Louisiana

Recredentialing Checklist for Professional Providers

All required documents must be fully completed with a handwritten signature and date (as applicable). Requests that are incomplete or missing information will be returned and the processing time will start over once all required information is received.

Please return completed the Recredentialing Application and all required documents to Blue Cross by the date on your recredentialing notification letter. See Professional Providers Credentialing Criteria for more information.

- ☐ Complete the Recredentialing Application
- ☐ Enclose a copy of state license
- ☐ Enclose a copy of DEA registration and CDS license *(as applicable)*
- ☐ Enclose a copy of Malpractice Liability Certificate (*copy of policy declarations page*)
- ☐ Enclose this completed checklist

Submit all required documents using one of the options below:

mail: BCBSLA - Network Operations
P.O. Box 98029
Baton Rouge, LA 70898-9029

email: network.administration@bcbsla.com
fax: (225) 297-2750
Attention: Network Operations

If you have any questions about our credentialing requirements, please visit our Provider page at www.BCBSLA.com/providers >Provider Networks >Join Our Networks.

18NW2521 04/18

Louisiana

Recredentialing Application

GENERAL INFORMATION

LAST NAME	SUFFIX	FIRST	MIDDLE	GENDER ❑ MALE ❑ FEMALE

DEGREE: ❑ MD ❑ DO ❑ DPM ❑ DC ❑ DDS ❑ DMD ❑ OTHER _____

Any other name under which you have been known? (AKA) LIST	ECFMG NUMBER	UPIN NUMBER	
HOME STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	PAGER NUMBER/ANSWERING SERVICE	HOME EMAIL ADDRESS **(optional)**

SOCIAL SECURITY NUMBER	DATE OF BIRTH	BIRTH PLACE (CITY, STATE)	RACE/ETHNICITY **(voluntary)**

NPI - INDIVIDUAL	MEDICARE PROVIDER NUMBER	MEDICAID PROVIDER NUMBER

PRIMARY PRACTICE LOCATION

CLINIC NAME

ADDRESS	CITY	STATE	ZIP CODE

APPOINTMENT PHONE NUMBER	MAIN PHONE NUMBER (if different)	FAX NUMBER
OFFICE MANAGER	OFFICE WEBSITE	OFFICE EMAIL

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED ❑ HOSPITAL EMPLOYED ❑ HEALTHPLAN/PAYOR OWNED
If Hospital employed or Healthplan/Payor owned, please indicate owner name: _____

TAX IDENTIFICATION NUMBER	EFFECTIVE DATE OF PROVIDER AT THIS PRACTICE LOCATION
NPI - GROUP	Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)

BILLING ADDRESS (Address where you want payments sent)			CONTACT PERSON	TELEPHONE NUMBER
CITY	STATE	ZIP CODE	BILLING EMAIL	FAX NUMBER
CORRESPONDENCE ADDRESS (Address where you want communications sent)			CONTACT PERSON	TELEPHONE NUMBER
CITY	STATE	ZIP CODE	CORRESPONDENCE EMAIL	FAX NUMBER
MEDICAL RECORDS ADDRESS (Address where you want medical records requests sent)			CONTACT PERSON	TELEPHONE NUMBER
CITY	STATE	ZIP CODE	MEDICAL RECORDS EMAIL	FAX NUMBER

OFFICE HOURS	MON ____-____	TUES ____-____	WED ____-____	THUR ____-____	FRI ____-____	SAT ____-____	SUN ____-____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated:	❑ 0-6 years ❑ Over 65	❑ 7-11 years ❑ All Ages	❑ 12-18 years ❑ Other (Specify): _____	❑ 19-65 years
Are PAs and/or nurse/paraprofessional practitioners used?	❑ Yes ❑ No	Is this facility wheelchair/handicapped accessible?	❑ Yes ❑ No	
Emergency After Hours Number		Arrangements for 24 hour/7 day a week coverage (Specify)		
Group, Covering, or Collaborating Physicians:	_____ _____ _____			
CONTACT NAME		CONTACT PHONE NUMBER		
Does the office offer handicapped access for:	Building ❑ Yes ❑ No Restroom ❑ Yes ❑ No	Parking ❑ Yes ❑ No Other: _____		
Accessible by public transportation:	Bus ❑ Yes ❑ No Other: _____	Courier Service ❑ Yes ❑ No		
Offer services for the disabled:	Text Telephony (TTY) ❑ Yes ❑ No Mental/Physical Impairment Services ❑ Yes ❑ No	American Sign Language ❑ Yes ❑ No Other: _____		
Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑ Yes ❑ No				

SECOND PRACTICE LOCATION

CLINIC NAME			
ADDRESS	CITY	STATE	ZIP CODE
APPOINTMENT PHONE NUMBER	MAIN PHONE NUMBER (if different)	FAX NUMBER	
OFFICE MANAGER	OFFICE WEBSITE	OFFICE EMAIL	

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED
❑ HOSPITAL EMPLOYED ❑ HEALTHPLAN/PAYOR OWNED
If Hospital employed or Healthplan/Payor owned, please indicate owner name: _____

TAX IDENTIFICATION NUMBER	EFFECTIVE DATE OF PROVIDER AT THIS PRACTICE LOCATION
NPI – GROUP	Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)

BILLING ADDRESS (Address where you want payments sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE		BILLING EMAIL	FAX NUMBER
CORRESPONDENCE ADDRESS (Address where you want communications sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE		CORRESPONDENCE EMAIL	FAX NUMBER
MEDICAL RECORDS ADDRESS (Address where you want medical records requests sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE		MEDICAL RECORDS EMAIL	FAX NUMBER

OFFICE HOURS	MON _____-_____	TUES _____-_____	WED _____-_____	THUR _____-_____	FRI _____-_____	SAT _____-_____	SUN _____-_____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated:	❑ 0-6 years ❑ Over 65	❑ 7-11 years ❑ All Ages	❑ 12-18 years ❑ Other (Specify): _____	❑ 19-65 years

Are PAs and/or nurse/paraprofessional practitioners used? ❑ Yes ❑ No	Is this facility wheelchair/handicapped accessible? ❑ Yes ❑ No
Emergency After Hours Number	Arrangements for 24 hour/7 day a week coverage (Specify)

Group, Covering, or Collaborating Physicians: _____

_____

_____

CONTACT NAME	CONTACT PHONE NUMBER

Does the office offer handicapped access for: Building ❑ Yes ❑ No Parking ❑ Yes ❑ No Restroom ❑ Yes ❑ No Other: _____

Accessible by public transportation: Bus ❑ Yes ❑ No Courier Service ❑ Yes ❑ No Other: _____

Offer services for the disabled: Text Telephony (TTY) ❑ Yes ❑ No American Sign Language ❑ Yes ❑ No Mental/Physical Impairment Services ❑ Yes ❑ No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑ Yes ❑ No

THIRD PRACTICE LOCATION

CLINIC NAME			
ADDRESS	CITY	STATE	ZIP CODE
APPOINTMENT PHONE NUMBER	MAIN PHONE NUMBER (if different)	FAX NUMBER	
OFFICE MANAGER	OFFICE WEBSITE	OFFICE EMAIL	

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED ❑ HOSPITAL EMPLOYED ❑ HEALTHPLAN/PAYOR OWNED
If Hospital employed or Healthplan/Payor owned, please indicate owner name: _____

TAX IDENTIFICATION NUMBER	EFFECTIVE DATE OF PROVIDER AT THIS PRACTICE LOCATION
NPI - GROUP	Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)

BILLING ADDRESS (Address where you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	BILLING EMAIL	FAX NUMBER
CORRESPONDENCE ADDRESS (Address where you want communications sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	CORRESPONDENCE EMAIL	FAX NUMBER
MEDICAL RECORDS ADDRESS (Address where you want medical records requests sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	MEDICAL RECORDS EMAIL	FAX NUMBER

OFFICE HOURS	MON ____-____	TUES ____-____	WED ____-____	THUR ____-____	FRI ____-____	SAT ____-____	SUN ____-____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients? ❑ New ❑ Existing Only ❑ Only family members of existing patients ❑ Other (Specify) _____

Age group(s) treated:	❑ 0-6 years ❑ Over 65	❑ 7-11 years ❑ All Ages	❑ 12-18 years ❑ Other (Specify): _____	❑ 19-65 years

Are PAs and/or nurse/paraprofessional practitioners used? ❑ Yes ❑ No	Is this facility wheelchair/handicapped accessible? ❑ Yes ❑ No
Emergency After Hours Number	Arrangements for 24 hour/7 day a week coverage (Specify)

Group, Covering, or Collaborating Physicians: _____

_____

_____

CONTACT NAME	CONTACT PHONE NUMBER

Does the office offer handicapped access for: Building ❑ Yes ❑ No Parking ❑ Yes ❑ No Restroom ❑ Yes ❑ No Other: _____

Accessible by public transportation: Bus ❑ Yes ❑ No Courier Service ❑ Yes ❑ No Other: _____

Offer services for the disabled: Text Telephony (TTY) ❑ Yes ❑ No American Sign Language ❑ Yes ❑ No Mental/Physical Impairment Services ❑ Yes ❑ No Other: _____

Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑ Yes ❑ No

FOURTH PRACTICE LOCATION

(If you have more than four locations, attach additional sheets with the following information)

CLINIC NAME			
ADDRESS	CITY	STATE	ZIP CODE
APPOINTMENT PHONE NUMBER	MAIN PHONE NUMBER (if different)	FAX NUMBER	
OFFICE MANAGER	OFFICE WEBSITE	OFFICE EMAIL	

TYPE OF PRACTICE: ❑ SOLO ❑ MULTISPECIALTY GROUP ❑ SINGLE SPECIALTY GROUP ❑ HOSPITAL-BASED ❑ HOSPITAL EMPLOYED ❑ HEALTHPLAN/PAYOR OWNED
If Hospital employed or Healthplan/Payor owned, please indicate owner name: _____

TAX IDENTIFICATION NUMBER	EFFECTIVE DATE OF PROVIDER AT THIS PRACTICE LOCATION
NPI - GROUP	Name to which Employer Identification Number (EIN) is registered with the IRS (Important: must match IRS information exactly)

BILLING ADDRESS (Address where you want payments sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE		BILLING EMAIL	FAX NUMBER
CORRESPONDENCE ADDRESS (Address where you want communications sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE		CORRESPONDENCE EMAIL	FAX NUMBER
MEDICAL RECORDS ADDRESS (Address where you want medical records requests sent)		CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE		MEDICAL RECORDS EMAIL	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	____-____	____-____	____-____	____-____	____-____	____-____	____-____

Do you practice at this location: ❑ Full-time ❑ Part-time ❑ Other (Specify) _____

Languages spoken at this location: (other than English) _____ _____ ❑ Provider ❑ Other

Accepting Patients?	❑ New ❑ Existing Only	❑ Only family members of existing patients ❑ Other (Specify) _____
Age group(s) treated:	❑ 0-6 years ❑ Over 65	❑ 7-11 years ❑ All Ages ❑ 12-18 years ❑ Other (Specify): _____ ❑ 19-65 years
Are PAs and/or nurse/paraprofessional practitioners used?	❑ Yes ❑ No	Is this facility wheelchair/handicapped accessible? ❑ Yes ❑ No
Emergency After Hours Number		Arrangements for 24 hour/7 day a week coverage (Specify)
Group, Covering, or Collaborating Physicians:	_____ _____ _____	
CONTACT NAME		CONTACT PHONE NUMBER
Does the office offer handicapped access for:	Building ❑ Yes ❑ No Restroom ❑ Yes ❑ No	Parking ❑ Yes ❑ No Other: _____
Accessible by public transportation:	Bus ❑ Yes ❑ No Other: _____	Courier Service ❑ Yes ❑ No
Offer services for the disabled:	Text Telephony (TTY) ❑ Yes ❑ No Mental/Physical Impairment Services ❑ Yes ❑ No	American Sign Language ❑ Yes ❑ No Other: _____
Does the office meet the Americans with Disabilities Act (ADA) accessibility requirements? ❑ Yes ❑ No		

SPECIALTY

TYPE OF PROVIDER:	❑ PRIMARY CARE PHYSICIAN ❑ BOTH	❑ PHYSICIAN SPECIALIST ❑ OTHER SPECIALTY: _____

PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)	**BOARD CERTIFIED (ABMS)**
SPECIALTY:	❑ Yes ❑ No
SUB-SPECIALTY:	❑ Yes ❑ No
SUB-SPECIALTY:	❑ Yes ❑ No

BOARD CERTIFICATION

(as recognized by American Board of Medical Specialties or other national certification body)
Please attach a copy of current certification(s)

PRIMARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
SECONDARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
THIRD SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE

DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by health care organization.**

Primary Location	**Second Location**	**Third Location**	**Fourth Location**
❑ Specialty ❑ Directory	❑ Specialty ❑ Directory	❑ Specialty ❑ Directory	❑ Specialty ❑ Directory
❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory
❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory	❑ Sub-specialty ❑ Directory

PHO / IPA AFFILIATIONS*

List any other PHO's, IPA's, which you participate in and dates of participation:

**The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in **chronological order** from oldest to most current all hospitals at which you currently have privileges:

HOSPITAL	LOCATION/ADDRESS	TYPE OF PRIVILEGES	EFFECTIVE DATE MO/YR

If you do not have admitting privileges, who admits for you and to what hospital? Please list provider's name, specialty and hospital.

EDUCATION

If additional training to what is requested below has been completed, please attach on a separate form.

MEDICAL/PROFESSIONAL SCHOOL:		
CITY	STATE	ZIP
DEGREE	YEAR OF GRADUATION	DATES ATTENDED (MO/YR)
INTERNSHIP: INSTITUTION NAME	TYPE OF TRAINING	
CITY	STATE	
UNIVERSITY AFFILIATION	COMPLETED ❑ Yes ❑ No	DATES ATTENDED (MO/YR)
RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	❑ Clinical ❑ Research
CITY	STATE	DATES ATTENDED (MO/YR)
UNIVERSITY AFFILIATION	COMPLETED ❑ Yes ❑ No	

RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	❑ Clinical ❑ Research
CITY	STATE	DATES ATTENDED (MO/YR)
UNIVERSITY AFFILIATION	COMPLETED ❑ Yes ❑ No	
FELLOWSHIP: INSTITUTION NAME	TYPE OF FELLOWSHIP	❑ Clinical ❑ Research
CITY	STATE	DATES ATTENDED (MO/YR)
SPECIALTY FIELD	COMPLETED ❑ Yes ❑ No	
FELLOWSHIP: INSTITUTION NAME	TYPE OF FELLOWSHIP	❑ Clinical ❑ Research
CITY	STATE	DATES ATTENDED (MO/YR)
SUBSPECIALTY FIELDS	COMPLETED ❑ Yes ❑ No	

WORK HISTORY

Using the following codes, please list in **chronological order** from oldest to most current your work history from the time you completed your medical training to the present. **It is very important that you use the month and year for each entity listed. Work history is critical. Failure to provide this information may delay your credentialing.**

CODE:

C = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments) **H** = Civilian Hospital Medical Staff Appointment
M = Military Service (Including Hospital Staff Appointments) **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE (From MO/YR to MO/YR)

In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history. **Failure to provide this information may delay your credentialing**.

PROFESSIONAL LICENSES

PROFESSIONAL LICENSES	LICENSE NUMBER	DATE OBTAINED	EXPIRATION DATE
STATE LICENSE			
FEDERAL DEA REG NUMBER			
STATE CDS LICENSE NUMBER			
CLIA CERTIFICATE			

Are laboratory testing procedures (as covered by the Clinical Improvement Act – CLIA) currently being performed at your office site where members are seen? ❑ Yes ❑ No **If yes, a current copy of your CLIA Registration must accompany this application**.

FOR DENTISTS ONLY – Do you perform any procedures in the office setting utilizing conscious sedation or any anesthesia (other than oral analgesic?) ❑ Yes ❑ No **If yes, a copy of your Anesthesia Permit must accompany this application.**

Have you been or are you **currently** licensed in any other state? If YES, please complete the following**:**

LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE
LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE
LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE

(Please attach a copy of all licenses listed above and additional ones in other states not listed.)

REFERENCES

List, as professional references, three or more peers (physicians of the same or similar specialty) who are familiar with your work effort and skills during the past two years. *References should not be relatives or current partners.*

NAME	SPECIALTY	PHONE NUMBER	
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
NAME	**SPECIALTY**	**PHONE NUMBER**	
STREET ADDRESS	**CITY**	**STATE**	**ZIP**
NAME	**SPECIALTY**	**PHONE NUMBER**	
STREET ADDRESS	**CITY**	**STATE**	**ZIP**

PROFESSIONAL LIABILITY INSURANCE COVERAGE

NAME OF CARRIER	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF CARRIER	
AMOUNTS PER OCCURRENCE/AGGREGATE	DATES OF COVERAGE
Do you participate in the Louisiana Patients' Compensation Fund? ❑ YES ❑ NO	
Has current liability insurance carrier required exclusion of any procedures from insurance coverage? (If yes, attach explanation) ❑ YES ❑ NO	Are you self-insured in accordance with the Louisiana Medical Malpractice Act? ❑ YES ❑ NO
Please attach a copy of the current Certificates of Insurance.	

GENERAL QUESTIONS

Please check the appropriate response to the following questions:
If you answered YES to any of the questions below, please attach a full explanation on a separate page.

	YES	NO	N/A
1. Has any disciplinary action ever been instituted against your license to practice in your profession in any state or country, or is any such action currently pending against you in the past three years?	❑	❑	❑
2. Has any disciplinary action ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or is any such action pending in the last three years?	❑	❑	❑
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charge or have you ever served a prison sentence in the past three years?	❑	❑	❑
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified in the past three years?	❑	❑	❑
5. Have your clinical privileges at any hospital or health care institutions been voluntarily or involuntarily revoked, not renewed, or subjected to probationary or other disciplinary conditions, or has any proceeding been instituted or recommended by a hospital administration, medical staff committee or governing board in the past three years?	❑	❑	❑
6. Have you ever received a sanction from any regulatory agency (e.g., CLIA, OSHA, etc.)?	❑	❑	❑
7. Have you engaged in the illegal use of drugs within the past three years? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner.	❑	❑	❑
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?	❑	❑	❑
9. Do you, your business entity or any family member have an ownership greater than 5% in any medical enterprise or business? If YES, please enter the ownership percentage _____ and attach a full explanation.	❑	❑	❑
10. Are you presently a named defendant in a pending professional liability lawsuit? If YES, please enter the number of cases _____ and attach a full explanation of each.	❑	❑	❑
11. During the past three years has any adverse medical review panel opinion been rendered, has any settlement or judgment been made, or has any payment been made by you or on your behalf in a professional liability action or potential action? If YES, please enter the number of cases _____ and attach a full explanation of each.	❑	❑	❑

REQUIRED ATTACHMENTS

- State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- Curriculum Vitae
- Certificate(s) of Professional Liability Insurance
- History of malpractice suits in past three years, regardless of whether judgments or settlements paid
- Explanation of any "Yes" answer(s) from **General Questions Section**
- Current Employer Identification Number (EIN) **and** W–9 Form or Federal Tax Deposit Coupon

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or health plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification that might positively impact the credentialing decision.

According to La. R.S. 22:1009.A (8) an adverse medical review panel option is included in the type of information a health plan may require you to submit on a credentialing or re-credentialing application.

According to La. R.S. 22:1009, a health insurance issuer is required to complete the credentialing process within 90 days from the date of receipt of all information needed. The issuer is required to inform you within 30 days of receipt all defects and reasons known at the time in the event an application is deemed to be not correctly completed. The issuer is also required to inform you in the event that any needed verification or verification supporting statement has not been received from a third party within 60 days of the date of such a request.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

Name (Please Print)	X Signature	Today's Date

Second Approval Date	Third Approval Date

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.