Please make sure each of the attached payer enrollment documents has your name printed and your signature. They must be completed using your legal name and it must match your medical license. Do not date any of the enrollment documents. We will add the date when they are submitted to payers. All documents requiring a signature must be returned to us through the mail.

Please return to:

CaroMont Medical Group Inc

2240 Remount Road

Gastonia, NC, 28054

Att: Liz McCourry

SECTION 15: CERTIFICATION STATEMENT *(Continued)*

First Name	Middle Initial	Last Name	M.D., D.O., etc.

Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink (blue ink preferred). Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

SECTION 16: FOR FUTURE USE (THIS SECTION NOT APPLICABLE)

SECTION 17: SUPPORTING DOCUMENTS

This section lists the documents that, if applicable, must be submitted with this enrollment application. For changes, only submit documents that are applicable to the change requested. The fee-for-service contractor may request, at any time during the enrollment process, documentation to support or validate information reported on the application. In addition, the Medicare fee-for-service contractor may also request documents from you, other than those identified in this section 17, as are necessary to bill Medicare.

MANDATORY FOR ALL PROVIDER/SUPPLIER TYPES

- ☐ Completed Form CMS-588, for Electronic Funds Transfer Authorization Agreement.
  NOTE: If a supplier already receives payments electronically and is not making a change to his/her banking information, the CMS-588 is not required. (Moreover, physicians and non-physician practitioners who are reassigning all of their payments to another entity are not required to submit the CMS-588.)
- ☐ Written confirmation from the IRS confirming your Tax Identification Number with the Legal Business Name (e.g., IRS form CP 575) provided in Section 2. (**NOTE:** This information is needed if the applicant is enrolling their professional corporation, professional association, or limited liability corporation with this application or enrolling as a sole proprietor using an Employer Identification Number.)

MANDATORY, IF APPLICABLE

- ☐ Copy of IRS Determination Letter, if provider is registered with the IRS as non-profit.
- ☐ Copy(s) of all final adverse action documentation (e.g., notifications, resolutions, and reinstatement letters).
- ☐ Completed Form CMS-460, Medicare Participating Physician or Supplier Agreement.
- ☐ Completed Form CMS-855R, Individual Reassignment of Medicare Benefits.
- ☐ Statement in writing from the bank. If Medicare payment due a supplier of services is being sent to a bank (or similar financial institution) where the supplier has a lending relationship (that is, any type of loan), then the supplier must provide a statement in writing from the bank (which must be in the loan agreement) that the bank has agreed to waive its right of offset for Medicare receivables.
- ☐ Written confirmation from the IRS confirming your Limited Liability Company (LLC) is automatically classified as a Disregarded Entity (e.g., Form 8832). (**NOTE:** A disregarded entity is an eligible entity that is treated as an entity not separate from its single owner for income tax purposes.)
- ☐ Copy of current CLIA and FDA certification for each practice location reported.

SECTION 4: AUTHORIZATION STATEMENTS

The signatures below authorize the reassignment of benefits to a supplier or the termination of a reassignment of benefits to a supplier, as indicated in Section 1.

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or supplier unless the individual practitioner who provided the services specifically authorizes another individual or supplier (employer, facility, or health care delivery system) to receive said payments in accordance with 42 C.F.R. 424.73 and 42 C.F.R. 424.80. By signing this Reassignment of Benefits Statement, you are authorizing the supplier identified in Section 2 to receive Medicare payments on your behalf.

Your employment or contract with this individual or supplier must be in compliance with CMS regulations and you must be in compliance with applicable Medicare program safeguard standards described in 42 C.F.R. 424.80. All individual practitioners who allow another supplier (employer, facility, or health care delivery system) to receive payment for their services must sign the Reassignment of Benefits Statement.

The signatures below acknowledge that you will abide by all laws and regulations pertaining to the reassignment of benefits.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.

Individual Practitioner Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

B. Authorized or Delegated Official of Group Practice/Clinic

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
David	M.	O'Connor	—

Authorized or Delegated Official's Signature *(First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.)*	Date Signed *(mm/dd/yyyy)*

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.

PROVIDER'S NOTARIZED FACSIMILE OR STAMP SIGNATURE AUTHORIZATION

STATE OF North Carolina

COUNTY OF Gaston

t _____ being first duly sworn, deposes and says: I hereby authorize PGBA, LLC / Health Net Federal Services in the state of South Carolina to accept my facsimile or stamp signature shown below

(Facsimile, stamp or computer-generated signature as it will appear on the claim form)

as my true signature for all purposes under TRICARE in the same manner as if it were my actual signature, including my agreeing to abide by the TRICARE payment system concept and the remainder of the certification normally signed by the source of care as it appears on all TRICARE claim forms.

X _____
SIGNATURE

SUBSCRIBED AND SWORN TO BEFORE ME THIS ___ DAY OF ____ 20 ____

_____
NOTARY PUBLIC IN AND FOR

COUNTY OF _____ STATE OF _____

(SEAL)

MY COMMISSION EXPIRES: _____

PGBA, LLC
Provider Data Management
P.O. Box 870156
Surfside Beach, SC 29587-9756
1-877-TRICARE (1-877-874-2273)
Fax 1-888-279-3540
www.myTRICARE.com by PGBA

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in Atlantic Integrated Health, I signify my willingness to appear for interview in regard to my application. I authorize Atlantic Integrated Health to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Atlantic Integrated Health materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Atlantic Integrated Health of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Atlantic Integrated Health for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Atlantic Integrated Health in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Atlantic Integrated Health.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Atlantic Integrated Health may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Atlantic Integrated Health, I hereby consent to Atlantic Integrated Health for inspection of my patient records relating to Atlantic Integrated Health enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Atlantic Integrated Health in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in Aetna, I signify my willingness to appear for interview in regard to my application. I authorize Aetna to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Aetna materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Aetna of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Aetna for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Aetna in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Aetna.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Aetna may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Aetna, I hereby consent to Aetna for inspection of my patient records relating to Aetna enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Aetna in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

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Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in AMERIGROUP Community Care, I signify my willingness to appear for interview in regard to my application. I authorize AMERIGROUP Community Care to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to AMERIGROUP Community Care materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of AMERIGROUP Community Care of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of AMERIGROUP Community Care for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to AMERIGROUP Community Care in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to AMERIGROUP Community Care.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, AMERIGROUP Community Care may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in AMERIGROUP Community Care, I hereby consent to AMERIGROUP Community Care for inspection of my patient records relating to AMERIGROUP Community Care enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify AMERIGROUP Community Care in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

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Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

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By application for membership in Blue Cross Blue Shield of North Carolina, I signify my willingness to appear for interview in regard to my application. I authorize Blue Cross Blue Shield of North Carolina to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Blue Cross Blue Shield of North Carolina materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Blue Cross Blue Shield of North Ca of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Blue Cross Blue Shield of North Carolina for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Blue Cross Blue Shield of North Carolina in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Blue Cross Blue Shield of North Carolina.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Blue Cross Blue Shield of North Caroli may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Blue Cross Blue Shield of North Carolina, I hereby consent to Blue Cross Blue Shield of North Carolina for inspection of my patient records relating to Blue Cross Blue Shield of North Carolina enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Blue Cross Blue Shield of North Carolina in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

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Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

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By application for membership in Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic, I signify my willingness to appear for interview in regard to my application. I authorize Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Bravo Health/Healthspring/RPO/Synergy materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Bravo Health/Healthspring/RPO/Sy of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Bravo Health/Healthspring/RPO/Synergy may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic, I hereby consent to Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic for inspection of my patient records relating to Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Bravo Health/Healthspring/RPO/Synergy Healthcare/Epic in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

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Attestation Statement

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No Stamps or Copies Please

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By application for membership in CIGNA / Great-West Healthcare, I signify my willingness to appear for interview in regard to my application. I authorize CIGNA / Great-West Healthcare to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to CIGNA / Great-West Healthcare materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of CIGNA / Great-West Healthcare of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of CIGNA / Great-West Healthcare for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to CIGNA / Great-West Healthcare in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to CIGNA / Great-West Healthcare.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, CIGNA / Great-West Healthcare may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in CIGNA / Great-West Healthcare, I hereby consent to CIGNA / Great-West Healthcare for inspection of my patient records relating to CIGNA / Great-West Healthcare enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify CIGNA / Great-West Healthcare in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

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Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in CignaHealthspring/RPO/Synergy Healthcare/EPIC, I signify my willingness to appear for interview in regard to my application. I authorize CignaHealthspring/RPO/Synergy Healthcare/EPIC to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to CignaHealthspring/RPO/Synergy Health materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of CignaHealthspring/RPO/Synergy H or all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of CignaHealthspring/RPO/Synergy Healthcare/EPIC for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to CignaHealthspring/RPO/Synergy Healthcare/EPIC in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to CignaHealthspring/RPO/Synergy Healthcare/EPIC.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, CignaHealthspring/RPO/Synergy Healt may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in CignaHealthspring/RPO/Synergy Healthcare/EPIC, I hereby consent to CignaHealthspring/RPO/Synergy Healthcare/EPIC for inspection of my patient records relating to CignaHealthspring/RPO/Synergy Healthcare/EPIC enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify CignaHealthspring/RPO/Synergy Healthcare/EPIC in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in Coventry Health Care/First Health Network, I signify my willingness to appear for interview in regard to my application. I authorize Coventry Health Care/First Health Network to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Coventry Health Care/First Health Netw materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Coventry Health Care/First Health of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Coventry Health Care/First Health Network for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Coventry Health Care/First Health Network in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Coventry Health Care/First Health Network.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Coventry Health Care/First Health Netv may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Coventry Health Care/First Health Network, I hereby consent to Coventry Health Care/First Health Network for inspection of my patient records relating to Coventry Health Care/First Health Network enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Coventry Health Care/First Health Network in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in Humana/ChoiceCare, I signify my willingness to appear for interview in regard to my application. I authorize Humana/ChoiceCare to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Humana/ChoiceCare materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Humana/ChoiceCare of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Humana/ChoiceCare for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Humana/ChoiceCare in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Humana/ChoiceCare.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Humana/ChoiceCare, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Humana/ChoiceCare, I hereby consent to Humana/ChoiceCare for inspection of my patient records relating to Humana/ChoiceCare enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Humana/ChoiceCare in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in MedCost, LLC, I signify my willingness to appear for interview in regard to my application. I authorize MedCost, LLC to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to MedCost, LLC materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of MedCost, LLC of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of MedCost, LLC for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to MedCost, LLC in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to MedCost, LLC.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, MedCost, LLC may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in MedCost, LLC, I hereby consent to MedCost, LLC for inspection of my patient records relating to MedCost, LLC enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify MedCost, LLC in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

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No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in Multiplan Inc., I signify my willingness to appear for interview in regard to my application. I authorize Multiplan Inc. to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Multiplan Inc. materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Multiplan Inc. of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Multiplan Inc. for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Multiplan Inc. in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Multiplan Inc.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Multiplan Inc. may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Multiplan Inc., I hereby consent to Multiplan Inc. for inspection of my patient records relating to Multiplan Inc. enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Multiplan Inc. in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in United Healthcare, I signify my willingness to appear for interview in regard to my application. I authorize United Healthcare to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to United Healthcare materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of United Healthcare of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of United Healthcare for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to United Healthcare in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to United Healthcare.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, United Healthcare, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in United Healthcare, I hereby consent to United Healthcare for inspection of my patient records relating to United Healthcare enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify United Healthcare in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application

Attestation Statement

(IMPORTANT: Submit Original Only)

This Application is to be signed by each individual provider submitting an application.

Fill in each space with the name of the Health Plan for which you are applying.

No Stamps or Copies Please

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in Tricare, I signify my willingness to appear for interview in regard to my application. I authorize Tricare to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Tricare materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical- surgical privileges. I further consent to the inspection by representatives of Tricare of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Tricare for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Tricare in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to TriCare.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Tricare may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in Tricare, I hereby consent to Tricare for inspection of my patient records relating to Tricare enrollees as necessary for its peer and utilization review purposes as permitted by state or federal law and regulation I further agree to notify Tricare in a timely manner (not to exceed 30 days) of any changes to the information requested on the initial application.

PRINT NAME OF PROVIDER

SIGNATURE OF PROVIDER

DATE

Please Sign and Complete this Application