



## Professional History and Attestation Supplement

**Please complete all items on this form. Incomplete forms will delay the credentialing process.** Items marked with an asterisk (\*) will be kept confidential to the extent permitted by law. If you need assistance completing this form, please call our Service Operations Department at 800-950-7040.

<b>History</b>				
Please describe the last five (5) years of your employment/professional history. Please include with your application a brief explanation of any gap of six months or greater.* Please note that your application cannot be processed if month and year specific detail is not provided.				
HISTORY	Activity / Position	Facility / Program	City, State	From-To (mm/yy) <div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <span style="margin: 0 5px;">/</span> <div style="border: 1px solid black; width: 20px; height: 20px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <span style="margin: 0 5px;">-</span> Present         </div>
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Be sure to complete all questions. (please provide a detailed description of all positive responses.)	
A. Have you ever had any negative action taken in connection with your license, including, but not limited, to refusal, suspension, revocation, probation reprimand, censure or restriction in any way by any state or jurisdictional board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Have you ever been censured by a medical society or other professional society or other professional board or association?	<input type="checkbox"/> Yes <input type="checkbox"/> No
C. Have you ever had your Drug Enforcement Administration number (DEA #) restricted, suspended, revoked or otherwise limited or DEA license application refused?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA
D. Have you ever had an agreement with Medicare or Medicaid that was restricted, probational, suspended, excluded or terminated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
E. Have you ever been required or agreed to pay civil monetary penalties under Medicare or Medicaid?	<input type="checkbox"/> Yes <input type="checkbox"/> No
F. Have you ever been convicted of a criminal offense other than a minor traffic violation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
G. Has any hospital or facility ever taken any action regarding your privileges, including, but not limited, to suspension, restriction, denial or revocation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
H. Have you ever voluntarily resigned privileges in lieu of disciplinary action?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I. Has there been, within the last five years, more than one malpractice judgment found against you or malpractice settlement made, with or without prejudice, in excess of five hundred thousand (\$500,000) dollars?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. Do you have an impairment, which even with reasonable accommodation would interfere with your ability to provide care according to accepted standards of professional performance, or would pose a threat to patient health and safety?	<input type="checkbox"/> Yes <input type="checkbox"/> No
K. Are you now or have you ever been an active or habitual user of any mind or mood altering substance, including, but not limited, to alcohol, narcotics, barbiturates, hypnotics, amphetamines, cocaine, benzodiazepines, or other controlled or illegal substances?	<input type="checkbox"/> Yes <input type="checkbox"/> No
L. Has your participation in any insurance carrier sponsored program been suspended or revoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No

ATTESTATION / RELEASE	I hereby submit this application for participation in MultiPlan, Inc.'s networks as indicated in my MultiPlan contract. I understand that this application will be reviewed based on the information I have provided herein.	
	I hereby certify that the information contained in the submitted state credentialing application and the Professional History and Attestation Supplement is complete, accurate and true, and that information found to be false could result in denial or subsequent termination of my participation in any or all of the MultiPlan networks.	
	To assist MultiPlan and/or its Credentials Verification Organization (CVO) in evaluating my application, I authorize any hospital, group practice, other clinical employer, professional society, malpractice carrier or other agency or organization with information regarding my professional credentials to release, furnish copies, or give details of my professional credentials, qualifications and hospital records related to my privileges, qualifications, type of clinical practice and competence, including my moral and ethical qualifications. I hereby release from liability any and all individuals and organizations who, in good faith and without malice, provide information to MultiPlan for the purposes of evaluating this application, and release MultiPlan from liability for its use of the information it gathers in the application process. A photocopy of this permission will be as valid as the original.	
X _____ Signature of Provider (Must be participating provider's signature)	_____ Name (please type or print)	_____ Date (mm/dd/yyyy)
<b>NOTE: Signature and date on this application MUST be within 30 days of submission to MultiPlan.</b>		

APPLICATION CHECKLIST	<input type="checkbox"/> Copy of current DEA and license certificate(s).
	<input type="checkbox"/> Copy of current insurance certificate which includes Professional and Comprehensive General Liability.
<input type="checkbox"/> Copy of Curriculum Vitae.	
<input type="checkbox"/> Detailed explanation and documentation for any affirmative responses to Professional Questions or Employment History Gaps six (6) months or greater.	
<input type="checkbox"/> Send your completed application and all supporting materials to MultiPlan: Online via the Provider Service Portal: <a href="http://provider.multiplan.com">http://provider.multiplan.com</a> . E-mail: <a href="mailto:registrar@multiplan.com">registrar@multiplan.com</a> . Include your case number. Fax: 781-487-8273. Include your case number. Mail: MultiPlan, Attention: Registrar, 16 Crosby Drive, Bedford, MA 01730. Include your case number.	