

ChiroCare Participating Chiropractor Application

Thank you for your interest in joining the ChiroCare network. We appreciate your taking time to provide this information and it will be kept confidential. Your application packet must be complete before we can process it. Please provide the following:

- Completed ChiroCare Participating Chiropractor Application (typed or legibly written in black ink), with all applicable attachments – i.e. malpractice history
- License with current renewal certificate
- Curriculum Vitae
- Declaration Face Sheet of Professional Malpractice Liability Insurance Coverage
- Completed Chiropractic Provider Service Agreement (enclosed)

Mail completed packet to:

ChiroCare
Credentials Coordinator
12400 West Hwy 71 Ste 350-428
Austin, TX 78738

Remember that the information on the application must be complete and accurate. An incomplete application packet will not be processed.
If you have any questions, please call ChiroCare at (512) 402-0070 or (866) 209-0070.

Participating Chiropractor Application

I. Identification:

Name:

Last:

First:

Middle:

Gender:

of years in active practice:

SSN #:

D.O.B.:

State License #:

Date Issued:

Primary Office address:

Office phone:

Office fax:

E-mail address:

Home phone:

Home fax:

Cell phone:

Mailing address (if different):

Billing address (if different):

Secondary office address, phone and fax:

Is your office ADA accessible?

Do you have on-site x-ray facilities?

Date of last inspection?

Office hours:

After hours and call coverage arrangements:

II. Education & Training:

Undergraduate Institution:

Enrollment dates:

Degree:

Accomplishment/Honors:

Chiropractic College Institution:

Enrollment dates:

Degree:

Accomplishments/Honors:

III. Professional Liability History

Please read AND initial each statement.

_____ 1. I do not have, nor have I had in the past five (5) years, any malpractice claims or legal actions brought against me. If you cannot affirm this statement, please complete an attached form describing the following information for each claim or suit.

- a. patient's name;
- b. diagnosis;
- c. date of incident, date filed, date closed;
- d. your involvement in the case;
- e. nature of the allegation(s);
- f. medical facts;
- g. patient outcome;
- h. other pertinent details;
- i. resolution of the case;
- j. settlement amount on your half (if applicable);

_____ 2. There are no past or current professional medical or chiropractic misconduct proceedings or peer review-type proceedings pending wherein I am a party in this state or any other state or country.

_____ 3. There have been no judgements, settlements, findings, decisions or any other determinations of any kind whatsoever entered or made in any professional medical misconduct proceedings or peer review-type proceedings wherein I was part in this state or any other state or country in the past five (5) years.

_____ 4. My license to practice chiropractic in any state or country has never been suspended, revoked, or subject to limitations or voluntary relinquishment.

_____ 5. I am not currently under investigation nor have any charges been brought against me by any hospital or other health care institution, third party payor, Medicaid or Medicare, or governmental licensing or other authority.

_____ 6. I am not now, nor have I ever been treated for a physical or mental health condition, including alcohol or substance abuse, which would interfere with my ability to perform my duties as a chiropractor.

_____ 7. I have never been sanctioned, denied participation in, nor terminated from a managed care organization.

If, for any reason, you cannot affirm to a particular statement with respect to statements 2 through 7 above, submit full details on a separate sheet.

I hereby affirm and represent that all statements, answers, and information contained in this application are true, correct and complete to the best of my knowledge and belief and that no information of an adverse nature has been knowingly withheld. I understand that misrepresentation or omission of any fact requested may result in automatic termination. I further understand and agree that acceptance of this application does not constitute approval or acceptance of participation status in Comprehensive Network Solutions and grants me no rights or privileges until such time as I receive a formal notice of participation.

My signature on this application indicates my agreement to cooperate fully with Comprehensive Network Solutions and its representatives during the processing of this application and any subsequent re-credentialing. I further indicate my willingness to provide documentation and other written or oral information as may be requested of me with regard to my application.

Print _____ Name _____
Here _____

Physician Signature _____
Date _____

IV. Certification:

I certify that the information in Sections I-III of this application and any attachments (including my curriculum vitae) 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 Network to which this application is submitted, its representatives, and any individuals or entities providing information to this Network 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 Participating Chiropractic Provider Application. In order for participating Networks 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 Network 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 is revoked by me in writing. I authorize the attorneys listed in Section V to discuss any information regarding the subject case with this Network.

Signature _____ Date _____
(Stamped Signature Is Not Acceptable)

Name (Print or Type) _____
(Stamped Signature Is Not Acceptable)

V. Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance (“credentialing information”), for the purpose of evaluating this application and any re-credentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state¹ laws provide immunity protections to certain individuals and entities for their acts and / or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including CNS engaged in quality assessment, peer review and credentialing on behalf of CNS and all persons and entities providing credentialing information to such representatives of CNS from any liability they might incur for their acts and / or communications in connection with evaluation of my qualifications for participation in CNS to the extent that those acts and / or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in CNS as may be required by state and federal law and regulation.

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.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided. In addition to any notice required by any contract with a Network or Healthcare Organization, I agree to notify CNS immediately in writing of the occurrence of any of the following: (i) the unstated suspension, revocation or nonrenewal of my license to practice chiropractic or; (ii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify CNS in writing promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Texas Board of Chiropractic Examiners taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice chiropractic; or (ii) any adverse action against me by any Managed Care Entity or Healthcare Organization which has resulted in the filing of a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Managed Care Entity or Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding minor traffic violations), or (vii) my receipt of written notice of any adverse action against me or any change to my status under the Medicare or Medicaid or Texas Workers’ Compensation system programs, including, but not limited to, fraud and abuse proceedings or convictions.

I understand and acknowledge that the National Practitioner Data Bank may be queried on my behalf to secure information about my history. A photocopy or facsimile of this document shall be as effective as the original; however, original signatures and current dates are required on pages 6, 8 and 9 of this application.

Print Name

Here _____

Physician Signature _____

Date _____ (Stamped Signature Is Not Acceptable)

Intent of this release is to apply, at a minimum, protections comparable to those available to any action, regardless of where such action is brought.