CREDENTIALING ELIGIBILITY CRITERIA

IPN maintains a Credentialing/Recredentialing Program to assist in selection and reevaluation of all providers within its delivery system. All providers must successfully complete the credentialing process to be approved as IPN Participating. The provider has the right to review information obtained in the process of evaluating the credentialing and recredentialing application exclusive of peer review information. **Included, as a requirement for completion of the attached application, is the signature and dating of page 2 of these Criteria Sheets which are to be returned as a part of the submitted application.**

Provider Criteria Consists of the Following:

1. Completion of the Universal Provider Credentialing Application to include:
   - Reasons for any inability to perform the essential functions of the position with or without accommodation
   - Lack of present illegal drug use
   - History of loss of license and or felony convictions
   - History of loss or limitation of privileges or disciplinary activity
   - Attestation to the correctness and completeness of the application
   - Malpractice history
   - History of loss of license
   - Signed release and waiver allowing access to any relevant information about the provider which may be held by third parties

2. Must hold a current unrestricted license to practice for each state as applicable

3. Medical staff membership and unrestricted clinical staff privileges, appropriate to the provider's area of practice, in good standing, at the hospital designated by the provider as his/her primary hospital. Indicated hospital must be within a reasonable proximity to the provider's location of practice. This requirement can be waived if the provider's area of practice is exclusively in an outpatient setting with evidence of satisfactory coverage arrangements for patients who may expectantly or un-expectantly require hospital admission. *Applicant's initials and date on this document confirms review of the cover document and application and acts as an attestation of the correctness of the information provided in this application including hospital privileges information*

4. A current DEA and State Board of Pharmacy certificates as applicable

5. Proof of graduation from medical or professional school with completion of a residency and or fellowship in the provider's area of practice

6. Physicians, will preferably be board certified by;
   - ABMS American Board of Medical Specialties
   - AOA American Osteopathic Association
   - ABFAS American Board of Foot and Ankle Surgery
   - ABPM American Board of Podiatric Medicine
   - ABMSP American Board of Multiple Specialties in Podiatry

7. Continuous work history of, at least, the most recent five (5) years including from and to dates MM/YYYY with an explanation of any gaps that exceed three (3) months.

8. Proof of Professional Liability insurance for at least the amount required by IPN:
   - $1,000,000 per occurrence and $3,000,000 aggregate

9. A professional liability claims history - does not exceed three (3) cases in the last five (5) consecutive years or exceed $250,000 singularly or in total within the last five (5) years. This criterion is based on date of settlement.

10. Be without sanction activity by Medicare and Medicaid

11. Practices in a quality office/facility.

12. The applicant has the right, upon request, subject to policies and procedures, to be informed of the status of their application. The Credentialing Department will make every effort to provide status at the time of request and, if unable, will respond by telephone or in writing with in three (3) working days

13. Applicants have the right to revise, supplement or correct erroneous information to the Credentialing and Recredentialing Applications. This may be done at the provider's discovery or if deficiencies are discovered during the verification process by IPN. The provider will be notified of the discrepancies by telephone, email or written correspondence. The provider will have thirty (30) days to respond. After thirty (30) days, if no response is received, the application will be withdrawn from the review process. When additional information is provided by the provider within the thirty (30) days but continues to fall short of meeting criteria requirement(s) the provider will be notified by telephone, email or written correspondence allowing the provider an additional thirty (30) days to respond. All supplemental documents and correspondence is to be forwarded to the Credentialing Department at PO Box 5406 Boise, ID 83705 or faxed to (208) 433-4604.

If information is not received by the Credentialing or Recredentialing Department within sixty (60) days of request, an updated Attestation may be required prior to final processing.

14. National Practitioner Identifier (NPI) Number.

15. Credentialing and Recredentialing is non-transferrable.

16. IPN maintains a policy and procedure for health care providers, facility/entity or organizations to enable review of decisions when denied network participation for reasons other than a failure to meet or maintain credentialing/recredentialing criteria. The policy and procedure, C-8 is available by request from the IPN Credentialing Department (208) 333-1570.

17. A copy of any portion/section of this Criteria Sheet and or Credentialing Application has the same force and effect as the original.

18. The applicant certifies by his/her signature on the application and the pages of this cover document that the information in the entire application is complete, accurate, current and acknowledges that any misstatements in or omissions from this application constitute cause for denial of membership/participation or cause for summary dismissal by the entity to which this statement has been made. A photocopy of the application has the same force and effect as the original. The applicant confirms that he/she has reviewed this information as of the most recent date listed in the application.

Signature: _____ Date: _____

Provider & or Subcontractor Ownership/Controlling Interest Worksheet

In order to comply with Federal Law (42 CFR 420.200 – 420.206 and 455.100 – 455.106), health plans with Medicare or Medicaid business are required to obtain certain information regarding the ownership and control of entities with which they contract directly or indirectly for services for which payment is made under the Medicaid or Medicare programs or any line of business that provides healthcare for federal employees.

The Centers for Medicare and Medicaid Services (CMS) requires companies to obtain this information to demonstrate that they are not contracting with providers that have been excluded from federal health programs or with an entity that is owned or controlled by any individual(s) who has been convicted of a criminal offense, has had civil monetary penalties imposed against them or has been excluded from participation in Medicare or Medicaid. Please complete the following information.

This form is required if you wish to participate with IPN. You are also reminded that pursuant to your Attestation, any changes to information contained in this application in the future must be reported to IPN.

Please make copies if you need additional space to complete your responses. If you have questions, please contact your IPN provider services representative.

Name of Provider/Subcontractor: _____

_____

Primary Address: _____

Type of Ownership: _____

(Examples: Private Practice, Corporate-Owned, Partnership, Limited Partnership, Investor-Owned or Government-Owned)

List any person that has a direct or indirect ownership interest of 5% or more; _____

_____

_____

Address: _____

List any person who is the owner of a whole or part interest in any mortgage deed of trust, note or other obligation secured, in whole or in part, by the entity or any of the property assets thereof in which whole or part interest is equal to or exceeds 5% of the total property and assets of the entity:

_____

_____

Address: _____

If the entity is a corporation or partnership, please list the officers and directors of the entity or list the partners:

_____

_____

Addresses: _____

List any managing employees: _____

(Managing employees are individual who exercise operational or managerial control over the entity or part thereof who directly or indirectly conduct the daily operations of the entity)

Addresses: _____

☐ **Check if you have included additional pages to complete the information requested.**

I certify that the information contained above is true complete and accurate.

Signature: _____ Date: _____

Universal Provider Credentials Verification Application

To use the Universal Provider Application (UPA), follow these instructions

- Complete the application in its entirety using black or blue ink. **Keep an unsigned and undated copy of the application on file for future requests.** When a request is received, send a copy of the completed application, making sure that all information is complete, current and accurate. Please sign and date pages 12 and 13. Please document any YES responses on the Attestation Question page.
- Prior to submitting this application to any health care related organization, inquire with the organization, as you may need authorization (through a pre-application process) before the application is accepted. Identify the health care related organization(s) to which this application is being submitted in the space provided below.
- Attach copies of requested documents each time the application is submitted.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.

This application is submitted to:

I. Instructions

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application** (all are required for MDs, DOs; as applicable for other health providers). If not available, indicate why.

- State Professional License(s)
- DEA Certificate w/ current address
- ECFMG (if applicable)
- State Controlled Substance Certificate (if applicable)
- Passport photo (for hospitals only)
- Face Sheet of Professional Liability Policy or Certificate
- Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety****

II. Provider Information

Last name (include suffix; Jr., Sr., III)	First (do not abbreviate)	Middle (do not abbreviate)	
Other name(s) under which you have been known by reference, licensing and or educational institutions?		Degree(s)	
Home telephone number	Pager number	Cell number	E-mail address
Home mailing address	City	State	Zip code
Birth date / Birth place (city, state, country)	Social security number	Medicare Opt-Out - §1128 of the Social Security Act ☐ Yes ☐ No	
Languages spoken by provider	Type of Provider ☐ PCP ☐ Urgent Care ☐ Specialist	Opt-Out Start Date	Opt-Out End Date
Individual NPI #	Individual Medicare Number	Individual Medicaid number(s)	Gender ☐ Male ☐ Female
Specialty at the primary practice location:	Taxonomy (10-digit code identifying specialty or subspecialty)		Subspecialties:

III. Practice Information

Effective Date at Primary Practice location _____

Name of practice, affiliation or clinic name		Department name (if hospital based)	
Primary office street address	City	State	Zip code
Patient appointment telephone number	Fax number	Name affiliated with tax ID number	Federal tax ID number
Mailing address (if different from above)	City	State	Zip code

Modification to the wording or format of the Universal Provider Application may invalidate the application.

III. Practice Information (Continued)

Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Fax number	E-mail address
Credentialing contact (if different from above)	Credentialing telephone number	Fax number	E-mail address

Effective Date at Secondary Practice location _____

Name of secondary practice, affiliation or clinic name		Department name (if hospital based)	
Secondary office street address	City	State	Zip code
Patient appointment telephone number	Fax number	Name affiliated with tax ID number	Federal tax ID number
Mailing address (if different from above)	City	State	Zip code
Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Fax number	E-mail address
Credentialing contact (if different from above)	Credentialing telephone number	Fax number	E-mail address

List other office locations with above information on a separate sheet.

IV. Professional Licensure

State professional license/registration/certificate number		Status ☐ Active ☐ Inactive ☐ Temporary
Issue date	Expiration date	**Name of sponsor if required by licensure, (i.e. Physician's Assistant).**
Drug Enforcement Administration (DEA) registration number	Issue date	Expiration date
State controlled substance certificate number	Issue date	Expiration date
ECFMG number (applicable to foreign medical graduates)		Date issued

V. All Other Professional Licenses

State	License/registration/certificate number	Date issued
Expiration date	Year relinquished	Reason
State	License/registration/certificate number	Date issued
Expiration date	Year relinquished	Reason
State	License/registration/certificate number	Date issued
Expiration date	Year relinquished	Reason

VI. Under-graduate Education

Name of college or university			**Does Not Apply** ☐
Degree received	Graduation date		
Mailing address	City	State	Zip code
Name of college or university			
Degree received	Graduation date		
Mailing address	City	State	Zip code

(*Do not abbreviate*) (Attach additional sheet if necessary)

VII. Medical/Professional Education

Medical/Professional school				
Start date	Graduation date	Degree received		
Mailing address		City	State	Zip code
		Phone	Fax	
Medical/Professional School				
Start date	Graduation date	Degree received		
Mailing address		City	State	Zip code
		Phone	Fax	

(*Do not abbreviate*) (Attach additional sheet if necessary)

VIII. Graduate Education

Institution **Does Not Apply** ☐			
Program or course of study	Faculty director		
Mailing address	City	State	Zip code
Dates attended (/) - (/)	Phone	Fax	

(*Do not abbreviate*) (Attach additional sheet if necessary)

IX. Internship/PGYI

Institution **Does Not Apply** ☐			
Program director			
Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of internship	Specialty		
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

(*Do not abbreviate*) (Attach additional sheet if necessary)

X. Residencies

Institution **Does Not Apply** ☐			
Program director			
Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of residency	Specialty		
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			
Institution **Does Not Apply** ☐			
Program director			
Mailing address	City	State	Zip code
Start date / Completion date	Phone	Fax	
Type of residency	Specialty		
Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)			

(*Do not abbreviate*) (Attach additional sheet if necessary)

XI. FELLOWSHIPS

Institution — **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

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

Institution — **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

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

(*Do not abbreviate*) (Attach additional sheet if necessary)

XII. PRECEPTORSHIP

Institution — **Does Not Apply** ☐

Department chairman

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Training

(*Do not abbreviate*) (Attach additional sheet if necessary)

XIII. FACULTY APPOINTMENT

Institution — **Does Not Apply** ☐

Faculty director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Position

(*Do not abbreviate*) (Attach additional sheet if necessary)

XIV. BOARD CERTIFICATION

Are you board or otherwise professionally certified? **Does Not Apply** ☐

☐ **Yes** If "Yes", please complete below ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

Issuing Board/Entity	Certificate Number	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date

If you participate in a specialty which does not have board certification, please indicate specialty

(*Do not abbreviate*) (Attach additional sheet if necessary)

XV. Other Certifications

ACLS, BLS, ATLS, PALS, NRP, NALS (i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)		Does Not Apply ☐
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date

XVI. Hospital and Other Institutional Affiliations

Does Not Apply ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(*Do not abbreviate*) (Attach additional sheet if necessary)

A. Current Affiliations

Name of primary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	
Name of secondary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	
Name of other facility (Do you have admitting privileges? ☐ **Yes** ☐ **No**)			
Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	

(*Do not abbreviate*) (Attach additional sheet if necessary)

B. Applications In Process

Hospital/Institution			
Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	
Hospital/Institution			
Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	

(*Do not abbreviate*) (Attach additional sheet if necessary)

C. Previous Affiliations

Name of facility			**Does Not Apply** ☐
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	
Name of facility			
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	
Name of other facility			
Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	

D. Inpatient Coverage Plan

This Section only applicable for those without admitting privileges

Provider may attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. **Does Not Apply** ☐

Name of participating admitting physician/practice/clinic/group	Hospital where privileged

(*Do not abbreviate*) (Attach additional sheet if necessary)

XVII. Work History

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vita may be substituted as long as it is current and has exact dates of employment.

Name of current practice/employer				
Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
Mailing address	City	State	Zip code	
Reason for leaving				
Name of practice/employer				
Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
Mailing address	City	State	Zip code	
Reason for leaving				

XVII. Work History (Continued)

Name of practice/employer				
Contact name	Telephone number	Fax number	From (mo/year)	To (mo/year)
Mailing address	City	State	Zip code	
Reason for leaving				

Please account for all gaps in time between dates of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.

Activity / Name	From	To

XVIII. Professional Affiliations

Please list membership in all professional societies. Complete Name of Society	Date Joined	Current Member	
		Yes	No

XIX. Peer References

List **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number

XX. Professional Liability

Current insurance carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	Origination (retroactive) date	
Per claim amount	Aggregate amount	Effective date	Expiration date

Please list **ALL** professional liability carriers within the past ten years

Name of carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier			Policy number
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier			Policy number
Mailing Address	City	State	Zip code
Phone number	Fax number	From	To

XXI. Professional Liability Action Detail – Confidential

Provider name(print or type) **Does Not Apply** ☐

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed provider narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events	
Date	Details

Your role and specific responsibility in the incident

Subsequent events, including patient's clinical outcome

Date suit or claim was filed

Name and Address of Insurance Carrier that handled the claim

Your status in the legal action (primary defendant, co-defendant, other)

Current status of suit or other action

Date of settlement, judgment, or dismissal

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**

UNIVERSAL PROVIDER ATTESTATION QUESTIONS - *To be completed by the provider*

Please answer **all** of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

			Yes	No
A.	**PROFESSIONAL SANCTIONS**			
①	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct? (Please include an explanation sheet for any "Yes" answer in this section)			
	a.	License to practice any profession in any jurisdiction		
	b.	Other professional registration or certification in any jurisdiction		
	c.	Specialty or subspecialty board certification		
	d.	Membership on any hospital medical staff		
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.		
	f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program		
	g.	Professional society membership or fellowship		
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity		
	i.	Academic Appointment		
	j.	Authority to prescribe controlled substances (DEA or other authority)		
②	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?			
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?			
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?			
B.	**CRIMINAL HISTORY** (Please include an explanation sheet for any "Yes" answers in this section)		**Yes**	**No**
①	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?			
	a.	Do you have notice of any such anticipated charges?		
	b.	Are you currently under governmental investigation?		
C.	**AFFIRMATION OF ABILITIES**		**Yes**	**No**
①	Do you presently use any drugs illegally?			
②	Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.			
③	Are you unable to perform any of the services/clinical privileges required by the applicable participating provider agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?			
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY** (**If you answer "Yes" to any of the questions in this section,** please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
①	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?			
②	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgment (court-ordered damage award) in a professional lawsuit?			
③	Are there any such claims being asserted against you now?			
④	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?			
⑤	Are any of the privileges that you are requesting not covered by your current malpractice coverage?			
E.	**ATTESTATION**			

I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Typed or printed name _____ Signature _____ Date _____

Modification to the wording or format of the Universal Provider Application may invalidate the application.

Universal Provider Credentials Verification Addendum

Supplemental Provider Authorization and Release of Information

XXII. PROVIDER AUTHORIZATON TO RELEASE INFORMATION	I hereby authorize the presenter of this Release and/or its representatives to consult with others who have information bearing on my professional competence, character, professional practice or ethical qualifications. I authorize all malpractice carriers to release coverage and/or claims history information which may exclude direct patient identification including name, address or telephone numbers to the presenter of this Release and/or its representatives. I hereby further consent to the inspection by the presenter, and/or its representatives, of all documents, including medical records, which may be relevant to evaluation of my professional competence, character, professional practice or ethical qualifications. *The presenter complies with the Health Insurance Portability and Accountability Act of 1996 "HIPAA" (as defined in 45 CFR § 160 et seq.) as well as other state and federal statutes, rules and regulations relating to confidentiality and privacy.* I understand that I have the right to review any information submitted in support of this Provider Application. I hereby release from liability any and all individuals and organizations that provide information to the presenter concerning my professional competence, practices, ethics, character or ethical qualifications for participating provider status, and hereby consent to the release of such information. I further agree to release and hold harmless from any liability the presenter and/or its representatives who participate within the scope of their duties in review of any information obtained under this Release. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, professional practice or ethical qualifications for resolving any doubts regarding such qualifications. A copy of any portion/section of the Authorization and Release, Criteria Sheet and or Application has the same force and effect as the original. I also understand that to participate, this application must be verified and I must be notified in writing whether this application has been approved or denied. I agree to immediately notify the entity to which this authorization has been given, in accordance with executed Agreements, of any change in submitted information. Failure to notify the entity of changes in the information contained in this application may result in immediate termination from participation with the entity to which this Release is given.
Medicare Opt-Out ATTESTATION	I certify that I have not filed an opt-out notice with the Center for Medicare Services (CMS) in the prior two years; I understand that should I choose to opt-out of Medicare, I must file a notice with CMS and promptly notify IPN.
XXIII. ATTESTATION	I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here _____

Signature _____

(Stamped signature is not acceptable)

Date _____

Review dates and initials

Modification to the wording or format of the Universal Provider Application may invalidate the application.