HEALTH POLICY AND ANALYTICS DIVISION
Office of Health Information Technology

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Oregon Health Authority

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Advisory Committee on Physician Credentialing Information (ACPCI) Members

October 2019

Chair **Valery Kriz, CPMSM** Oregon Regional Quality Management & Medical Staff Services Coordinator Providence Health & Services Hospital Representative Term expires: January 2020	**Khen T Lau, CPCS, MBA** Credentialing Manager Kaiser Permanente Northwest Health Care Service Contractor Representative Term expires: January 2020	**Mark A. Bonanno, JD, MPH** General Counsel & Director of Health Policy The Oregon Medical Association Health Care Practitioner Organization Representative Term expires: January 2021
Deborah S. Herman Director of Medical Staff Services McKenzie-Willamette Medical Center Hospital Representative Term expires: January 2022	**Dorothy-Jane O'Keeffe** Credentialing Coordinator PacificSource Health Plans Health Care Service Contractor Representative Term expires: January 2022	**Cindy Madden** Business Manager Baker Allergy, Asthma and Dermatology Health Care Practitioner Organization Representative Term expires: January 2020
Eric Novak Payer Credentialing Program Manager St. Charles Health System Hospital Representative Term expires: January 2022	**Hillary Parks** Credentialing Supervisor Moda Health Health Care Service Contractor Representative Term expires: January 2021	**Melissa Perry** Provider Relations & Credentialing PrimeCare Health Care Practitioner Organization Representative Term expires: January 2022

Staff	Luke Glowasky Operations & Policy Analyst Office: (503) 576-9041 Email: luke.a.glowasky@dhsoha.state.or.us

MINUTES

Advisory Committee on Physician Credentialing Information
Oregon Health Authority – Five Oak Building
Suite 875 Conference Room
421 SW Oak Street, Portland, OR 97209
November 20, 2018
2:00 – 4:00PM

Members Present: Valery Kriz, CPMSM, *Chair*; Mark Bonanno, JD, MPH (Phone); Danielle Coates, CPCS (Phone); Khen T Lau, CPCS, MBA; Cindy Madden; Eric Novak (Phone); Dorothy-Jane O'Keeffe (Phone); Hillary Parks; Melissa Perry (Phone).

Staff Present: Luke Glowasky; Rachel Ostroy.

Valery Kriz, Chair, called the Advisory Committee on Physician Credentialing Information (ACPCI) meeting to order at 2:03PM.

Minutes Review
The December 14, 2017 ACPCI draft meeting Minutes were reviewed. There was no discussion.

MOTION: To accept the December 14, 2017 Minutes without alteration. Two members abstained from voting. MOTION CARRIES: 7-0.

New Member Introductions
Luke Glowasky introduced Hillary Parks, a new health care services organization representative from Moda Health, and Melissa Perry, a new health care practitioner organization representative from PrimeCare.

Current Member Expirations
The Committee discussed current member expirations. Four positions will become vacant in January 2019.

Luke outlined the process for maintaining Committee membership including the possible need to go through a solicitation for new applicants. The upcoming vacancies include hospital representatives Danielle Coates and Eric Novak, health care services organization representative Dorothy-Jane O'Keeffe, and practitioner organization representative, Melissa Perry. Luke noted that in the past the Committee has allowed for members to remain on the ACPCI if they are willing and able since the group only meets once a year and needs experienced members. Members not seeking re-appointment may provide a recommendation for their replacement. Barring any objections and ensuring the replacement fulfills the statutory requirements for organizational representation on the Committee, the recommendations will be made to the Oregon Health Authority's (OHA's) director or designee for a final decision. If

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recommendations are not received from retiring members, current members may propose recommendations. If the Committee cannot agree on their own recommendations, there will be a formal call for applicants to fill those spots via OHA director or designee appointment.

All four members with expiring terms in 2019 agreed to remain on the Committee for additional three-year terms.

ACPCI Process Review
Luke provided an overview of the ACPCI and its process, and the impact of the Oregon Common Credentialing Program (OCCP) suspension. The ACPCI develops the content and format of the uniform applications used by credentialing organizations to credential and recredential health care practitioners in the State of Oregon, the Oregon Practitioner Credentialing Application (OPCA) and Oregon Practitioner Recredentialing Application (OPRA). The Committee meets at least once every calendar year to review and confirm that the applications comply with current credentialing standards and regulations. Prior to the meeting Oregon Health Authority (OHA), on behalf of the Committee, publicly solicits for application change suggestions. Those suggestions are reviewed and evaluated by the ACPCI at its annual meeting. Any Committee recommendations are brought to the Director of the OHA for approval.

The philosophy of the ACPCI is to ensure the OPCA and OPRA are kept as credentialing applications, i.e., contain the minimum uniform information required by credentialing accrediting entity standards and federal regulations. Changes should only be recommended by the Committee if they are needed to meet the requirements of an accreditation or regulatory body. In reviewing solicited change suggestions, the ACPCI should assess whether the changes are needed for credentialing or are just a convenience to credentialing organizations. Information with uses strictly outside of credentialing (e.g., languages spoken by provider, office hours, etc.), should not be included on the applications.

The OCCP was suspended in July 2018 and the Common Credentialing Advisory Group (CCAG) went on hiatus on August 1, 2018. Upon the start of OCCP operations, the OPRA would have been retired and replaced by regular practitioner attestations in the system. Moving forward, the OPRA and OPCA will continue to be managed by OHA staff based on ACPCI recommendations. The CCAG will no longer be consulted regarding ACPCI recommendations.

Review Solicited Suggestions
The Committee reviewed change suggestions to the Oregon Practitioner Credentialing and Recredentialing Applications submitted by interested parties and Members. ***See Attachment A for the specific conclusions of the Committee.***

MOTION: To accept the 2018 recommendations as amended and use the accepted 2018 recommendations as amended to revise the credentialing and recredentialing applications. MOTION CARRIES: 9-0.

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Mandating New Application Version Discussion
Luke lead the Committee in a discussion about mandating use of the new credentialing and recredentialing applications when they are next updated. Currently the 2012 versions of the applications are required for use by credentialing organizations and practitioners. The 2017 OPCA version was never made mandatory as it was intended to be the basis for the information gathered in the OCCP system, which would have replaced use of the paper applications. A summary of all updates made to the 2012 versions and reflected on the 2017 versions was reviewed by the Committee and included in the meeting materials.

Luke noted that OHA is considering whether to adopt requirements for use of the newest application versions via administrative rulemaking and is seeking input from the ACPCI as to the potential cost and value of this action. Hillary commented that organizations would not be greatly impacted by a transition to a new version given adequate time, and that a mandate to a newer version is overdue. Danielle noted that the changes made since the 2012 versions are not substantial and do provide value in meeting accrediting entity requirements and were based on recommendations from the Committee.

OHA will consider the feedback received from the Committee relating to mandating new application versions. After the 2019 legislative session, OHA intends to remove or amend the currently adopted administrative rules relating to use of the OCCP (OAR 409-045-0025 through 0135). Any changes to the mandated credentialing and recredentialing application versions would be part of this rulemaking process.

Public Comment
There was no public comment.

Next Steps
Recommendations will be brought to the Director of the OHA for review and final approval or denial. Any approved changes to the credentialing and/or recredentialing applications will be made and published by OHA in new versions of the applications. The Committee will meet again in late 2019.

Adjournment
The meeting was adjourned at 3:45PM.

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Suggestions for the Oregon Practitioner Credentialing and Recredentialing Applications
For ACPCI Consideration - November 2018

No.	Suggestions	Action	Notes
1	Page 6 Section XIV. Health Care Licensure, Registrations, Certificates & ID Numbers Suggest that "Group" NPI be added to the Licensure page since most groups have "employed providers" and require a Group NPI for billing anyway.	Accepted, as Amended	-Melissa commented that almost all health plan providers are employed providers so the Group NPI is a requirement when building their file at the health plans -Danielle commented that in the past the Committee has assessed suggestions based on compliance with accrediting standards rather than operational convenience, and this change is not an accreditation requirement for health plans. -Group agreed that placement of this field on the OPCA is important and that Group NPI is specific to individual employers/practices not to the provider themselves. -Add Entity type 2 (group) NPI number field to Practice and Employment Information section (OPCA page 3 Section VI; OPRA page 3 Section VI). -Accepted 9-0.
2	OPCA Page 7 Section XVI. Hospital and Other Health Care Facility Affiliations (A. Current Affiliations) and OPRA Section XII a. Remove the following section asking "If you do not have hospital admitting privileges, check here": **If you do not have hospital admitting privileges, check here: ☐** **Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.** b. Add the option for the provider to indicate whether or not they can admit at each hospital affiliation (similar to Washington and Idaho applications). CMS allows plans to accept attestation of hospital privileges and the ability to admit, but the checkbox in the current application is often missed and more plans are less likely to accept attestation of this element, causing the credentialing process to take longer.	Accepted, as Amended	-Dorothy noted that CMS requires verification of whether or not provider is able to admit and that the admitting privileges question is currently used as a provider attestation to meet this requirement. -Can be discrepancies caused by current wording, i.e., not checking the box implies provider has admitting privileges when it might have just been an oversight. Causes credentialing process to take longer. -Add question, "Do you have admitting privileges at this facility? Yes □ No □", to each entry in the Current Affiliations sub-section of the Hospital and Other Health Care Affiliations section (OPCA page 7 Section XVI; OPRA page 5 Section XII). -Amend the "If you do not have hospital admitting privileges, check here: □. Please explain...plan for continuity of care..." instruction to read: "If you do not have admitting privileges at any of the affiliations listed in this section, please explain on a separate sheet your plan for continuity of care for your patients who require admitting." (OPCA page 7 Section XVI; OPRA page 5 Section XII). -Accepted 9-0

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No.	Suggestions	Action	Notes
3	To help reduce the burden of printing multiple pages, I would like to recommend that the applications in fillable PDF file format be updated/changed to allow a provider to type in their initials & date on the individual pages within the PDF file. These fields are not "fillable" in the 2017 versions and thus require printing and manual insertion. Note: No changes to the signature pages are needed, which would still require a provider's signature.	Accepted, as Amended	-Danielle commented that each non-signature page where information is collected needs to have initials and date fields for providers to use if they make amendments to that page. Those initials/dates can be input electronically. Khen confirmed that Kaiser also follows this policy. -Group agreed that this change, as amended, should be made when application forms are next updated. -Accept change as written and additionally remove initials and date fields from page 1 of OPCA and OPRA as no information is collected on these pages -Accepted 9-0
4	From my prior work related to Provider Data, a question about primary care providers being a continuity provider, something like "may health plans assign patients to this provider on their ongoing primary care provider panel" is missing from the current application. Suggest adding this question.	Not Accepted	-Dorothy commented that this change is not required for credentialing; more for directory purposes. Better death with outside of the credentialing form. -Denied 9-0.
5	Page 3 Section VI. Practice and Employment Information: Suggest changing wording from "Effective Date at Location, Month/Year:" to "Provider's Effective Date at this Location, Month/Year:". The hope is that this will clean up confusion that comes from when groups either enter the effective date of the location itself rather than when the provider started there.	Accepted, as Amended	-Cindy and Hillary commented that this field causes confusion on the provider/office manager side. Mark and Erik disagreed: this is an application specific to the provider - it is clear that the effective date refers to the provider at the location not the date the practice moved to the current location. This could be cleared up with more education vs. form changes -Start date for the provider with each current/previous practice or employer is collected in Work History section (XVII). Some members do not believe that the start date at a clinic's current physical location is needed from a regulatory standpoint and should be removed. -Remove "Effective date at location, month / year" questions from Practice and Employment Information section (OPCA page 3 Section VI; OPRA page 3 Section VI). -Accepted 7-2. Mark and Erik opposed.

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No.	Suggestions	Action	Notes
6	(1) Page 3 Section VI. Practice and Employment Information - Add fields for: a. Telehealth at the practice location with the ability to list telehealth services available. b. Interpreter services at the practice location with the ability to list the services available.	Not Accepted	-Group thinks this is outside the scope of credentialing. -Denied 9-0.
	(2) Page 2 Section II. Practitioner Information: Add a third checkbox, "X", to the gender question to indicate non-binary.	Accepted	-Accepted as written 8-0 (1 abstaining).
	(3) Page 2 Section III. Specialty Information: Add fields for specialty taxonomy codes.	Not Accepted	-Taxonomy is not a regulatory issue. -Denied 9-0.
	(4) Page 3 Section VI. Practice and Employment Information - Add fields for: a. Multiple choice question for practice setting information: Clinic/Group; Solo Practice; Home Based; Hospital Based; Primary Care Site; Urgent Care b. Practice website c. Organizational NPI at the practice location d. Office hours e. ADA at the practice location	Not Accepted	-Not required for credentialing. -Denied 9-0.
	(5) Page 7 Section XVI. Current Affiliation sub-section: Have boxes to select affiliation status rather than free-form comment field.	Not Accepted	-Not required for credentialing. -Denied 9-0.
	(6) OPCA Page 8 Section XVII. Professional Practice / Work History: Remove does not apply checkbox.	Accepted	-Group agreed that this change, as written, should be made when application forms are next updated. -Accepted 8-0 (1 abstaining).

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No.	Suggestions	Action	Notes
7	Suggest ACPCI consider allowing organizations that employ an electronic provider data collection system to also use the initial credentialing application for recredentialing purposes. In an electronic data collection environment, paper applications are an output of data providers enter into the system. No need for provider to fill out different forms as the data necessary for both credentialing and recredentialing – which is the same data – is housed in the system and can be automatically populated into the credentialing application. Provider can attest to the application via an electronic signature and then print the application directly from the system. The NCQA supports this approach. Original intent of a separate recredentialing application form was to reduce provider burden by not requiring the manual re-submission of data that typically doesn't change between credentialing cycles. Utilizing a paper re-credentialing application is more burdensome to the provider, and more costly and complex to manage. With a paper recredentialing process, providers are compelled to revert to having to complete multiple forms (that request the same information) for different plans at different points of time during a year. An electronically updated initial credentialing application would contain all the data that would be captured on the recredentialing application without placing any additional burden on providers.	Not Accepted	-No statute or rule prohibits credentialing organizations or credentials verification organizations from using the OPCA form for recredentialing purposes in lieu of the OPRA. -Denied 9-0.
8	OPCA Page 6 Section XIV Health Care Licensure, Registrations, Certificates & ID Numbers (OPRA page 4 Section X) "DMAP number," a question in this section of the OPCA, is no longer the official term for the Oregon Medicaid identifier number. This question should be changed to match the correct identifier terminology, i.e., "Oregon Medicaid Provider ID".	Accepted, as Amended	-Accept change as written and additionally remove "DMAP" from the Glossary. -Accepted 9-0.

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No.	Suggestions	Action	Notes
9	OPCA/ OPRA Page 3 Section VI Practice and Employment Information Delete "(if different from above)" from the "Credentialing Contact and Address" field in the sub-sections for primary and secondary practice/affiliation or clinic. Causes unnecessary confusion for providers.	Accepted	-Accepted 9-0.

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Oregon Health Authority

CHARTER – Advisory Committee on Physician Credentialing Information (updated August 2019)

Authority

Established by House Bill (HB) 2144 (1999) and codified in 2017 Oregon Revised Statute (ORS) 441.221-223, the Advisory Committee on Physician Credentialing Information (ACPCI) develops the uniform applications used by hospitals and health plans to credential and recredential health care practitioners within the State of Oregon. Under ORS 441.221-223, the Oregon Health Authority (OHA) must convene an advisory group at least once a calendar year that consists of health care practitioners licensed by the Oregon Medical Board or representatives of health care practitioners' organizations doing business within the State of Oregon, representatives of hospitals licensed by OHA, and representatives of health care service contractors that have been issued a certificate of authority to transact health insurance in this state by the Department of Consumer and Business Services. This group will advise OHA on the implementation of ORS 441.221-223.

Advisory Group Scope

The ACPCI shall develop and submit recommendations to OHA for the collection of uniform information necessary for credentialing organizations to credentialing health care practitioners seeking designation as a participating provider or member of a credentialing organization. The recommendations must specify:

(a) The content and format of the Oregon Practitioner Credentialing Application (OPCA) form; and
(b) The content and format of the Oregon Practitioner Recredentialing Application (OPRA) form.

The Committee consists of nine members appointed by the Director of the OHA as follows:

(a) Three members who are health care practitioners licensed by the Oregon Medical Board or representatives of health care practitioners' organizations doing business within the State of Oregon;
(b) Three representatives of hospitals licensed by the Oregon Health Authority; and
(c) Three representatives of health care service contractors that have been issued a certificate of authority to transact health insurance in this state by the Department of Consumer and Business Services.

Process

The process of the ACPCI providing recommendations, and any subsequent amendments to the OPCA/OPRA forms is documented in the flowchart in Appendix A.

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Membership, Roles & Responsibilities

ACPCI Chair

Valery Kriz, CPMSM - Oregon Regional Quality Management & Medical Staff Services Coordinator, Providence Health & Services, Hospital Representative

ACPCI Members

Mark A. Bonanno, JD, MPH **-** General Counsel & Director of Health Policy, The Oregon Medical Association, Health Care Practitioner Organization Representative

Deborah S. Herman, CPCS, CPMSM – Directory of Medical Staff Services, McKenzie-Willamette Medical Center, Hospital Representative

Khen T Lau, CPCS, MBA - Credentialing Manager, Kaiser Permanente Northwest, Health Care Service Contractor Representative

Cindy Madden - Business Manager, Baker Allergy, Asthma and Dermatology, Health Care Practitioner Organization Representative

Eric Novak - Payer Credentialing Program Manager, St. Charles Health System, Hospital Representative

Dorothy-Jane O'Keeffe - Credentialing Coordinator, PacificSource Health Plans, Health Care Service Contractor Representative

Hillary Parks - Credentialing Supervisor, Moda Health, Health Care Service Contractor Representative

Melissa Perry - Provider Relations & Credentialing, PrimeCare, Health Care Practitioner Organization Representative

OHA Staff
Luke Glowasky, HIT Portfolio Program Analyst, Office of Health Information Technology

Meeting Schedule

The ACPCI convenes at least once each calendar year, typically in the Fall or Winter. Public meeting notices are posted to the Committee's website at: https://www.oregon.gov/oha/hpa/ohit-acpci/pages/index.aspx.

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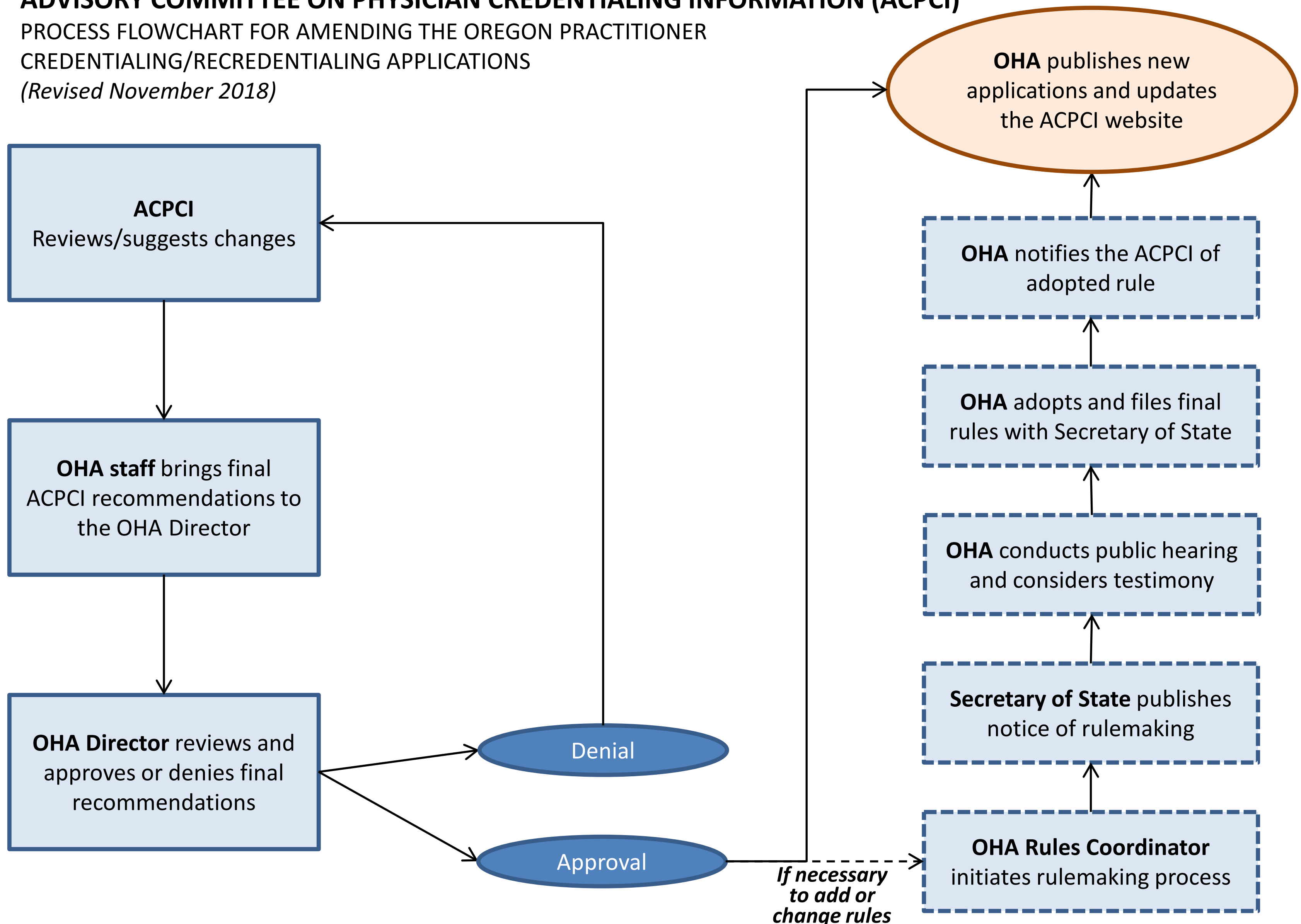
Appendix A

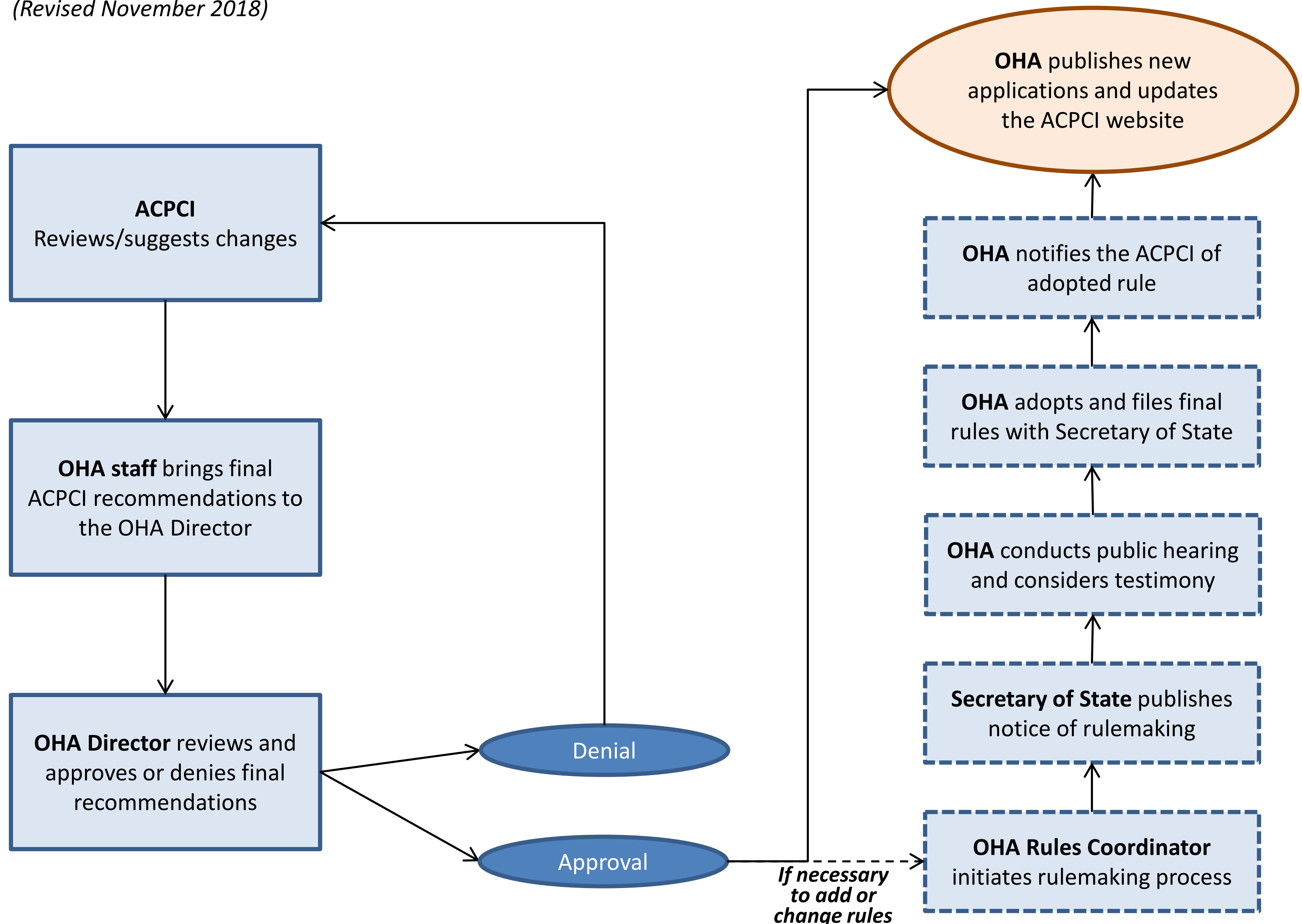


Prepared By: *The Office of Health Information Technology*

ADVISORY COMMITTEE FOR PHYSICIAN CREDENTIALING INFORMATION (ACPCI)

PROCESS FLOWCHART FOR AMENDING THE OREGON PRACTITIONER CREDENTIALING/RECREDENTIALING APPLICATIONS

(Revised November 2018)



Prepared By: *The Office of Health Information Technology*

Suggestions for the Oregon Practitioner Credentialing and Recredentialing Applications
For ACPCI Consideration - October 2019

No.	Received	Source	Suggestions	Notes
1	9/10/2019	Jennifer Richardson, Rebound Physical Therapy, LP	Allow the initials on each page to be typed in as on the 2012 version. Central Credentialing completes the application with the providers initials, application is then sent to the provider for review, if no changes or updates needed then the Provider only has to sign the last 3 signature pages of the application.	This change was approved in 2018 and will be included on 2019 applications.
2	9/25/2019	Hannah Wuilliez, Linn County Health Services	(1) OPCA Page 2 Section II. Practitioner Information-Phone Numbers **Suggestion:** Change “Home telephone number” and “Mobile /alternate number” to “Primary telephone number” and “Secondary telephone number”. **Reason:** Several providers no longer have home phone numbers, but may have a work number they would like to list secondary to their mobile phone number, or vice versa.	
			(2) OPCA Page 8 Section XVII. Professional Practice/Work History- Professional Liability Carrier **Suggestion:** Include a “does not apply” checkbox in the Professional Liability Carrier field for each previous practice/employer. **Reason:** Several providers have work history related to their degree, but were not required to have Professional Liability Insurance with their previous employer. Leaving the field blank or even typing “none” does not satisfy all insurance companies.	Adding "(if applicable)" to the field is consistent with other fields on the application and may conserve space.

OREGON PRACTITIONER CREDENTIALING APPLICATION

- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT A)**

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RECREDENTIAL PRACTITIONERS WITHIN THE STATE OF OREGON.

REVIEWED, AMENDED & APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
APRIL 26, 2017

OREGON PRACTITIONER CREDENTIALING APPLICATION

Prior to completing this credentialing application, please read and observe the following:

I. Instructions

This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 11, Attestation Questions and page 12, Authorization and Release of Information Form (and Attachment A, Professional Liability Action Detail, if applicable)**.
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.**
- **Submit application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG (if applicable)
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

***Note: Please return completed application to the health care related organization to which you are applying not to the State of Oregon.**

Initials: __________ Date: _______________

OREGON PRACTITIONER CREDENTIALING APPLICATION

II. Practitioner Information

Please provide the practitioner's full legal name.

Last Name (include suffix; Jr., Sr., III):	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? Yes ☐ No ☐
Name(s) and Year(s) Used:

Home street address:	Home telephone number: - -	Mobile/alternate number: - -
	Email address:	
City:	State:	ZIP:
Country:	Birth date: Month / Day / Year	Birth place:
Citizenship:	Social Security number:	Gender: Male ☐ Female ☐

Immigrant Visa number *(if applicable)*:	Visa expiration date:	Status:	Type:
Educational Commission for Foreign Medical Graduates (ECFMG) number *(if applicable)*:		Month / Year Issued:	

III. Specialty Information

This information may be included in directory listings.

Principal clinical specialty **(For most current specialties list, see: http://www.wpc-edi.com/codes):**	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐
Additional clinical practice specialties:	

Category of professional activity, check all boxes that apply:

Clinical practice:

☐ Full Time ☐ Part Time
☐ Locum / Temporary ☐ Telemedicine
☐ Other (explain)

Other professional activities:

☐ Administration ☐ Teaching
☐ Research ☐ Retired
☐ Other (explain)

IV. Board Certification / Recertification

This section does not apply to licensure.

Does not apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name and address of issuing board	Specialty	Date certified/ recertified month/year	Expiration date *(if any)* month/year

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.

Initials: __________ Date: _______________

V. Other Certifications

Please attach copy of certificate(s), if applicable.

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type:	Number:	Month / Year of certification:	Month / Year of expiration:
Type:	Number:	Month / Year of certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of certification:	Month / Year of Expiration:
Type:	Number:	Month / Year of certification:	Month / Year of Expiration:

For additional certifications, please attach a separate sheet.

VI. Practice and Employment Information

Name of primary practice/affiliation or clinic:		Department name *(if hospital based):*	
Primary Clinical Practice street address:		Effective date at location, month / year:	
City:	County:	State:	ZIP:
Primary office telephone number: - - Ext.	Primary office fax number: - -	Patient appointment telephone number: - - Ext.	
Mailing/Billing Address (if different from above):			Attn:
Office manager:	Office manager's telephone number: - - Ext.	Office manager's fax number: - -	
Exchange / answering service number: - - Ext.	Pager number: - -	Office email address:	
Credentialing Contact and Address (if different from above):			
Credentialing contact's telephone number: - - Ext.	Credentialing contact's fax number: - -	Credentialing contact's email address:	
Federal tax ID number or social security number, if used for business purposes:		Name affiliated with tax ID number:	
Name of secondary practice/affiliation or clinic:		Department name *(if hospital based):*	
Secondary Clinical Practice street address:		Effective date at location, month / year:	
City:	County:	State:	ZIP:
Primary office telephone number: - - Ext.	Primary office fax number: - -	Patient appointment telephone number: - - Ext.	
Mailing/Billing Address (if different from above):			Attn:
Office manager:	Office manager's telephone number: - - Ext.	Office manager's fax number: - -	
Exchange / answering service number: - - Ext.	Pager number: - -	Office email address:	
Credentialing Contact and Address (if different from above):			
Credentialing contact's telephone number: - - Ext.	Credentialing contact's fax number: - -	Credentialing contact's email address:	
Federal tax ID number or social security number, if used for business purposes:		Name affiliated with tax ID number:	

Please list other office locations with above information on a separate sheet.

Initials: __________ Date: _______________

VII. Practice Call Coverage

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

Name:	Specialty:
1.	
2.	
3.	
4.	
5.	

VIII. Undergraduate Education

Please attach additional sheets, if necessary.

Complete school name and street address:	Degree received:		Month / year of start:
			Month / year of graduation:
City:	State:	Course of study or major:	

IX. Graduate Education

Please attach additional sheets, if necessary.

Does not apply ☐

Complete school name and street address:	Degree received:		Month / year of start:
			Month / year of graduation:
City:	State:	Course of study or major:	

X. Medical / Professional Education

Please attach additional sheets, if necessary.

Complete medical / professional school name and street address:		
City:	State	ZIP:
Degree received:	Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:

Did you complete the program? Yes ☐ No ☐ **(if you did not complete the program, please explain on a separate sheet.)**

Complete medical / professional school name and street address:		
City:	State	ZIP:
Degree received:	Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:

Did you complete the program? Yes ☐ No ☐ **(if you did not complete the program, please explain on a separate sheet.)**

XI. Post-Graduate Year 1 / Internship *Please attach additional sheets, if necessary.*

Does not apply ☐

Complete institution name and street address:			
City:		State	ZIP:
Type of internship / specialty:		Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:	
Did you complete the program? Yes ☐ No ☐	**(if you did not complete the program, please explain on a separate sheet.)**		

XII. Residencies *Please attach additional sheets, if necessary.*

Does not apply ☐

Complete institution name and street address:			
City:		State	ZIP:
Specialty:		Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:	
Did you complete the program? Yes ☐ No ☐	**(if you did not complete the program, please explain on a separate sheet.)**		

Complete institution name and street address:			
City:		State	ZIP:
Specialty:		Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:	
Did you complete the program? Yes ☐ No ☐	**(if you did not complete the program, please explain on a separate sheet.)**		

XIII. Fellowships, Preceptorships, or Other Clinical Training Programs

Please attach additional sheets, if necessary.

Does not apply ☐

Complete institution name and street address:			
City:		State	ZIP:
Specialty:		Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:	
Did you complete the program? Yes ☐ No ☐	**(If you did not complete the program, please explain on a separate sheet.)**		

Complete institution name and street address:			
City:		State	ZIP:
Specialty:		Phone number: - -	Fax number, if available - -
From month / year:	To month / year:	Month / year of completion:	
Did you complete the program? Yes ☐ No ☐	**(if you did not complete the program, please explain on a separate sheet.)**		

Initials: __________ Date: _______________

XIV. Health Care Licensure, Registrations, Certificates & ID Numbers

Please attach additional sheets, if necessary.

Oregon license or registration number:	Type:	Month / Day / Year of Expiration:
Drug Enforcement Administration (DEA) registration number (if applicable):		Month / Day / Year of Expiration:
Controlled substance registration (CSR) number (if applicable):		Month / Day / Year of Issue:
Entity type 1 (individual) NPI number:	Medicare number:	DMAP number:
Physician Assistant Supervising Physician Full Name and Oregon License Number:		

XV. Other State Health Care Licenses, Registrations & Certificates

Please include all ever held.

Does not apply ☐

State / Country:	Number:	Type:
Year obtained:	Month / Day / Year of expiration:	Year relinquished:
Reason:		

State / Country:	Number:	Type:
Year obtained:	Month / Day / Year of expiration:	Year relinquished:
Reason:		

State / Country:	Number:	Type:
Year obtained:	Month / Day / Year of expiration:	Year relinquished:
Reason:		

State / Country:	Number:	Type:
Year obtained:	Month / Day / Year of expiration:	Year relinquished:
Reason:		

State / Country:	Number:	Type:
Year obtained:	Month / Day / Year of expiration:	Year relinquished:
Reason:		

Please attach additional sheets, if necessary.

Initials: __________ Date: _______________

XVI. Hospital and Other Health Care Facility Affiliations

Please list in reverse chronological order, with the current affiliation(s) first, all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include (A) current affiliations, (B) applications in process, and (C) previous hospitals, and other facility affiliations (e.g., hospitals, surgery centers or any other health care related facility). **If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XVII, Professional Practice/Work History.**

A. Current Affiliations

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / day / year of appointment		
Professional liability carrier:			
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / day / year of appointment		
Professional liability carrier:			
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / day / year of appointment		
Professional liability carrier:			
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / day / year of appointment		
Professional liability carrier:			

If you do not have hospital admitting privileges, check here: ☐
Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

B. Applications In Process

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / day / year of submission		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
Status (e.g. active, courtesy, provisional, allied health, etc.):	Month / day / year of submission		

C. Previous Affiliations

Please attach additional sheets, if necessary.

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year:	To month / day / year:		
Professional liability carrier:	Reason for leaving:		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year:	To month / day / year:		
Professional liability carrier:	Reason for leaving:		
Facility name:	Phone number: - -	Fax number, if available - -	Complete address:
From month / day / year:	To month / day / year:		
Professional liability carrier:	Reason for leaving:		

XVII. Professional Practice / Work History

Curriculum vitae is not sufficient.

Does not apply ☐

A. **Please account for all periods of time from the date of entry into medical/professional school to present. Chronologically list all work, professional and practice history activities since completion of postgraduate training, including military service. Please explain in section B any gaps greater than two (2) months. <u>Please attach additional sheets, if necessary.</u>**

Name of current practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year:	To month / year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year:	To month / year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year:	To month / year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year:	To month / year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year:	To month / year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice / employer:		Contact's name:
Telephone number: - - Ext	Fax number: - -	Complete address:
From month / year:	To month / year:	
Contact's email address, if available:		Professional liability carrier:

B.	**<u>Please explain any gaps greater than two (2) months</u>. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.**	Does not apply ☐

Activities and/or names:	From month / year:	To month / year:

XVIII. Peer References

Please list three (3) references, from peers who through recent observations are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: - - ext	Fax number: - -	Email address, if available:
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: - - ext	Fax number: - -	Email address, if available:
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: - - ext	Fax number: - -	Email address, if available:

XIX. Continuing Medical Education

Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.

Does not apply ☐

Name:	**Month / year attended:**	**Hours:**
Name:	**Month / year attended:**	**Hours:**
Name:	**Month / year attended:**	**Hours:**
Name:	**Month / year attended:**	**Hours:**
Name:	**Month / year attended:**	**Hours:**
Name:	**Month / year attended:**	**Hours:**

XX. Professional Liability Insurance

Current insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (check one): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective:	Month / day / year retroactive date, if applicable:		Month / day / year of expiration:

Please list all previous professional liability carriers within the past five (5) years.
Please attach additional sheets, if necessary.

Does not apply ☐

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (check one): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective:	Month / day / year retroactive date, if applicable:		Month / day / year of expiration:

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (check one): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective:	Month / day / year retroactive date, if applicable:		Month / day / year of expiration:

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (check one): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective:	Month / day / year retroactive date, if applicable:		Month / day / year of expiration:

Insurance carrier / provider of professional liability coverage:		Policy number:	Type of coverage (check one): Claims-made ☐ Occurrence ☐
Name of local contact:		Mailing address:	
Contact's telephone number: - - Ext	Fax number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / day / year effective:	Month / day / year retroactive date, if applicable:		Month / day / year of expiration:

XXI. 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.	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.	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.	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 relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES ☐	NO ☐
D.	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.	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.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES ☐	NO ☐
G.	Have you **ever** voluntarily or involuntarily left or been discharged from the education program leading to your current licensure or any subsequent training programs?	YES ☐	NO ☐
H.	Have you **ever** had board certification revoked?	YES ☐	NO ☐
I.	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.	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.	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.	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:**

OREGON PRACTITIONER CREDENTIALING 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 Credentialing 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 Credentialing Application will invalidate the application.

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

- **APPLICATION**
- **PROFESSIONAL LIABILITY ACTION DETAIL (ATTACHMENT B)**

PURPOSE: ESTABLISHED BY HOUSE BILL 2144 (1999), THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI) DEVELOPS THE UNIFORM APPLICATIONS USED BY HOSPITALS AND HEALTH PLANS TO CREDENTIAL AND RECREDENTIAL PRACTITIONERS WITHIN THE STATE OF OREGON.

REVIEWED, AMENDED AND APPROVED
BY THE ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION (ACPCI)
APRIL 26, 2017

OREGON PRACTITIONER RECREDENTIALING APPLICATION

Prior to completing this recredentialing application, please read and observe the following:

I. Instructions

This form should be **typed** ***(using a different font than the form)*** **or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

- **Modification to the wording or format of the Oregon Practitioner Recredentialing Application will invalidate the application.**
- **Complete the application in its entirety. Keep an unsigned and undated copy of the application on file for future requests. When a request is placed, send a copy of the completed application to the health care related organization to which you are applying, making sure that all information is complete, current and accurate.**
- **Please sign and date page 9, Attestation Questions and page 10, Authorization and Release of Information Form** ***(and Attachment A, Professional Liability Action Detail, if applicable)***.
- **Each page of the application requires the applicant's initials and the date on which the application was last reviewed.**
- **Attach copies of the documents requested each time the application is submitted.**
- **If a section does not apply to you or your practitioner type, please check the "Does Not Apply" box at the top of the section.**
- **Submit application to the requesting organization(s).**

Current copies of the following documents must be submitted with this application:

- State Professional License(s)
- DEA Certificate or CSR Certificate
- ECFMG *(if applicable)*
- Face Sheet of Professional Liability Policy or Certificate

A curriculum vitae is optional and not an acceptable substitute.

***Note: Please return completed application to the health care related organization to which you are applying, not to the State of Oregon.**

OREGON PRACTITIONER RECREDENTIALING APPLICATION

II. Practitioner Information

Please provide the practitioner's full legal name.

Last name *(include suffix; Jr., Sr., III)*:	First:	Middle:	Degree(s):

Is there any other name under which you have been known or have used since starting professional training? Yes ☐ No ☐
Name(s) and year(s) used:

Home street address:	Home telephone number: - -	Mobile/alternate number: - -
	Email address:	
City:	State:	ZIP:
Country:	Birth date (month/day/year):	Birth place:
Citizenship:	Social Security number:	Gender: Male ☐ Female ☐
Immigrant visa number (if applicable):	Visa expiration date:	Type:

III. Specialty Information

This information may be included in directory listings.

Principal clinical specialty ***(For most current specialties list, see: http://www.wpc-edi.com/codes.)***:	Do you want to be designated as a primary care practitioner (PCP)? Yes ☐ No ☐
Additional clinical practice specialties:	

Category of professional activity, check all boxes that apply:

Clinical practice:

☐ Full time ☐ Part time
☐ Locum/temporary ☐ Telemedicine
☐ Other *(explain)*:

Other professional activities:

☐ Administration ☐ Teaching
☐ Research ☐ Retired
☐ Other *(explain)*:

IV. Board Certification/Recertification

This section does not apply to licensure.

Does not apply ☐

List all current and past certifications. Please attach additional sheets, if necessary.

Name and address of issuing board	Specialty	Date certified/recertified month/year	Expiration date *(if any)* month/year

If not currently board certified, describe your intent for certification, if any, and dates of previous testing and/or intended future testing for certification below. Please attach additional sheets, if necessary.

V. Other Certifications

Please attach copy of certificate(s), if applicable. Does not apply ☐

Examples include: ACLS, BLS, ATLS, PALS, NRP, AANA, Fluoroscopy, Radiography, etc.

Type:	Number:	Month/year of certification:	Month/year of expiration:
Type:	Number:	Month/year of certification:	Month/year of expiration:
Type:	Number:	Month/year of certification:	Month/year of expiration:
Type:	Number:	Month/year of certification:	Month/year of expiration:

For additional certifications, please attach a separate sheet.

VI. Practice And Employment Information

Name of primary practice/affiliation or clinic:	Department name *(if hospital based)*:		
Primary clinical practice street address:	Effective date at location, month/year:		
City:	County:	State:	ZIP:
Primary office telephone number: - - Ext.:	Primary office fax number: - -	Patient appointment telephone number: - - Ext.:	
Mailing/billing address *(if different from above)*:	Attn:		
Office manager:	Office manager's telephone number: - - Ext.:	Office manager's fax number: - -	
Exchange/answering service number: - - Ext.:	Pager number: - -	Office email address:	
Recredentialing contact and address *(if different from above)*:			
Recredentialing contact's telephone number: - - Ext.:	Recredentialing contact's fax number: - -	Recredentialing contact's email address:	
Federal tax ID number or Social Security number, if used for business purposes:	Name affiliated with tax ID number:		
Name of secondary practice/affiliation or clinic:	Department name *(if hospital based)*:		
Secondary clinical practice street address:	Effective date at location, month/year:		
City:	County:	State:	ZIP:
Secondary office telephone number: - - Ext.:	Secondary office fax number: - -	Patient appointment telephone number: - - Ext.:	
Mailing/billing address *(if different from above):*	Attn:		
Office manager:	Office manager's telephone number: - - Ext.:	Office manager's fax number: - -	
Exchange/answering service number: - - Ext.:	Pager number: - -	Office email address:	
Recredentialing contact and address *(if different from above)*:			
Recredentialing contact's telephone number: - - Ext.:	Recredentialing contact's fax number: - -	Recredentialing contact's email address:	
Federal tax ID number or Social Security number, if used for business purposes:	Name affiliated with tax ID number:		

Please list other office locations with above information on a separate sheet.

VII. Practice Call Coverage

Please provide the name and specialty of those practitioners who provide care for your patients when you are unavailable.

NAME:	SPECIALTY:
1.	
2.	
3.	
4.	
5.	

VIII. Additional Education

If you have completed additional residencies, internships or advanced specialized education within the past three (3) years, please provide the following information. Please attach additional sheets, if necessary.

Does not apply ☐

Complete name and street address of program:

City:	State:	ZIP:

Specialty:	Phone number: - -	Fax number, if available: - -
From month/year:	To month/year:	Month/year of completion:

Did you complete the program? Yes ☐ No ☐ ***(If you did not complete the program, please explain on a separate sheet.)***

Complete name and street address of program:

City:	State:	ZIP:

Specialty:	Phone number: - -	Fax number, if available: - -
From month/year:	To month/year:	Month/year of completion:

Did you complete the program? Yes ☐ No ☐ ***(If you did not complete the program, please explain on a separate sheet.)***

IX. Continuing Medical Education

Please list activities for which you have received CME credit(s) during the past two (2) years. Please attach a separate sheet, if needed.

Does not apply ☐

Name:	Month/year attended:	Hours:
Name:	Month/year attended:	Hours:
Name:	Month/year attended:	Hours:
Name:	Month/year attended:	Hours:
Name:	Month/year attended:	Hours:

X. Health Care Licensure, Registrations, Certificates and ID Numbers

Please attach additional sheets, if necessary.

Oregon license or registration number:	Type:	Month/day/year of expiration date:
Drug Enforcement Administration (DEA) registration number *(if applicable)*:		Month/day/year of expiration date:
Controlled substance registration (CSR) number *(if applicable)*:		Month/day/year issued:
Entity Type 1 (Individual) NPI number:	Medicare number:	OMAP number:
Physician Assistant Supervising Physician Full Name and Oregon License Number:		

XI. Other State Health Care Licenses, Registrations and Certificates

Please attach additional sheets, if necessary

Does not apply ☐

State/country:	Number:	Type:
Year obtained:	Month/day/year of expiration:	Year relinquished:
Reason:		
State/country:	Number:	Type:
Year obtained:	Month/day/year of expiration:	Year relinquished:
Reason:		
State/country:	Number:	Type:
Year obtained:	Month/day/year of expiration:	Year relinquished:
Reason:		

XII. Hospital and Other Health Care Facility Affiliations

Please list for the past three (3) years all health care institutions where you have and/or have had clinical privileges and/or staff membership. Include all (A) affiliations in the past three (3) years, and/or (B) applications in process *(i.e., hospitals, surgery centers or any other health care related facility)*. **If more space is needed, please attach additional sheets. Do not list residencies, internships or fellowships. Please list employment in Section XIII, Professional Practice/Work History.**

A. Affiliations in the Past Three (3) Years

Facility name:	Phone number: - -	Fax number, if available: - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/day/year of appointment:		
Professional Liability Carrier:			
Facility name:	Phone number: - -	Fax number, if available: - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/day/year of appointment:		
Professional Liability Carrier:			
Facility name:	Phone number: - -	Fax number, if available: - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/day/year of appointment:		
Professional Liability Carrier:			

If you do not have hospital admitting privileges, check here: ☐

Please explain on a separate sheet your plan for continuity of care for your patients who require admitting.

B. Applications in Process

Does not apply ☐

Facility name:	Phone number: - -	Fax number, if available: - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/year of submission:		
Facility name:	Phone number: - -	Fax number, if available: - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/year of submission:		
Facility name:	Phone number: - -	Fax number, if available: - -	Complete address:
Status *(e.g. active, courtesy, provisional, allied health, etc.)*:	Month/year of submission:		

XIII. Professional Practice/Work History *A curriculum vitae is not sufficient.*

A. Please chronologically list and account for work, professional and practice history activities **for the past three (3) years** to present, including military service. **Please explain in section B any gaps greater than two (2) months.**
Please attach additional sheets, if necessary.

Name of current practice/employer:		Contact's name:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice/employer:		Contact's name:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month/year:	To Month/year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice/employer:		Contact's name:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month / Year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice/employer:		Contact's name:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice/employer:		Contact's came:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice/employer:		Contact's name:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

Name of previous practice/employer:		Contact's name:
Telephone number: - - Ext.:	Fax number: - -	Complete address:
From month/year:	To month/year:	
Contact's email address, if available:		Professional liability carrier:

B.	Please explain any gaps greater than two (2) months in the past three (3) years. Include activities and/or names and dates where applicable. Please attach additional sheets, if necessary.	Does not apply ☐

Activities and/or names:	From month/year:	To month/year:

XIV. Peer References

Please list three (3) references, from peers who through recent observations, are directly familiar with your clinical skills and current competence. Do not include relatives. If possible, include at least one member from the Medical Staff of each facility at which you have privileges.

Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: - - Ext.:	Fax number: - -	Email address, if available:
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: - - Ext.:	Fax number: - -	Email address, if available:
Name of reference:		Complete address, include department if applicable:
Specialty:		
Professional relationship:		
Telephone number: - - Ext.:	Fax number: - -	Email address, if available:

XV. Professional Liability Insurance

Current Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: - - Ext.:	Fax Number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		Month / Day / Year of Expiration:

Please list all previous professional liability carriers within the past three (3) years. Please attach additional sheets, if necessary. Does Not Apply ☐

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: - - Ext.:	Fax Number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		Month / Day / Year of Expiration:

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: - - Ext.:	Fax Number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		Month / Day / Year of Expiration:

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: - - Ext.:	Fax Number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		Month / Day / Year of Expiration:

Insurance Carrier / Provider of Professional Liability Coverage:		Policy Number:	Type of Coverage (check one): Claims-Made ☐ Occurrence ☐
Name of Local Contact:		Mailing Address:	
Contact's Telephone Number: - - Ext.:	Fax Number, if available: - -		
Per claim limit of liability:	Aggregate amount:	Contact's email address, if available:	
Month / Day / Year Effective:	Month / Day / Year Retroactive Date, if applicable:		Month / Day / Year of Expiration:

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 relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, 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 relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, 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 the education program leading to your current licensure or any 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:**

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.

Attachment B

Professional Liability Action Detail — Confidential

Please list any past or current professional liability claim or lawsuit, which has been filed against you **in the past five (5) years. 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:

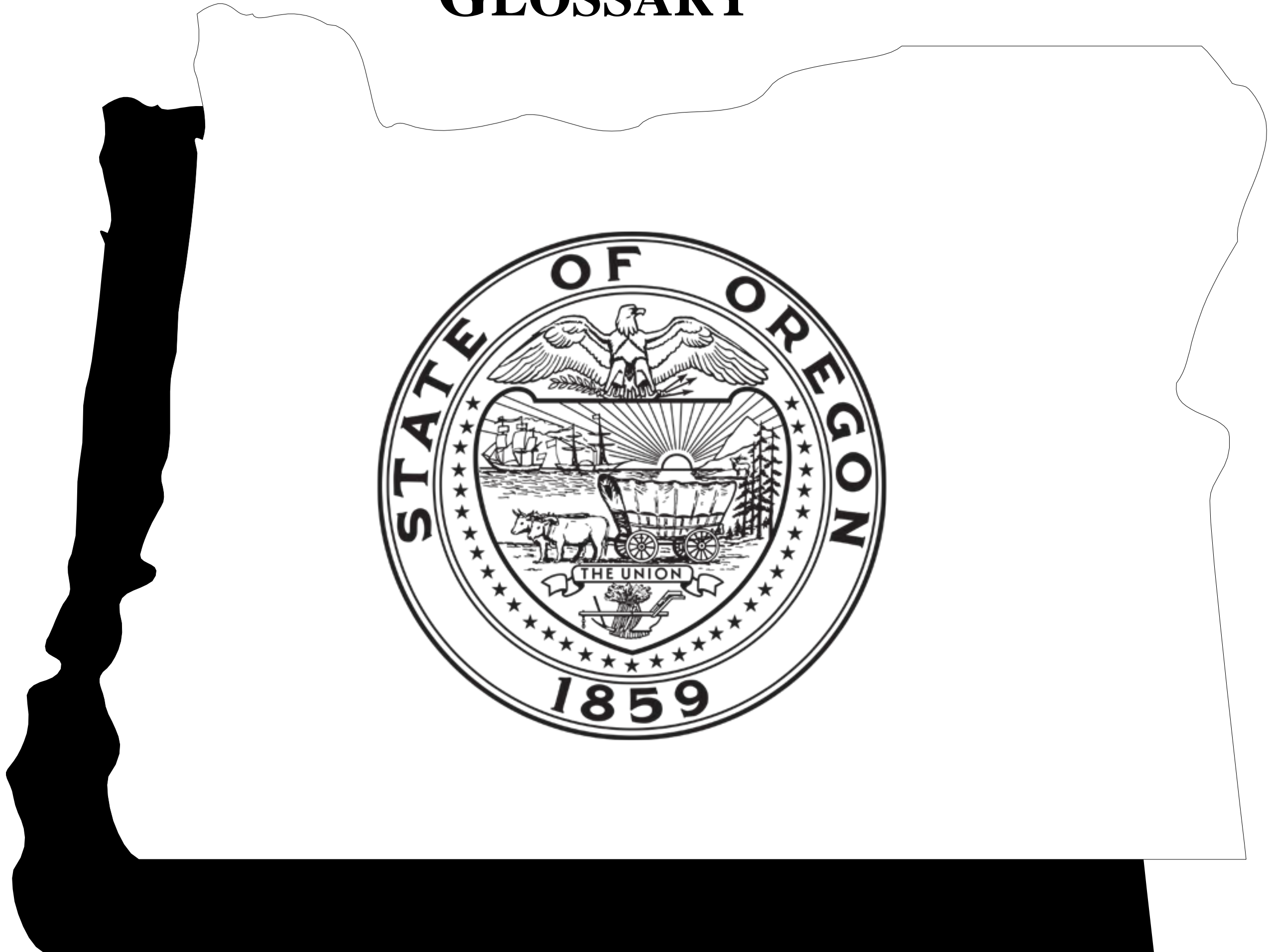
If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

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 Recredentialing Application will invalidate the application.

OREGON PRACTITIONER CREDENTIALING APPLICATION GLOSSARY



GLOSSARY OF TERMS AND ACRONYMS

AAAHC: Accreditation Association for Ambulatory Health Care — an organization that offers voluntary accreditation for ambulatory care organizations.

ACUMENTRA: Oregon Medical Professional Review Organization — a private, non-profit organization that contracts to undertake appropriateness of care, utilization management and quality improvement projects for the CMS, other public agencies and insurance companies.

ACCREDITATION: A comprehensive, standardized evaluation process that involves assessing the degree to which an organization/individual complies with a defined set of standards.

ACGME: Accreditation Council for Graduate Medical Education — this organization is responsible for the Accreditation of post-M.D. medical training programs within the United States. Accreditation is accomplished through a peer review process and is based upon established standards and guidelines.

ACLS: Advanced Cardiac Life Support.

ADMITTING PRIVILEGES: The right granted to a doctor to admit patients to a particular hospital.

AGENT: An insurance company representative licensed by the state, who solicits, markets, negotiates, binds and administers contracts of insurance.

AGPA: American Group Practice Association.

AHA: American Hospital Association.

AHP: Allied Health Personnel - Specially trained and licensed, or registered when required by Oregon law, health workers who perform tasks, which might otherwise be performed by physicians or nurses.

AMA: American Medical Association.

ANA: American Nurses Association.

ANCILLARY SERVICES: Supplemental health care services provided to a person while being treated. Included are laboratory, radiology, physical therapy, etc.

ATLS: Advanced Trauma Life Support.

ATTESTATION: A signed statement indicating that a practitioner personally confirmed the validity, correctness, and completeness of his or her credentialing/recredentialing application.

BHC: Behavioral Health Care — a broad array of mental health, chemical dependency, forensic, mental retardation or developmental disabilities and cognitive rehabilitation services provided in settings such as acute, long term and ambulatory care.

BLS: Basic Life Support.

CALL COVERAGE: Practitioners who provide care for your patients when you are unavailable.

CLAIM PENDING: A current request by the insured for indemnification by the insurance company for a loss that is a covered peril.

CLAIMS-MADE COVERAGE: A policy providing liability coverage only if a written claim is made during the policy period or any applicable extended reporting period. For example, a claim made in the current year could be charged against the current policy even if the injury or loss occurred many years in the past. If the policy has a retroactive date, an occurrence prior to that date is not covered. *(contrast with Occurrence Coverage).*

CME: Continuing Medical Education.

CMS: Centers for Medicare and Medicaid Services — The federal agency that administers funds and oversees provision of medical care to Medicare and Medicaid patients.

COA: Certificate of Authority — a certificate issued by a state government, licensing the operation of a health maintenance organization.

CON: Certificate of Need — a certificate issued by a government body to an individual or organization proposing to construct or modify a health facility, acquire major new medical equipment or offer a new or different health service.

CONTINUITY OF CARE: The provision of care by the same set of practitioners over time or, if the same practitioners are not available, a mechanism to promptly provide appropriate clinical information to the practitioners who continue to provide the same type and level of care.

COORDINATION OF CARE: The mechanisms ensuring that patients and practitioners have access to, and take into account, all required information on patient condition and treatment to ensure that the patient receives appropriate health care services.

COVERAGE: The services for which an insurance policy does and does not pay.

CPR: Cardio-Pulmonary Resuscitation.

CREDENTIALING/RECREDENTIALING: The process of determining eligibility, for organizations such as hospitals or PHOs, for medical staff membership and privileges to be granted to physicians. Credentials and performance are periodically reviewed, which could result in physician privileges being denied, modified or withdrawn.

CSO: Clinical Service Organization — a medical center integrating the activities of the medical school, faculty practice plan and hospital to negotiate with managed care plans.

CSR: Controlled Substance Registration.

CVO: Credential Verification Organization — a group that provides a centralized, uniform process for state medical boards, private and governmental entities to obtain a verified, primary source record of a physician's core medical credentials by gathering, verifying and permanently storing a physician's credentials in a centralized repository.

DCO: Direct Contracting Organization — individual employers or business coalitions contract directly with providers for health care services with no HMO/PPO intermediary.

DEA: Drug Enforcement Agency — the federal agency that issues licenses to prescribe and dispense scheduled drugs.

DMAP: Division of Medical Assistance Programs — a state agency that acts as the administrator for the Medicaid component of the Oregon Health Plan.

ECFMG: Educational Commission for Foreign Medical Graduates — a certification process that assesses the readiness of graduates of foreign medical schools to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduate Medical Education (ACGME).

EPO: Exclusive Provider Organization - A managed care organization that designates specific physicians and other providers who can provide health care services.

EXCLUSIONS: The specific conditions or circumstances listed in an insurance policy for which the policy will not provide benefit payments.

HCFA: See CMS.

HMO: Health Maintenance Organization — an organized health care system that is accountable for both the financing and delivery of a broad range of comprehensive health services to an enrolled population. An HMO is accountable for assessing access and ensuring quality and appropriate care. Health care services are rendered by practitioners affiliated with the health care system. In these types of managed care organizations, in order to receive reimbursement, members must obtain all services from an affiliated practitioner or provider and must comply with a pre-defined authorization system.

HSA: Health Systems Agency — a health-planning agency created under the National Health Planning and Resource Development Act of 1974.

ID: Identification.

INCIDENT REPORT: The documentation for any unusual problem, incident, or other situation that is likely to lead to undesirable effects or that varies from established health department licenses, policies, procedures and/or practices.

INDEMNIFICATION: Insurance benefits paid to or on behalf of an insured for the provision of goods and services covered by the policy.

INSURANCE: Protection by written contract against financial hazards *(in whole or in part)* of the happenings of specified fortuitous events.

INSURED: A person or organization, covered by an insurance policy, including the "named insured" and any other parties for whom protection is provided under the policy.

INSURER: The party to the insurance contract who promises to pay losses or benefits or a corporation engaged primarily in the business of furnishing insurance.

INTERNSHIP: Receiving supervised practical experience in the health care field, usually as an advanced or graduate student, also referred to as post-graduate year 1 (PGY1).

IPA: Independent Practice Association — a federation of independently-practicing physicians and/or other practitioners organized to contract with health plans and other third party payers as to the conditions under which medical services will be covered for insured patients with the understanding that said conditions shall be considered and independently agreed to by each practitioner or legally-integrated group of practitioners belonging to the IPA.

IPN: Integrated Provider Network — a group comprised of primary and secondary hospitals, physicians and other health care practitioners within a city or other geographic area.

ISN: Integrated Service Network — a group comprised of a combination of physicians and other health care providers who deliver health care in an integrated way.

LAPSED POLICY: A policy terminated for non-payment of premiums.

LOCUM TENENS: The act of a practitioner temporarily taking the place of another practitioner.

MALPRACTICE: Professional misconduct or lack of ordinary skill in the performance of a professional act, which renders the responsible practitioner liable to suit for damages.

MCO: Managed Care Organization — any type of organizational entity providing managed care such as an HMO, PPO, and EPO, etc.

MEDICAID: A joint federal and state-funded health care program for low-income families and individuals or disabled persons.

MEDICARE: Federal health insurance administered by CMS. It is the nation's largest health insurance program, which provides health insurance to people age 65 and over, those who have permanent kidney failure and certain people with disabilities.

NA (N/A): Not Applicable.

NCHSR: National Center for Health Services Research.

NCQA: National Committee for Quality Assurance — an independent non-profit organization that has worked with consumers, health care purchasers, state regulators and the manage care industry in developing standards that evaluate the structure and function of medical and quality management systems in managed care organizations.

NEGLIGENCE: The failure to use the reasonable care that a prudent person would have used under the same or similar circumstances.

NIMH: National Institute of Mental Health.

NPI: National Provider Identification number, a unique health identification number for health care providers, became an HIPAA (Health Insurance Portability and Accountability Act of 1996) standard by May 23, 2007 for most covered health care entities and May 23, 2008 for small health plans. There are two types of health care providers in terms of NPIs:

- Entity Type 1 NPI providers: Health care providers who are individuals, including physicians, dentists, and all sole proprietors. An individual is eligible for only one NPI.
- Entity Type 2 NPI providers: Health care providers who are organizations, including physician groups, hospitals, nursing homes, and the corporation formed when an individual incorporates him/herself.

NON-PARTICIPATING PROVIDER: Physicians/providers and facilities that are not under contract as health providers for a HMO/PPO.

NOTICE OF CANCELLATION: A written notice by an insurance company of their intent to cancel the policy.

NRP: Neonatal Resuscitation Program.

OCCURRENCE COVERAGE: A policy form providing liability coverage only for injury or damage that occurs during the policy period, regardless of when the claim is actually made. For example, a claim made in the current policy year could be charged against a prior policy period, or may not be covered, if it arises from an occurrence prior to the effective date. *(contrast with Claims-Made Coverage)*

OHMO: Office of Health Maintenance Organizations — a component of the U.S. Department of Health and Human Services that is charged with the responsibility for directing the federal HMO program.

PALS: Pediatric Advanced Life Support.

PARTICIPATING PROVIDER: A physician or other health care practitioner who has contracted with a health plan to provide medical services to members.

PCG: Physician Care Groups — a classification system used to determine payment for physician services.

PCN: Primary Care Network — a group of primary care providers linked for purposes of administering health coverage.

PCP: Primary Care Provider — a physician or other health care practitioner who is responsible for monitoring an individual's overall health care needs.

PEER: Individual(s) in the same professional discipline as the applicant with personal knowledge of the applicant.

PERIL: The cause of a loss insured against in a policy.

PGY 1: Post-graduate Year 1 *(see Internship)*

PHO: Physician/Hospital Organization — a legal entity formed and owned by one or more hospitals and physician groups in order to obtain payer contracts and to further mutual interests.

POLICY: The term used for the legal document issued by the company to the policyholder, which outlines the conditions and terms of the insurance; also called the policy contract or the contract.

POS: Point of Service — a type of managed care coverage that allows members to choose to receive services either from participating HMO physicians and other health care practitioners and providers, or from those not in the HMO's network. Patients pay less for in-network care and for out-of-network care; members usually pay deductibles and a percentage of the cost of care.

PPO: Preferred Provider Organization — a network of doctors and hospitals that provide care to an enrolled population at a pre-arranged discounted rate.

PRACTITIONER: a physician or other licensed or registered health care professional qualified to render medical services.

PREMIUM: The amount paid for any insurance policy.

PRO: Peer Review Organization or Physician Review Organization.

PROFESSIONAL LIABILITY CLAIM: Written demand for money or services.

PROFESSIONAL LIABILITY INSURANCE: Insurance purchased by physicians and other health care providers to help protect themselves from financial risks associated with medical liability claims.

PROVIDER: An institution or organization, such as hospitals, home health agencies, and skilled nursing facilities, that provides services to patients.

PROVIDER TAXONOMY CODES: A provider classification system, which is a nationally recognized list of provider types and specializations, initially setup by the Centers for Medicare/Medicaid Services (CMS) with the intent to provide a single coding structure to support work on the National Provider System. The current list is now administered and published by the National Uniform Claim Committee (NUCC).

REHABILITATION SERVICE: An organization service providing medical, health-related, social and vocational services for disabled persons to help them attain or retain their maximum functional capacity.

RISK: The degree of probability of loss or the amount of possible loss to the insuring company.

SETTLEMENT: A policy benefit or claim payment. It refers to an agreement between both parties to the policy contract as to the amount and method of payment.

SNF: Skilled Nursing Facility — a nursing care facility participating in the Medicaid and Medicare programs which meets specified requirements for services, staffing and safety.

TAXONOMY CODES: See Provider Taxonomy Codes.

TELEMEDICINE: Using telecommunication technology to deliver health services, including but not limited to clinical diagnosis, clinical services, patient consultation and the practice of medicine across state lines.

TERM: The period of time a policy is in effect.

TJC: The Joint Commission — a private, not-for-profit organization that evaluates and accredits hospitals and other health care organizations providing home care, mental health care, ambulatory care and long term care services.

USMLE: United States Medical Licensing Examination — a certifying examination that fulfills requirements for medical licensure, as well as providing a common evaluation system for all applicants for medical licensure. Results of USMLE are reported to medical licensing authorities in the United States for use in granting the initial license to practice medicine.

Chapter 441

2017 EDITION

Oregon Revised Statutes 441.221 to 441.223

ADVISORY COMMITTEE ON PHYSICIAN CREDENTIALING INFORMATION

441.221 Advisory Committee on Physician Credentialing Information; membership; terms. (1) The Advisory Committee on Physician Credentialing Information is established within the Oregon Health Authority. The committee consists of nine members appointed by the Director of the Oregon Health Authority or the director's designee as follows:

(a) Three members who are health care practitioners licensed by the Oregon Medical Board or representatives of health care practitioners' organizations doing business within the State of Oregon;

(b) Three representatives of hospitals licensed by the Oregon Health Authority; and

(c) Three representatives of health care service contractors that have been issued a certificate of authority to transact health insurance in this state by the Department of Consumer and Business Services.

(2) All members appointed pursuant to subsection (1) of this section must be knowledgeable about national standards relating to the credentialing of health care practitioners.

(3) The term of appointment for each member of the committee is three years. If, during a member's term of appointment, the member no longer qualifies to serve as designated by the criteria of subsection (1) of this section, the member must resign. If there is a vacancy for any cause, the director or the director's designee shall make an appointment to become immediately effective for the unexpired term.

(4) Members of the committee are not entitled to compensation or reimbursement of expenses. [Formerly 442.800; 2015 c.318 §25; 2017 c.101 §33; 2017 c.384 §6]

Note: 441.221 to 441.223 were enacted into law by the Legislative Assembly but were not added to or made a part of ORS chapter 441 or any series therein by legislative action. See Preface to Oregon Revised Statutes for further explanation.

441.222 Committee recommendations. (1) The Advisory Committee on Physician Credentialing Information shall develop and submit recommendations to the Director of the Oregon Health Authority for the collection of uniform information necessary for credentialing organizations to credential health care practitioners seeking designation as a participating provider or member of a credentialing organization. The recommendations must specify:

(a) The content and format of a credentialing application form; and

(b) The content and format of a recredentialing application form.

(2) The committee shall meet at least once every calendar year to review the uniform credentialing information and to assure the director that the information complies with credentialing standards developed by national accreditation organizations and applicable regulations of the federal government.

(3) The Oregon Health Authority shall provide the support staff necessary for the committee to accomplish its duties. [Formerly 442.805; 2015 c.318 §26]

Note: See note under 441.221.

441.223 Implementation of committee recommendations; rules. (1) Upon receiving the recommendations of the Advisory Committee on Physician Credentialing Information, the Oregon Health Authority shall:

(a) Adopt administrative rules in a timely manner, as required by the Administrative Procedures Act, for the purpose of effectuating the provisions of ORS 441.221 to 441.223;

(b) Consult with the advisory group convened under ORS 441.232 to review the recommendations and obtain advice on the rules; and

(c) Ensure that the rules adopted by the Oregon Health Authority are identical and are consistent with the recommendations developed pursuant to ORS 441.222 for affected credentialing organizations.

(2) The uniform credentialing information required pursuant to the administrative rules of the Oregon Health Authority represents the minimum uniform credentialing information required by the affected credentialing organizations. Except as provided in subsection (3) of this section, a credentialing organization may request additional credentialing information from a health care practitioner for the purpose of completing credentialing procedures used by the credentialing organization to credential health care practitioners.

(3) In credentialing a telemedicine provider, a hospital is subject to the requirements prescribed by rule by the authority under ORS 441.056. [Formerly 442.807]

Note: See note under 441.221.