A HELPFUL TIP ON COMPLETING THIS FORM:

For your convenience, you may find it useful to complete this form by typing in the form fields of this PDF file before printing it out. The result will be cleaner and more easily edited. Be sure to save the file to your computer for your records.

Please check one:

☐

☐

Secondary Office Street Address:	City: State: ZIP:
Office Manager/Administrator:	Telephone Number: FAX Number:
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Tertiary Office Street Address:	City: State: ZIP:
Office Manager/Administrator:	Telephone Number: ( ) FAX Number: ( )
Name Affiliated with Tax ID Number:	Federal Tax ID Number:
Handicap Access: Ä Yes Ã No	24 Hour Coverage: Ä Yes Ã No
Will you accept new patients? Ä Yes Ã No	Back office Telephone Number: ( )

Please identify other networks in which you participate:

Please identify other networks from which you have been denied admission or de-selected:

Name of Network	**Address**	**Reason for Denial or Deselection**

Do you have ownership in any health or medical related organization, e.g., laboratory, home health care agency, radiology facility, lithotrips, mobile testing, MRI, etc? Ä Yes Ä No

Institution:	Program Director:

ECFMG Number (applicable to foreign medical graduates):	Date Issued:	Valid Through:
Visa Number:	Date Issued:	Valid Through:

Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:
Name of Carrier:	Policy # :	From: (mm/yy)	To: (mm/yy)
Mailing Address:		City:	
		State & Country:	ZIP:

XVII. CURRENT HOSPITAL AND OTHER INSTITUTIONAL AFFILIATIONS

Please list in (A) in reverse chronological order, with the most current affiliation(s) first, all institutions with which you are currently affiliated. List previous affiliations during the past ten years in (B). Include hospitals, surgery centers, institutions, corporations, military assignments, or government agencies.

A. CURRENT AFFILIATIONS **(Attach additional sheets if necessary. Reference this section number and title.)**

Name and Mailing Address of Primary Admitting Hospital:	City:	
	State:	ZIP:

Name and Mailing Address of Other Hospital/Institution:	City:	
	State:	ZIP:
From: (mm/yy)	To: (mm/yy)	Reason for Leaving:

XIX. PEER REFERENCES

List three professional references, preferably from your specialty area. Do not list relatives, current partners or associates in practice. If possible, include at least one member from the Medical Staff of each facility at which you have privileges. Do not include program directors previously listed under post graduate training and education in Section X.

NOTE: References must be from individuals who are directly familiar with your work, either via direct clinical observation or through a close working relationship.

Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:
Name of Reference:	Specialty:	Telephone Number:	
Mailing Address:		City:	
		State:	ZIP:

XX. WORK HISTORY (Attach additional sheets if necessary. Reference this section number and title.)

Chronologically list all work history for at least the past five years (use extra sheets if necessary). This information must

Name of Practice/Employer:	Contact Name:	Telephone Number: ( )
		Fax Number: ( )
Mailing Address:		City:
		State: ZIP:
From: (mm/yy)	To: (mm/yy)	

Section B.

SUMMARY

SECTION C.

I certify that the information in Section A and B of this application and any attached documents (including my curriculum-vitae if attached) is true, current, correct and complete to the best of my knowledge and belief and is furnished in good faith. I understand that intentionally withholding or omitting material information or intentionally submitting material false or misleading information may result in denial of my application or termination of my privileges, employment or physician participation agreement. I agree that the Managed Care Entity to which this application is submitted, its representatives, and any individuals or entities providing information to this Managed Care Entity in good faith shall not be liable, to the fullest extent provided by law, for any act or occasion related to the evaluation or verification contained in this Mississippi Participating Physician Application. In order for participating Managed Care Entities or Healthcare Organizations to evaluate my application for participation in and/or my continued participation in those organizations, I hereby give permission to release to this Managed Care Entity information about my medical malpractice insurance coverage and malpractice claims history. This authorization is expressly contingent upon my understanding that the information provided will be maintained in a confidential manner and will be shared only in the context of legitimate credentialing and peer review activities. This authorization is valid unless and until it is revoked by me in writing. I authorize the attorneys listed in Section B, Page 9, to discuss any information regarding the subject case with this Managed Care Entity.

Print Name Here: _____

Physician Signature: _____ Date: _____

(Stamped Signature Is not Acceptable)

Section D.

Please answer the following questions “Yes” or “No”. If your answer to any question is “Yes” please provide full details on separate sheet.

1. Has your license to practice medicine in any jurisdiction, your Drug Enforcement Administration (DEA) registration or any applicable narcotic registration in any jurisdiction ever been denied, limited, restricted, suspended, revoked, not renewed, or subject to probationary conditions, or have

Section E.

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing information”) by and between “this Managed Care Entity” and other Healthcare Organizations (e.g. hospital medical staffs, medical groups, independent practice associations (IPAs), health plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical