



Dear Provider:

CenCal Health has always strived to bring the best care possible to our members. Like most managed care organizations, we have a quality of care program designed and implemented to look for ways of improving the plan and the delivery of health care to our members. As part of this program, we credential providers practicing as individuals or belonging to groups contracted with CenCal Health.

Enclosed you will find an abbreviated version of the California Participating Physician Application (CPPA) that must be completed and returned to CenCal Health as soon as possible. Please include copies of the following:

- Current California license to practice,
- Current malpractice insurance policy face sheet.
- Completed Addendum B or equivalent explanation of any malpractice cases, if applicable
- Practice e-mail address in space provided on the application
- **Provide the full names, addresses and phone numbers of 3 peer references.** These references should be from individuals currently familiar with your work via clinical observations or through close work.

Name	Address	Phone
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Once we receive the completed application and requested attachments, we will verify license, peer references, any sanctioning activity, malpractice insurance and case history. Providers requesting access to the information within their records may do so as permitted by applicable federal and state laws and regulations. In the event that the information obtained from other sources varies substantially from that provided by you, we will notify you in writing with a request that you correct the erroneous information. Our Credentials Committee will review the completed application, and you will then be notified of the outcome in writing.

If this is an initial application, it is important that you do not provide services to any CenCal Health members until you receive written notice that your credentialing application has been approved. Claims for services rendered prior to approval of your credentialing application may not be reimbursed.

Thank you for your time and cooperation. Please feel free to contact me directly with any questions or concerns at (805) 685-9525 or (800) 421-2560, extension 1670. For specific questions about the credentialing process, please contact our Quality Improvement Manager, Sheila Thompson at extension 1677.

Sincerely,

Cindy Lansing, CPCS  
Credentialing Specialist  
CenCal Health

Enclosure (1)



	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Tertiary Office Street Address:	City:	
	State:	ZIP:
Office Manager/Administrator:	Telephone Number: ( )	
	Fax Number: ( )	
Name Affiliated with Tax ID Number:	Federal Tax ID Number:	
Other Professional Interests in Practice, Research, etc.:		

**IV. EDUCATION** (Attach additional sheets if necessary. Reference This Section Number and Title)

College or University Name:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State:	ZIP:

**V. PROFESSIONAL EDUCATION** (Attach additional sheets if necessary. Reference This Section Number and Title)

Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:
Professional School:	Degree Received:	Date of Graduation: (mm/yy)
Mailing Address:	City:	
	State & Country:	ZIP:

**POSTGRADUATE TRAINING AND EXPERIENCE**

**VI. TRAINING** (Attach additional sheets if necessary. Reference This Section Number and Title)

Institution:	Program Director:		
Mailing Address:	City:		
	State & Country:	ZIP:	
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)

Did you successfully complete the program?  Yes  No (If "No," please explain on separate sheet.)

Institution:	Program Director:		
Mailing Address:	City:		

		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			
Institution:		Program Director:	
Mailing Address:		City:	
		State:	ZIP:
Type of Training:	Specialty:	From: (mm/yy)	To: (mm/yy)
Did you successfully complete the program? <input type="checkbox"/> Yes <input type="checkbox"/> No (If "No," please explain on separate sheet.)			
<b>VII. OTHER CERTIFICATIONS (E.G. FLUOROSCOPY, RADIOGRAPHY, ETC.)</b> (Attach additional sheets if necessary. Reference This Section Number and Title)			
Type:	Number:	Expiration Date:	
Type:	Number:	Expiration Date:	
<b>VIII. PROFESSIONAL LICENSURE/CERTIFICATIONS (Remember to attach copies of documents)</b>			
California State License/Certificate Number:		Issue Date:	Expiration Date:
Medicare UPIN:		Medi-Cal/Medicaid Number:	
National Physician Identifier (NPI):			
<b>IX. ALL OTHER STATE PROFESSIONAL LICENSES. List All Professional Licenses Now or Previously Held.</b> (Attach additional sheets if necessary. Reference This Section Number and Title)			
State:	License Number:	Expiration Date:	
State:	License Number:	Expiration Date:	
State:	License Number:	Expiration Date:	
<b>X. PROFESSIONAL LIABILITY (Remember to attach copy of professional liability policy or certification face sheet)</b>			
Current Insurance Carrier:		Policy Number:	Original effective date:
Mailing Address:		City:	
		State:	ZIP:
Per Claim Amount \$	Aggregate Amount: \$	Expiration Date:	
Please explain any surcharges to your professional liability coverage on a separate sheet. Reference This Section Number and Title.			
<b>Please list all of your professional liability carriers within the past seven years, other than the one listed above:</b>			
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
<hr/>			
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:
<hr/>			
Name of Carrier:	Policy #:	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State:	ZIP:

## XI. ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If your answer to questions A through J is "yes," or if your answer to K is "no," please provide full details on separate sheet.

A. Has your license/certification to practice in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have you voluntarily or involuntarily relinquished any such license or certification, or voluntarily or involuntarily accepted any such actions or conditions, or have you been fined or received a letter of reprimand or is such action pending?

Yes

No

B. Have you ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?

Yes

No

C. Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, professional school faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?

Yes

No

D. Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g., hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, medical school faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?

Yes

No

E. Have you ever surrendered, voluntarily withdrawn, or been requested or compelled to relinquish your status as a student in good standing in any professional education program?

Yes

No

F. Has your membership or fellowship in any local, county, state, regional, national, or international professional organization ever been revoked, denied, reduced, limited, subjected to probationary conditions, or not renewed, or is any such action pending?

Yes

No

G. Have you ever been convicted of any crime (other than a minor traffic violation)?

Yes

No

H. Do you presently use any drugs illegally?

Yes

No

I. Have any judgments been entered against you, or settlements been agreed to by you within the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you pending?

Yes

No

J. 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, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?

Yes

No

K. Are you able to perform all the services required by your agreement with the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients?

Yes

No

I hereby affirm that the information submitted in this Section XIII, Attestation Questions, and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material, omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Print Name Here: \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Stamped Signature Is Not Acceptable)

**INFORMATION RELEASE/ACKNOWLEDGMENTS**

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("verification information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, professional school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-verification application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect verification information from being further disclosed.

I am informed and acknowledge that federal and state<sup>3</sup> laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and verification on behalf of this Healthcare Organization, and all persons and entities providing verification information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice in California; or (ii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by any license/certificate issuing body taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or practitioner participation agreement. A photocopy or electronic reproduction of this document shall be as effective as the original.

Print Name Here \_\_\_\_\_

Practitioner Signature \_\_\_\_\_ Date \_\_\_\_\_

(Stamped Signature Is Not Acceptable)

<sup>3</sup> The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.