PROVIDENCE Health Plan

Primary: Yes **Eligible:** No **Certified:** Yes
Expiration: **Lifetime:** Yes

Hospital Affiliations

Hospital: Providence St Vincent Medical Center **From:** 03/25/1991 **Thru:**
Status: Active

Hospital: Legacy Good Samaritan Hospital & Medical Center **From:** 11/20/1996 **Thru:**
Status: Active

Hospital: Legacy Meridian Park Hospital **From:** 04/19/1991 **Thru:** 12/31/1997
Status:

Education/Training

Medical education Baylor College of Medicine **From:** 08/01/197[illegible] **Thru:** 6/20/1976
Grad Year: 1976 **Degree:** MD **Specialty:**

Residency Baylor College of Medicine **From:** 01/01/197[illegible] **Thru:** 12/31/197[illegible]
Grad Year: 1979 **Degree:** **Specialty:** Internal Medicine

Licensure, Registrations, Certificates and ID Numbers

Type/Number	State	Expiration Date	Issued Date
State License: [redacted]	OR	12/31/2017	07/13/1990
DEA Number: [redacted]	OR	03/31/2020	
NPI Number: [redacted]			
UPIN: E40919			
Taxonomy NPI: [redacted]			
Medicare Provider [redacted]			
DMAP: 151344			

Professional Liability Insurance

Company: **Physicians Insurance Exchange
1730 Minor Avenue Suite 1800
Seattle, WA 98101-1499

Policy Number: [redacted] **Issued:** 01/01/2014
Amount Per Incident: [redacted] **Expires:** 01/01/2018
Aggregate Amount: [redacted]
Comment:

Company: **CNA HealthPro/Oregon
Coverage/Claims Verification - 27S
Portland, OR 97208-4267

Generated: April 03, 2017 9:51 AM

PROVIDENCE Health Plan

Policy Number: [redacted]
Amount Per Incident: [redacted]
Aggregate Amount: [redacted]
Comment:

Issued: 03/15/1994
Expires: 05/01/2012

References

Peer Reference:

[redacted]
2400 SW Vermont
Portland, OR 97219

Title: Dr.
Salutation:
Phone: (503)452-0915

Peer Reference:

[redacted]
2400 SW Vermont
Portland, OR 97219

Title: Dr.
Salutation:
Phone: (503)452-0915

Peer Reference:

[redacted]
2400 SW Vermont
Portland, OR 97219

Title: Dr.
Salutation:
Phone: (503)452-0915

Peer Reference:

[redacted]
2400 SW Vermont
Portland, OR 97219

Title: Dr.
Salutation:
Phone: (503)452-0915

Peer Reference:

[redacted]
2400 SW Vermont
Portland, OR 97219

Title: Dr.
Salutation:
Phone: (503)452-0915

April 3rd, 2017

RE: Recredentialing with Providence Health Plans (PHP)

IF THE PROVIDER ON THE ADDRESS LABEL NO LONGER PRACTICES AT THIS LOCATION PLEASE CONTACT PHP IMMEDIATELY – Contact Information below

Thank you for participating with PHP. Please review the attached Provider Profile and make any necessary updates to the attached document. Please include the following when you return the Provider Profile by April 30, 2017:

- Signed & current dated Attestation & Release of Information pages.
- Complete Attachment A (if applicable) and provide an explanation for all Attestation questions with a "yes" answer
- A copy of your **current** malpractice insurance certificate (minimum 1,000,000/3,000,000)
- A copy of your **current** DEA (which lists your practice address)
- Your hospital admitting privileges (or formal hospital admit plan-include agreements with hospitalists)
- Call coverage arrangements for all non-office hours

Please Note:

- If you have a recently completed application (rev. 5/2012), this may be used along with newly signed Attestation and Release of Information forms
- The NPI number (and DMAP number, if applicable) are used for claims payment, please make sure to include this on the application
- THIS PROVIDER PROFILE IS FOR **PROVIDENCE HEALTH PLAN** MEMBERSHIP (Providence Hospitals require a separate process)

PHP requires board certification for MD's, DO's and DPM's. Few exceptions are made, but may be made for geographic need or residency within the last 5 years. When a completed application has been received it will be sent to the PHP Credentials and Quality Committee for review. It is your right to review information received during the application process, except for information that is peer review protected. PHP staff will notify you of any information received that is possibly erroneous, or that substantially varies from the information provided. Applicants have the right, upon request, to be informed of the status of their application. Applicants may contact PHP via telephone, email or in writing.

Mail: Providence Health Plans
Credentialing Services
PO Box 5428
Portland, OR 97228

Fax: 503-574-8181
E-Mail: PHPCredentialing@providence.org

Please do not hesitate to contact us at the above information if you have any questions.

XVI. ATTESTATION QUESTIONS – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. **Please sign and date each additional sheet.**

A.	**In the last three (3) years** has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES ☐ NO ☐
B.	**In the last three (3) years** have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES ☐ NO ☐
C.	**In the last three (3) years** have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐ NO ☐
D.	**In the last three (3) years** have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES ☐ NO ☐
E.	**In the last three (3) years** has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?	YES ☐ NO ☐
F.	**In the last three (3) years** has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES ☐ NO ☐
G.	**In the past three (3) years,** have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES ☐ NO ☐
H.	**In the last three (3) years** have you ever had board certification revoked?	YES ☐ NO ☐
I.	**In the last three (3) years** have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES ☐ NO ☐
J.	**In the last three (3) years** have you ever been charged with a criminal violation *(felony or misdemeanor)*?	YES ☐ NO ☐
K.	Do you presently use any illegal drugs?	YES ☐ NO ☐
L.	Do you now have, or have you had, any physical condition, mental health condition, or chemical dependency condition *(alcohol or other substance)* that affects or is reasonably likely to affect your current ability to practice, with or without reasonable accommodation, the privileges requested? If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.	YES ☐ NO ☐
M.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES ☐ NO ☐
N.	**In the last five (5) years** have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail**, for **each** past or current claim and/or lawsuit.	YES ☐ NO ☐
O.	**In the last three (3) years** has your professional liability insurance **ever been** terminated, not renewed, restricted, or *modified (e.g. reduced limits, restricted coverage, surcharged)*, or have you **ever been** denied professional liability insurance?	YES ☐ NO ☐

*e.g. ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system***

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature: **Date:**

ATTACHMENT A

PROFESSIONAL LIABILITY ACTION DETAIL – *CONFIDENTIAL*
Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.
Practitioner's Name (print or type):
Month / Day / Year of the incident: and clinical details:
Your role and specific responsibilities in the incident:
Subsequent events, including patient's clinical outcome:
Month / Day / Year the suit or claim was filed:
Name and address of insurance carrier/professional liability provider that handled the claim:
Your status in the legal action (primary defendant, co-defendant, other):
Current status of suit or other action:
Month / Day / Year of settlement, judgment, or dismissal:
If case was settled out-of-court, or with a judgment, settlement amount attributed to you:
I verify the information contained in this form is correct and complete to the best of my knowledge. Signature: Date:

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

OREGON PRACTITIONER RECREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and recredentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed name: _____

Signature: _____ **Date:** _____

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

_____

_____

_____

Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.

This form must be completed for Credentialing Approval

Addendum

Date: _____

Provider Name: _____

If a provider cannot admit patients to an in-plan hospital, they must submit a hospital action plan which documents their process in the event of a member requiring hospitalization.

- *The provider must have a system in place that allows a patient to be evaluated telephonically by a live person. The evaluator will be able to give the patient clinical advice or to facilitate contact with another individual who has that ability.*
- *Sending Providence Health Plan Members directly to an Emergency Room without communicating directly with the member or other responsible party is not considered acceptable coverage.*

If you do not have active admitting privileges, please explain how your patients are triaged and admitted?

Description of Action plan, should a patient need to be admitted to a hospital:

Name and title of person completing this form:

_____

Applicant Signature and Date:

_____