KOVA Healthcare, Inc.
Doctor focused patient centered.
7257 N. Maple Ave Suite 104 Fresno CA 93720

Dear Practitioner,

We would like to thank you for choosing KOVA Healthcare. My name is Joie Olmos and I will be assisting you through your credentialing and approval process.

The documents listed below are required for credentialing all contracted health practitioners. These documents must be submitted as soon as possible, along with your completed application to complete the enrollment process. If you have a currently attested CAQH profile, it can be used in lieu of completing the attached application. Please provide your CAQH # along with the required documents listed below.

Please remember that you may not see KOVA patients until your credentialing is complete. We will notify you with your approval date.

- ❑ Completed and signed Participating Practitioner Application, including: Gap Explanation (if applicable), HIV/AIDS Specialist Delegation, Attestation Questions, Information Release/Acknowledgment, Affirmative Statement and Professional Liability Action Explanation (if applicable)
- ❑ Copy of current California Medical License (pocket card)
- ❑ Copy of current DEA License (must have California Address)
- ❑ Current and updated Curriculum Vitae (CV) outlining *at least* 5 years of your work history (including current Hospital and Surgical Center Affiliations). Please list dates in Month/Year format
- ❑ Copy of Board Certificate(s) or Eligibility documentation (if applicable)
- ❑ Copy of ECFMG Certificate (if applicable)
- ❑ Copy of current Professional Liability Insurance Certificate or Malpractice (indicating a minimum of $1 million / $3 million in coverage with the coverage period dates)
- ❑ Copy of General/Commercial Liability Insurance
- ❑ Copy of CHDP (Child Health and Disability Program) Certificate (if applicable)
- ❑ Proof of FQHC Certification (if applicable)

The following application is designed to be typed on for your convenience. Please do not leave anything blank as incomplete applications and/or missing documents may delay the credentialing and verification process.

I thank you in advance for providing this information to me promptly and I look forward to working with you. Please feel free to call me at (559) 207-3198 or email at JoieO@Kovahealth.com with any questions.

Respectfully,

Joie Olmos

Credentialing Specialist
Email: JoieO@Kovahealth.com
Office: 559-207-3198
Fax: 559-207-3901

KOVA Healthcare, Inc.
Participating Practitioner Application

I. Instructions

This form is intended to be typed on for your convenience. If more space is needed, attach additional sheets. Please be as thorough as possible and **do not** type "See CV." Incomplete applications will delay the credentialing process.

II. Identifying Information

Last Name:	First Name:	Middle:
Cell:	Email:	
Citizenship (If not US citizen, please provide copy of Registration Card):		CAQH#:
Date of Birth:	SSN:	Gender: ❑ Male ❑ Female
Specialty:	Subspecialty:	

III. Practice Information

Primary Practice Name:		
Address, City, State, Zip:		
Phone:	Fax:	Website:
Office Manager/ Credentialing Contact:	Office Manager/ Credentialing Contact Email:	
Tax ID:	Name Associated with Tax ID:	
Languages spoken by Provider:	Languages spoken by Staff:	
Primary Office Hours of Operation:		Group NPI:
Is your practice limited to certain ages? ❑ Yes ❑ No	If yes, specify limitation:	

Secondary Practice Name:		
Address, City, State, Zip:		
Phone:	Fax:	Group NPI:
Office Manager/ Credentialing Contact:	Office Manager/ Credentialing Contact Email:	
Tax ID:	Name Associated with Tax ID:	

Tertiary Practice Name:		
Address, City, State, Zip:		
Phone:	Fax:	Group NPI:
Office Manager/ Credentialing Contact:	Office Manager/ Credentialing Contact Email:	
Tax ID:	Name Associated with Tax ID:	

IV. Billing Information

Which of your practices handles your billing? ❑ Primary ❑ Secondary ❑ Tertiary ❑ Other (If Other, please list below)	
Billing Company:	Contact Person:
Address, City, State, Zip:	
Tax ID:	Name Associated with Tax ID:

V. Practice Description

Do you employ any allied health professionals (Nurse Practitioners, Physician Assistants, Psychologists, etc.)? ❑ Yes ❑ No

Name/Title:	License #:	Supervising Physician:

VI. Education, Training, Experience *This section must be completed. Please do not type "See CV"*

Medical/Professional Education

Medical/Professional School:		Program Director:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Degree Received:	Begin Date (mm/yy):	Grad Date (mm/yy):	

Internship

Institution:		Program Director:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Specialty:	From (mm/yy):	To (mm/yy):	
Did you successfully complete the program? ❑ Yes ❑ No (If "No," please explain on a separate sheet)			

Residencies/Fellowships Include residencies, fellowships, preceptorships, and postgraduate education in chronological order. Include ALL programs you attended, whether or not completed.

Institution:		Program Director:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Type of training (residency, fellowship, etc.):		Specialty:	
From (mm/yy):	To (mm/yy):	Did you successfully complete the program? ❑ Yes ❑ No (If "No," please explain on a separate sheet)	

VI. Education, Training, Experience - *Continued*

Residencies/Fellowships - Continued

Institution:		Program Director:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Type of training (residency, fellowship, etc.):		Specialty:	
From (mm/yy):	To (mm/yy):	Did you successfully complete the program? ❑ Yes ❑ No (If "No," please explain on a separate sheet)	

Institution:		Program Director:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
Type of training (residency, fellowship, etc.):		Specialty:	
From (mm/yy):	To (mm/yy):	Did you successfully complete the program? ❑ Yes ❑ No (If "No," please explain on a separate sheet)	

VII. Medical Licensure & Certifications *This section must be completed. Please do not type "See CV"*

CA Medical License:		Issue Date:	Exp. Date:
DEA:	Schedules:	Issue Date:	Exp. Date:
CDS (if applicable):		Issue Date:	Exp. Date:
ECFMG # (foreign graduates):		Issue Date:	Exp. Date:
NPI:	Medi-Cal #:	Medicare PTAN:	

Other Certifications (e.g., Fluoroscopy, Radiography, BLS, ACLS, PALS, etc.)

Type of Certification:	License Number:	Exp. Date:

Board Certifications Include certifications by boards which are organized/recognized by: American Board of Medical Specialties, American Osteopathic Association, Medical Board of California, Accreditation Council of Graduate Medical Education

Name of Issuing Board:	Certificate Number:	Date Certified/Recertified:	Expiration Date:

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

If so, list board(s) and date(s) applied:

VIII. Hospital & Institutional Affiliations ***This section <u>must</u> be completed. Please <u>do not</u> type "See CV"***

Please list is reverse chronological order (current affiliations first) all institutions where you have current affiliations and have had previous hospital privileges. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheets.

Current Affiliations

Affiliation Name:		Department:	
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
Status:	From (mm/yy):	To (mm/yy):	

Affiliation Name:		Department:	
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
Status:	From (mm/yy):	To (mm/yy):	

Affiliation Name:		Department:	
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
Status:	From (mm/yy):	To (mm/yy):	

Affiliation Name:		Department:	
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
Status:	From (mm/yy):	To (mm/yy):	

If you do not have hospital privileges, please explain. Practitioners without hospital privileges must provide a written plan for continuity of care:

Previous Affiliations

Affiliation Name:		Department:	
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
Status:	From (mm/yy):	To (mm/yy):	
Reason for leaving:			

VIII. Hospital & Institutional Affiliations - *Continued*

Previous Affiliations - Continued

Affiliation Name:		Department:	Status:
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
From (mm/yy):	To (mm/yy):	Reason for leaving:	

Affiliation Name:		Department:	Status:
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
From (mm/yy):	To (mm/yy):	Reason for leaving:	

Affiliation Name:		Department:	Status:
Address:	City:	State:	Zip:
Medical Staff Phone:		Medical Staff Fax:	
From (mm/yy):	To (mm/yy):	Reason for leaving:	

IX. Work History ***This section must be completed. Please do not type "See CV"***

Chronologically list all work history activities since completion of post graduate training. This information must be complete. Please do not type "See CV." Any gaps greater than six months will need to be explained on a separate sheet.

Practice:		Contact Name:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
From (mm/yy):	To (mm/yy):	Reason for leaving:	

Practice:		Contact Name:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
From (mm/yy):	To (mm/yy):	Reason for leaving:	

Practice:		Contact Name:	
Address:	City:	State:	Zip:
Phone:	Fax:	Email:	
From (mm/yy):	To (mm/yy):	Reason for leaving:	

X. Professional Liability

Please list all of your professional liability carriers for the past five years, listing the most recent first.

Insurance Carrier:				Policy #:	
Address:		City:		State:	Zip:
Phone:	Fax:	Email:			
Claim Amount: $	Aggregate Amount: $		Eff. Date:		Exp. Date:

Insurance Carrier:				Policy #:	
Address:		City:		State:	Zip:
Phone:	Fax:	Email:			
Claim Amount: $	Aggregate Amount: $		Eff. Date:		Exp. Date:

Insurance Carrier:				Policy #:	
Address:		City:		State:	Zip:
Phone:	Fax:	Email:			
Claim Amount: $	Aggregate Amount: $		Eff. Date:		Exp. Date:

XI. Professional and Practice Services

What type of anesthesia do you provide in your group/office?

❑ None ❑ General ❑ Local ❑ Regional ❑ Conscious Sedation ❑ Other (please specify):

If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver.

Tax ID:	Type of Service Provided:	Billing Name:
Do you have a CLIA Certificate? ❑ Yes ❑ No	Do you have a waiver? ❑ Yes ❑ No	
CLIA Certificate #:	CLIA Certificate Exp. Date:	

Have you or your office received any of the following accreditations, certificates or licensures?

❑ Child Health and Disability Prevention Program (CHDP)

❑ California Children Services

❑ Medicare Certification

❑ The Medical Quality Commission (TMQC)

❑ Comprehensive Perinatal Services Program (CPSP)

❑ Family Planning

❑ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

❑ Institute for Medical Quality-Accreditation Association for Ambulatory Health Care (IMQ-AAAHC)

❑ Other (please specify):

XII. Gap Explanation: *Please provide a brief explanation to explain any gaps of time longer than six months during Education/Training, Work History and/or Coverage Period with Malpractice Carriers.*

Gap Begin Date:	Gap End Date:
Explanation:	

Gap Begin Date:	Gap End Date:
Explanation:	

Gap Begin Date:	Gap End Date:
Explanation:	

XIII. HIV/AIDS Specialist Delegation

This legislation requires standing referrals to HIV/AIDS specialists for patients who need continued care for their HIV/AIDS. The Department of Managed Health Care (DMHC) defined an HIV/AIDS specialist under Regulation LS-34-01. In order to comply with this regulation, we need to identify appropriately qualified specialists within our network who meet the definition of an HIV/AIDS specialist. We will use your information for internal referral procedures and for publication listing in the Provider Directory. As always, if information about your practice changes, please notify us promptly.

❑ No, I do not wish to be designated as an HIV/AIDS specialist.

❑ Yes, I wish to be designated as an HIV/AIDS specialist based on the below criteria: (***Please choose from the following)***

- ❑ I am credentialed as an "HIV Specialist" by the American Academy of HIV Medicine; ***OR***
- ❑ I am Board Certified in HIV Medicine or have earned a Certificate of Added Qualification in the field of HIV Medicine granted by a member board of the American Board of Medical Specialties; ***OR***
- ❑ I am Board Certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
  - ❑ In the immediately preceding 12 months, I have clinically managed medical care to a minimum of 25 patients who are infected with HIV; ***AND***
  - ❑ In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both of HIV infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; ***OR***
- ❑ I am Board Certified in Infectious Disease by a member board of the American Board of Medical Specialties and meet the following qualifications:
  - ❑ In the immediately preceding 24 months, I have clinically managed medical care to a minimum of 20 patients who are infected with HIV; ***AND***
    - ❑ In the immediately preceding 12 months, I have obtained board certification or re-certification in the field of infectious disease from a member board of the American Board of Medical Specialties; ***OR***
    - ❑ In the immediately preceding 12 months, I have successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both of HIV infected patients; ***OR***
    - ❑ In the immediately preceding 12 months, I have successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment or both, of HIV-infected patients and successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV Medicine.

PRINT NAME: _____

SIGNATURE: _____ Date: _____

XIV. Attestation Questions

Please answer the following questions. If you answer "Yes" to any of the questions, please provide full details on a separate sheet.

Licensure	
Has your license, registration or certification to practice in your profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation, or any conditions or limitations by any state or professional licensing, registration or certification board?	❑ Yes ❑ No
Has there been any challenge to your licensure, registration or certification?	❑ Yes ❑ No
Hospital Privileges and Other Affiliations	
Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal, or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	❑ Yes ❑ No
Have you voluntarily or involuntarily surrendered, limited your privileges, or not reapplied for privileges while under investigation?	❑ Yes ❑ No
Have you ever been terminated for cause, or not renewed for cause, from participation or been subject to any disciplinary action by any managed care organization (including HMOs, PPOs, or provider organizations such as IPAs or PHOs)?	❑ Yes ❑ No
Education, Training and Board Certification	
Were you ever placed on probation, disciplined, formally reprimanded, suspended, or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?	❑ Yes ❑ No
Have you ever, while under investigation, or to avoid investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship or any other clinical education program?	❑ Yes ❑ No
Have any of your board certifications or eligibility ever been revoked?	❑ Yes ❑ No
Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?	❑ Yes ❑ No
Have you ever been denied certification/recertification by a specialty board, or has your eligibility, certification, or recertification status changed (other than changing from eligible to certified?)	❑ Yes ❑ No
DEA or CDS	
Has your Federal DEA or State Controlled Dangerous Substance (CDS) Certificate or authorization ever been challenged, denied, suspended, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?	❑ Yes ❑ No
Medicare, Medi-Cal or Other Governmental Program Participation	
Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted, in regard to participation in Medicare or Medi-Cal, or in regard to other federal or state government health care plans or programs?	❑ Yes ❑ No
Other Sanctions or Investigations	
Are you currently the subject of an investigation by any hospital, licensing authority, DEA, CDS authorizing entities, education or training program, Medicare or Medi-Cal program, or any other private, federal or state health care program, or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse, or a sexual offence or sexual misconduct?	❑ Yes ❑ No
To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?	❑ Yes ❑ No

XIV. Attestation Questions -- Continued

Have you ever received sanctions from, or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?	❑ Yes ❑ No
Have you ever been convicted of, plead guilty to, pled nolo contendare to, sanctioned, reprimanded, restricted, disciplined, or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct?	❑ Yes ❑ No
Are you currently being investigated, or have you ever been sanctioned, reprimanded, or cautioned by a military hospital, facility or agency, or voluntarily terminated or resigned while under investigation or in exchange for no investigation by a hospital or healthcare facility or any military agency?	❑ Yes ❑ No
Professional Liability Insurance Information and Claims History	
Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?	❑ Yes ❑ No
Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history?	❑ Yes ❑ No
Have you ever had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past ten years? If yes, provide information for each case using Addendum B.	❑ Yes ❑ No
Are there any filed and served professional liability lawsuits pending against you?	❑ Yes ❑ No
Have you ever practiced without professional liability coverage when you were required to have it?	❑ Yes ❑ No
Criminal/Civil History	
Have you ever been convicted of, plead guilty to, or pled nolo contendare to any felony?	❑ Yes ❑ No
In the past ten years, have you been convicted of, plead guilty to, or pled nolo contendare to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offence or sexual misconduct?	❑ Yes ❑ No
Have you ever been court-martialed for actions related to your duties as a medical professional?	❑ Yes ❑ No
Ability to Perform Job	
Are you currently engaged in the illegal use of drugs?	❑ Yes ❑ No
Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?	❑ Yes ❑ No
Do you have a current or pending enrollment in a drug and/or alcohol treatment program?	❑ Yes ❑ No
Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?	❑ Yes ❑ No
Do you have any reason to believe that you are not able to perform the essential mental and physical functions of a practitioner in your area of practice with or without reasonable accommodation?	❑ Yes ❑ No
Continuing Education Attestation – If you answer "No" to this question, please provide full details on a separate sheet.	
I hereby state that I have completed my Continuing Medical Education credit units for the last two years. 25 hours of CME's for each year required or a combined total of 50 CME's used in the renewal of my medical licensure.	❑ Yes ❑ No

I hereby affirm that the information submitted in this section 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: _____

SIGNATURE: _____ Date: _____

XV. Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance ("credentialing information") by and between KOVA Healthcare, Inc. and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical 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 recredentialing 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 peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state 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 KOVA Healthcare, Inc. and its employees, engaged in quality assessment, peer review and credentialing on behalf of KOVA Healthcare, Inc., and all persons and entities providing credentialing information to such representatives of KOVA Healthcare, Inc., from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in KOVA Healthcare. Inc., 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 KOVA Healthcare, Inc. 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 KOVA Healthcare, Inc. immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify KOVA Healthcare, Inc. in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California 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 medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board 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 any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medi-Cal programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

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 physician participation agreement.

A photocopy of this document shall be as effective as the original.

PRINT NAME: _____

SIGNATURE: _____ Date: _____

XVI. Practitioner Rights

Right to Review: The practitioner has the right to review information obtained by KOVA Healthcare, Inc. for the purpose of evaluating that practitioner's credentialing/recredentialing application. This includes non-privileged information obtained from any outside source, but does not extend to review of information, references or recommendations protected by law from disclosure. The practitioner may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at KOVA Healthcare, Inc. The Credentialing Department will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

Right to be Informed of the Status of Credentialing/Recredentialing Application: Practitioners may request status of their credentialing/recredentialing application. The practitioner may request this information by sending a letter, email or fax to the Credentialing Department at KOVA Healthcare, Inc. The provider will be notified no more than seven working days of the status of the application with respect to outstanding information required to complete the application process.

Notification of Discrepancy: Practitioners will be notified when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information with substantial variance include reports of malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these have not been disclosed by the practitioner on the application. Practitioners will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

Correction of Erroneous Information: If a practitioner believes that erroneous information has been supplied to KOVA Healthcare, Inc. by primary sources, the practitioner may correct such information by submitting written notification to the Credentialing Department. Practitioners must submit a detailed explanation to the Credentialing Department at KOVA Healthcare, Inc. within 48 hours of notification to the practitioner of the discrepancy or within 24 hours of a practitioner's review of his/her credentials file. Upon receipt of notification from the practitioner, KOVA Healthcare, Inc. will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the file. The practitioner will be notified that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the practitioner. The practitioner may then provide proof of correction by the primary source body to KOVA Healthcare, Inc.'s Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

KOVA Healthcare, Inc. Credentialing Department Address:
7257 N. Maple Ave., Ste 104, Fresno, CA 93720

XVII. Affirmative Statement

Affirmative Statement Regarding Incentives for Utilization Management Decisions

KOVA requires that all utilization related decisions regarding member coverage and or services must be based on appropriateness of care and service and existence of coverage. Also, these decisions may not be influenced by any financial reward or incentive. KOVA will not allow any reward or incentive that could discourage appropriate care.

KOVA does not reward providers, employees, or other individuals for issuing denials of coverage or service care. All denials must be based strictly on a lack of medical appropriateness or benefit coverage.

UM Decisions for members must be based only on appropriateness of care and service and existence of coverage. KOVA does not specifically reward practitioners or other individuals (directly or indirectly) for issuing denials of coverage or service care; financial incentives for UM decision makers do not encourage decisions that result in underutilization. KOVA ensures that contracts with physicians do not encourage or contain financial incentives for denial coverage or service.

Practitioners are ensured independence and impartiality in making referral decisions that will not influence: hiring, compensation or financial gain, termination, promotion, and any other similar matters. Any applicable state or federal mandated policies supersede the plan's policy and the KOVA policy.

Reference: National Committee for Quality Assurance (NCQA) Utilization Management (UM) Standard 4, Element F: Affirmative Statement About Incentives

ACKNOWLEDGMENT

I acknowledge that I have read and understand this Affirmative Statement.

PRINT NAME: _____

SIGNATURE: _____ Date: _____

XVIII. Professional Liability Action Explanation

Please complete this form for EACH pending, settled or otherwise concluded professional liability lawsuit or arbitration filed and served against you, in which you were named a party in the past seven years, whether the lawsuit or arbitration is pending, settled or otherwise concluded, and whether or not any payment was made on your behalf by any insurer, company, hospital or other entity. All questions must be answered completely in order to avoid delay in expediting your application. If there is more than one professional liability lawsuit or arbitration action, please copy this Addendum B prior to completing, and complete a separate form for each.

❑ ***Please check here if there are no claims to report and proceed to next page for signature. <u>Please Note:</u> Signature IS REQUIRED even if there are no claims to report.***

I. Practitioner Identifying Information

Last Name:	First Name:	Middle:

II. Case Information

Patient Name:	Patient Gender: ❑ Male ❑ Female	Patient DOB:
City, County, State where lawsuit filed:		
Court Case Number, if known:	Date of Alleged Incident:	Date suit filed:

Location of Incident: ❑ Hospital ❑ My Office ❑ Surgery Center ❑ Other (specify):

Relationship to Patient (Attending Physician, Surgeon, Consultant, etc.):

Allegation:

Is/Was there an insurance company or other liability protection company or organization providing coverage/defense of the lawsuit or arbitration action? ❑ Yes ❑ No

If yes, please provide company name, contact person, phone number, location and carrier's claim identification number, or other liability protection company or organization information:

If you would like us to contact your attorney regarding any of the above, please provide attorney's name and phone number. Please fax this document to your attorney as this will serve as your authorization.

Name:	Phone:	Fax:

III. Status of Lawsuit/Arbitration

Please check all that apply:

❑ Lawsuit/arbitration still ongoing or unresolved.

❑ Judgment rendered, and payment was made on my behalf. Amount paid on my behalf: _____

❑ Judgment rendered, and I was found not liable.

❑ Lawsuit/arbitration settled, and payment made on my behalf: Amount paid on my behalf: _____

❑ Lawsuit/arbitration settled/dismissed, no judgment rendered, no payment made on my behalf.

IV. Summary

Summarize the circumstances giving rise to the action. If the action involves patient care, provide a narrative, with adequate clinical detail, including your description of your care and treatment of the patient. If more space is needed, attach additional sheets.

Please include:
1. Condition and diagnosis at the time of incident.
2. Dates and description of treatment rendered
3. Condition of patient subsequent to treatment

SUMMARY

I certify that the information in this document and any attached documents is true and correct. I agree that KOVA Healthcare, Inc., its representatives, and any individuals or entities providing information to Kova Healthcare, Inc. in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this document, which is part of the Participating Practitioner Application. In order for the participating healthcare organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to KOVA Healthcare, Inc. information about my medical malpractice insurance coverage and information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless it is revoked by me in writing. I authorize the attorney(s) listed on page 1 of Addendum B to discuss any information regarding this case with KOVA Healthcare, Inc.

PRINT NAME: _____

SIGNATURE: _____ Date: _____