed organization.

The information from the enclosed recredentialing form will be used to update the information in your membership file. If you utilize CAQH, you may submit a paper copy along with the signed attestation. Any requests from Medical Provider Resources are legitimate and vital to quality initiatives. Please also inform your office credentialing coordinator/manager that MPR staff may be contacting your office directly in the event additional information is needed to complete your recredentialing. As a member of our provider network, your prompt response and cooperation with MPR (as our credentialing partner) is vital.

If you, or your office staff, have questions regarding the recredentialing process or completion of the enclosed forms, contact MPR's Customer Service Representatives at 316-683-0117. Questions regarding the program's operation should be directed to Josette Donaldson at 316-683-4111 ext. 229.

If you have questions about MPR, please refer to the Frequently Asked Questions at http://medicalproviderresources.com.

We greatly value our network providers. Thank you for your cooperation. Sincerely,

F. APPROVED RE-CREDENTIAL STATUS

Date

Dear Dr.

I am pleased to inform you that the Membership Peer Review Committee of WPPA, Inc. approved your recredentialing to maintain your active membership with WPPA, Inc. dba ProviDRs Care.

Should you have any questions, please feel free to call Provider Relations at (316) 683-4111. We thank you for your interest and continued participation in the Network.

Sincerely,

WPPA, Inc. dba ProviDRs Care

Attachment V.

A. CONFIDENTIALITY, DISCRIMINATION, CONFLICT OF INTEREST AGREEMENT

The undersigned understands and acknowledges that all information related to WPPA, Inc. dba ProviDRs Care (Network), and its operations is strictly confidential and that under no circumstances can there be any unauthorized disclosure of such information. Included as confidential, without limitation, are data including financial, quality and utilization or other information concerning patients, hospitals, physicians, other providers, insurance companies and third-party administrators. As one who will have access from time to time to confidential information, the undersigned agrees and declares, and hereby solemnly binds himself or herself, to Network, as follows:

1. The undersigned will hold in strictest confidence all information of every nature learned or obtained as a result of his or her affiliation with, or services for, Network, whether such is obtained in meetings, in telephone conferences, in other discussions, or in written form. No such information will be discussed outside the offices of Network or shared with any other parties not affiliated with Network, unless expressly authorized in writing.

2. If the undersigned is engaged, or is about to be engaged, in any proceeding or other matter of Network, in which he or she has, or may have, a conflict of interest (such as the person under consideration has a business arrangement with, or is related to, or otherwise is affiliated with the undersigned), the undersigned will disclose such immediately and will abstain from any discussion or voting on the matter being discussed or acted upon.

3. All credentialing decisions will be made in a nondiscriminatory manner.

It is understood that the Network will place its reliance upon the declarations and agreements wherein made by the undersigned.

This ____day of _____, 20____.

_____

Signature of Declarant

Revision History:

Revision	Date	Section	Description of Changes	Modified By
1	1/1/2018	Facility Required Credentialing Criteria	Facility liability insurance changed to require state minimums.	Justin Leitzen
		Credentialing Criteria for APRN (NP, CNM) and PA	CNM provision removing collaborative practice agreement requirements in accordance with state statute.	
		General Practitioner Selection Criteria	DEA verification for all states in which applicant is practicing	
		Disciplinary Procedures	Process outlining notification to authorities	
		General Practitioner Selection Criteria	Removed Board Certification requirements for physicians	