Dear Provider:

Thank you for your interest in becoming a Rocky Mountain Health Plans (RMHP) participating provider. To avoid delays in processing your credentialing request, please be sure the following information and documentation is included with your completed Credentialing Data Form.

- Current W-9
- Group roster, if you are part of a group practice
- Colorado Credentialing Application Signature Pages
- CV or five years of work history
- If you are using the Council for Affordable Quality Healthcare (CAQH) online application:
  - Be sure RMHP is authorized to view your application.
  - Please verify the professional claims history section of the disclosure information accurately reflects your complete claims history (settled, dismissed, etc.). If information is missing, please add it or complete the attached supplemental form, making copies as needed.

If your application is incomplete or missing documentation, the credentialing process will be suspended until all information is received.

Thank you for your diligence in ensuring your packet is complete.

Sincerely,

RMHP Provider Relations Team
Rocky Mountain Health Plans

ROCKY MOUNTAIN HEALTH PLANS®

Today's date:
Is the provider hospital based or a physician assistant?
If so, effective date:

CREDENTIALING DATA FORM

NAME Last:	**First:**	**MI:**	**Title (i.e. MD):**
Credentialing Contact Name:		**Phone:**	
Credentialing Contact Email:			
CAQH ID:		**Are you a primary care physician (PCP)?** ☐ **Y** ☐ **N**	
Provider's Degree (i.e. BA, MA):	**Specialty:**	**CO License #:**	
DOB:	**SSN:**	**DEA#:**	**Provider NPI:**
Supervising Physician (if a physician assistant):			
Is provider enrolled in the interChange as a participating provider through Health First Colorado (Colorado's Medicaid Program): ☐ **Y** ☐ **N** **State Location ID #:** **Date application approved:**			

GROUP/PRACTICE INFORMATION

Group Name:		**Tax ID:**	
Office Manager's Name:			
Office Manager's Email:			
Primary Practice Address:		**City:**	
State:	**Zip:**	**Phone:**	**Fax:**
Mailing Address:		**City:**	
State:	**Zip:**	**Phone:**	**Fax:**
Billing (Remit) Address:		**City:**	
State:	**Zip:**	**Phone:**	**Fax:**

ADDITIONAL PRACTICE ADDRESSES

Please attach additional practice addresses on a separate sheet.

Please fax completed form to RMHP Provider Relations:
Front Range: 303-967-2090
Southern Front Range: 303-967-2011
Western Slope: 970-244-7957

CAQH ID: _____ Provider's Name: _____

Indicate the number of the questions in **Section X. Professional Liability Insurance: Professional Claims History** on Page 17 to which you answered "yes":

Malpractice Claims Explanation

Supplemental Form

☐ **- N/A: I have never had a Malpractice Claim filed against me.**

*Required Response

+If you need additional space to explain a Yes response or have more than one case to document, photocopy this page as needed and submit as instructed.

***Date of Occurrence:** ***Date Claim was Filed:**

***Status of Claim:** (Note: If Case is Pending, Select Open): ☐ Open ☐Closed

***If settled, date claim was settled:**

Professional Liability Carrier Involved:

Number: Street: Suite/Building

City: State: Zip Code:

Telephone: Policy Number:

***Amount of Award or Settlement:**

***Method of Resolution? Please circle correct option:** ☐Dismissed ☐ Settled ☐ Mediation ☐ Arbitration ☐ Judgement for Defendant(s) ☐Judgement for Plaintiff(s)

***Description of Allegations:**

***Description of Alleged Injury to the patient:**

Did the alleged injury result in death? ☐ Yes ☐No

To the best of your knowledge, is the case included in the National Practitioner Data Bank (NPDB)? ☐Yes ☐No

XIII. ATTESTATION AND SIGNATURE

By signing this Application, I certify, agree, understand and acknowledge the following:

1. The information in this entire Application, including all subparts and attachments, is complete, current, correct, and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this Application may constitute cause for denial of my Application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement without right of hearing.
3. A photocopy of this Application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this Application on the most recent date indicated below and it continues to be true and complete.
5. While this Application is being processed, I agree to update the information originally provided should there be any change in the information.
6. No action will be taken on this Application until it is complete and all outstanding questions with respect to the Application have been resolved.
7. I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not per se an application for employment with the Entity and that acceptance of my application by the Entity may not result in my employment by the Entity.
8. I understand and agree that I will notify all credentialing entities to which I have submitted this Uniform Application of any and all changes to the information contained in this Application

This attestation statement and Application must be signed no more than 180 days prior to the credentialing decision date.

Please print your name: _____

_____
Signature

_____
Date

REMEMBER TO SAVE THE COMPLETED APPLICATION TO YOUR PERSONAL COMPUTER!

Schedule A

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM
Modified Releases Will Not Be Accepted

By submitting this Application, including all subparts and attachments, I acknowledge, understand consent and agree to the following:

1. 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), managed care organization network, medical society, professional association, medical school faculty position, other healthcare delivery entity or system, hereinafter referred to as a "Healthcare Entity")* indicated on this Application, I have the burden of producing adequate information for proper evaluation of this Application.
2. I also understand that I have the continuing responsibilities to resolve any questions, concerns or doubts regarding any and all information in this Application. If I fail to produce this information, then I understand that the Healthcare Entity will not be required to evaluate or act upon this Application. I also agree to provide updated information as may be required or requested by the Healthcare Entity or its authorized representatives or designated agents.
3. The Healthcare Entity and its authorized representatives or designated agents will investigate the information in this Application. I consent and agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Entity as a part of the verification and credentialing process.
4. I specifically authorize the Healthcare Entity and its authorized representatives and designated agents to obtain and act upon information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health status, emotional stability, utilization practices, professional licensure of certification, and any other matter related to my qualification or matters addressed in this Application (my "Qualifications")
5. I authorize all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, companies, agencies, licensing authorities, boards, plans, organizations, Healthcare Entities or others with which I have been associated as well as all professional liability insures with which I have had or currently have professional liability insurance, who may have information bearing on my Qualifications to consult with the Healthcare Entity and its authorized representatives and designated agents and to report, release, exchange and share information and documents with the Healthcare Entity, for the purpose of evaluating this application and my Qualifications.
6. I consent to and authorize the inspection of appropriate records and documents that may be material to an evaluation of this Application and my Qualifications and my ability to carry out the clinical privileges/services/participation I have requested. I authorize each and every individual and organization with custody of such records and documents to permit such inspection and copying as may be necessary for the evaluation of this Application. I also agree to appear for interviews, if required or requested by the Healthcare Entity, in regard to this Application.

7. I further consent to and authorize the release by the Healthcare Entity to other Healthcare Entities and interested persons on request of information the Healthcare Entity may have concerning me (including but not limited to peer review information which is provided to another Healthcare Entity for peer review purposes). I hereby release from all liability the Healthcare Entity and its authorized representatives or designated agents from any claim for damages of whatever nature for any release of information made in good faith by the Healthcare Entity or its representatives or agents.

8. I release from any liability, to the fullest extent permitted by law, all persons and entities (individuals and organizations) for their acts performed in a reasonable manner in conjunction with investigating and evaluating my Application and Qualifications, and I waive all legal claims of whatever nature against the Healthcare Entity and its representatives and designated agents acting in good faith and without malice in connection with the investigation of this Application and my Qualifications.
9. For Healthcare Entity membership and privileges, I acknowledge that I have been informed of or have been given the opportunity to review the medical staff bylaws, rules, regulations and policies of the entity and I hereby agree to abide by them. I agree to conduct my practice in accordance with applicable laws and ethical principles of my profession.
10. I acknowledge that any investigations, actions or recommendations of any committee or the governing body of the Healthcare Entity with respect to the evaluation of this Application and any periodic reappraisals or evaluations will be undertaken as a medical review and/or peer review committee and in fulfillment of the Healthcare Entity's obligations under Colorado law to conduct a review of professional practices in the facility, and are therefore entitled to any protections provided by law.
11. I have read and understand this Authorization and Release of Information Form. A photocopy of this Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this Application. This Authorization and Release shall apply in connection with the evaluation and processing of this Application as well as in connection with any periodic reappraisals and evaluation undertaken. I agree to execute such additional releases as may be required from time to time in connection with such periodic reappraisals and evaluations.
12. I understand that I have an opportunity to review the information submitted in support of this application pursuant to each entity's policy regarding review. If during the process of credentialing, an entity receives information that varies substantially from information I have provided, I will be notified of this and will have an opportunity to correct erroneous information. I have the right, upon request, to be informed of the status of my application

COLORADO HEALTH CARE PROFESSIONAL CREDENTIALS APPLICATION
AUTHORIZATION AND RELEASE OF INFORMATION FORM

Please print your name: _____

Signature: _____ **Date:** _____

REMEMBER TO SAVE THE COMPLETED APPLICATION TO YOUR PERSONAL COMPUTER!