# Locum Tenens Form

A practitioner who is new to the Moda Health panel and provides coverage for an absent practitioner or due to practitioner shortage for a period of 90 consecutive calendar days or less is not required to complete the full credentialing process, but rather an expedited process that will approve credentialing for the Locum Tenens coverage period.

Please fill out the following fields for the provider you wish to add a Locum Tenens provider:

Is the provider covering for less th	nan 90 consecutive days (including weekends)?	Yes 🗆	No 🗆
Name of locum provider			
Degree			
Specialty			
Date of birth			
Social security number			
Name of practitioner requiring			
coverage, or reason for			
coverage			
NPI number			
Medicare number			
Medicaid number			
Practice name			
Practice address			
Phone/fax number (s)			
Tax ID number			
Date range of coverage			

Please attach the following documents:

- W-9 form.
- Any additional locations where the locum practitioner will be providing coverage.
- Copy of DEA certificate.
- Copy of professional liability insurance.
- Please fill out, sign and date the attached; Attestation Questions and Authorization to Release Information forms.

Please return all documentation to <u>Credentialing@modahealth.com</u> or by fax to (503) 265-5707.

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ልል	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.							
Plea and i	se answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", pl 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 🗌	№ 🗌					
В.	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 🗌	№ 🗌					
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 or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES 🗌	№ 🗌					
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 or involuntarily relinquished or not renewed, or is any such action pending or under review?	YES 🗌	NO 🗌					
G	Have you ever voluntarily or involuntarily left or been discharged from medical school or subsequent training programs?	YES 🗌	NO 🗌					
B	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 🗌	мо 🗌					
K	Do you presently use any illegal drugs?	YES 🗌	по 🗌					
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?	YES 🗌	но 🗌					
	If reasonable accommodation is required, please specify the accommodation(s) required on a separate sheet.							
М	Are you <b>unable</b> 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?	YES 🗌	NO 🗌					
	If yes, please complete Attachment A, Professional Liability Action Detail, for each past or current claim and/or lawsuit.							
0	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 ornissions 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 or 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.								
	ordance with contract provisions.	anaanaanaa ahaanaa keesa keesa ahaa ka madaaya	er a 1949 a decembra decembra de 2014 a					
ĺ	Oregon Practitioner Credentialing Application 5/1/12 Page 11 of 12 INITIALS:DATE:							

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## 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:	ng pangan munang na pangang mananang munang munan dina munaharan na kata na kata kata kata kata kata k
	Date:

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

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Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

INITIALS: DATE: