SOTERIA HEALTHCARE'S RE-CREDENTIALING APPLICATION FOR GEORGIA

By Soteria Healthcare Network

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SOTERIA HEALTHCARE NETWORKS
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PROVIDER RE-CREDENTIALING APPLICATION

Please Print Legibly or Type Date: _____

Personal Information

Last Name: _____ First Name: _____ Middle Initial: _____

Corporation Name: _____ Title: _____

Social Security Number: _____-_____-_____ CorporateTax ID Number: _____

Indiv. NPI #: _____ Group/Practice NPI #: _____

E-Mail: _____ Website: _____ Date Of Birth: _____

Are You Licensed In Any Of The Following Areas:

- Acupuncture Yes_____ No_____ License Number_____ Expiration Date _____
- Massage Therapy Yes_____ No_____ License Number_____ Expiration Date _____
- Other _____ License Number_____ Expiration Date _____

Number of Continuing Chiropractic Education Credits for past 12 months: _____

State License Number: _____ Year Issued: _____
(Please Attach A Copy of Your License)

Medicare Provider Number: _____ UPIN Number_____

Does Your office have electronic claims filing capability? Yes _____ No _____

Have you ever been named in a malpractice lawsuit in the past 26 months? Yes _____ No _____
If Yes, Please Attach a Complete Explanation of the Circumstances and Outcome

Has your professional liability insurance been canceled or renewal refused in the past 26 months? If Yes, Attach Complete Details. Yes _____ No _____

Has any action to suspend, limit or terminate licensure, hospital privileges or professional society membership been taken, is pending or is being threatened in the past 26 months? If Yes, Attach Complete Details. Yes _____ No _____

Have you convicted of a felony, any offense involving moral turpitude, or any offense related to the practice or ability to practice chiropractic care in the past 26 months? If Yes, Attach Complete Details. Yes _____ No _____

Is there anything that would prevent you from performing the essential functions and duties required as part of your clinical practice with or without reasonable accommodation? If Yes Attach Complete Details. Yes _____No _____

Have been expelled or sanctioned from participation in Medicare, any Medicaid, or managed care program in the last 26 months? If Yes Attach Complete Details. Yes _____ No _____

Are you currently using illegal drugs? Yes _____ No _____

Has your chiropractic license suspended, revoked or otherwise sanctioned by the Georgia Board of Chiropractic Examiners or the licensing authority of any other state in the last 26 months? Yes _____ No _____
If Yes, Attach Complete Details.

Office Location

Have your office location(s) information changed: **Yes**_____ (If Yes Please complete enclosed form) No_____
Have any additional offices been added: **Yes**_____ (If Yes Please complete enclosed form) No_____

SOTERIA™
HEALTHCARE NETWORK

RELEASE AUTHORIZATION

PLEASE READ AND UNDERSTAND THE FOLLOWING AGREEMENT BEFORE SIGNING THIS INQUIRY.

I certify that all of the information submitted by me in this document is true and complete to the best of my knowledge and belief.

I understand that any misstatement in or omissions from this document constitutes cause for denial or termination of participation in Soteria Healthcare network.

I understand that I have the right to correct information used in the initial credentialing or recredentialing process, including information submitted by myself or another party. This right does not extend to information prohibited from release by statute, such as the NPDB report or peer review documents. If Soteria Healthcare has received conflicting information from a third party, I will be notified via the Credentialing Supervisor at Soteria Healthcare.

I understand that this application does not entitle me to participation in the network of any health plan using the application. I agree that any health plan using this application, their representatives, and any individuals or entities providing information to such health plan in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify the health plan with which I participate and which use this application about any changes to the information provided in this application by the next business day. Information requested in this application that is not publicly available will be treated as confidential by the health plan using it.

I authorize Soteria Healthcare, or its designated representative, to contact and consult with administrators, administrative staff, licensing organizations and professional peers at institutions and health care or other organizations with which I am or have been associated, and with past and present insurance carriers, who may have information relating to my professional and ethical qualifications, competence, character and personality.

I consent to the inspection by Soteria Healthcare or its designated representative for Soteria Healthcare beneficiaries of all records regarding beneficiaries, including institutions and health care organizations with which I am or have been associated which may contain information related to my professional and ethical qualifications, competence, character and personality.

I release from liability all individuals, corporations and organizations which provide information to Soteria Healthcare in good faith, including medical and otherwise privileged or confidential information.

I release Soteria Healthcare, its chiropractic administrators, management agents, directors, and staff from liability for acts performed in good faith in connection with the evaluation and investigation of information and materials I have authorized them to request and inspect.

I release Soteria Healthcare, its administrators, staff, directors and management agents from liability for disclosing information obtained in the course of their efforts to evaluate and/or investigate my qualifications an from liability for responding in good faith to inquiries from persons or entities to whom I may submit applications for employment and privileges in the future. I agree that photocopies of this signed authorization will be acceptable as an original signature.

I understand that Soteria Healthcare will rely upon the information given on this document during the evaluation of my credentials to determine compliance with network credentialing standards.

Name: _____ Date: _____

Signature: _____ GA License # _____