Peer Review Credentialing Application

Dear Peer Reviewer Applicant:

Thank you for your interest in the Acentra Health Peer Review Program as it signals your commitment to a significant objective
– continuing improvement of the quality and utilization of health care services. We fully appreciate the value of your time and earnestly suggest that your participation in the peer review process in today's healthcare climate is close to an ethical imperative.

Acentra Health is a nationally recognized provider of healthcare management solutions in both state and federal government, as well as commercial clients, providing prior authorization, utilization and specialty review, and case and disease management services.

To accomplish our objectives, Acentra Health must have sufficient numbers of qualified peer reviewers who must meet the following criteria. The peer reviewer:

- Shall have a minimum of five (5) years active practice experience, providing direct clinical care to patients as recent as within the past three (3) years
- Are Doctors of Medicine, Osteopathic Medicine, Dentistry, Podiatry, or other Allied Health Care Practitioners
- Holds an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States
- Must be Board Certified in a specialty recognized by one of the following; American Board of Medical Specialties (ABMS), the Bureau of Osteopathic Specialists American Osteopathic Association (AOA), the National Board of Physicians and Surgeons (NBPAS), American Board of Physician Specialties (ABPS), American Dental Association (ADA), the American Board of General Dentistry (ABGD), the American Board of Podiatric Surgery
(ABPS), or the American Board of Podiatric Medicine (ABPM)
- Must be located within the United States or one of its territories when conducting an internal appeal or external review

Acentra Health can then ensure that all quality and utilization determinations completed and follow-up actions taken are the result of true peer review. Acentra Health provides liability coverage for peer reviewer activities. The reviewer's name will remain confidential, except in instances where identification is required by law or by specific contract. Acentra Health provides compensation for our reviewers based on the type of review or service being requested and/or amount allowed by the individual customer for whom the work is being performed. Compensation of services will be made within 30 days of receipt of the completed report and invoice.

While Acentra Health cannot guarantee any pre-established volume commitments, your approval as a credentialed peer reviewer will present you with opportunities to work with our organization in both the private and public sector. Please contact our Credentialing Department at AcentraCredentialing@acentra.com with questions. We look forward to your participation in the peer review process.

~Acentra Health Credentialing

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INSTRUCTIONS FOR COMPLETING THE PEER REVIEWER APPLICATION AND CREDENTIALING PROCESS

Acentra Health and its subsidiary companies contract with various state and federal government agencies, as well as commercial insurance entities, to perform reviews. Individual contracts have unique requirements for documentation of reviewer credentials. The questions asked and information sought on the forms that follow are either requirements of those contracts and/or will facilitate our staff in contacting you regarding the performance of review services. The Acentra Health application packet includes:

1. **Peer Reviewer Application:**
   This form collects information about your office, licensure, potential conflicts of interest, and experience. It includes questions applicable to Peer Reviewer Small Business Administration (SBA) information, which helps Acentra Health comply with federal government contracting requirements. Please complete this portion to allow Acentra Health to comply with contract requirements. *Note: The SBA section of the application requires your signature.*
   ****All applicants must complete this application.****
2. **Review Agreement:**
   This agreement explains the obligations of a peer reviewer and requests each applicant to specify those review types which he/she agrees to perform.
   ****All applicants must complete this Agreement.****
3. **Authority to Release Information:**
   To meet the requirements of certain contracts, a copy of this form may need to be submitted to the Medical Staff President (or designee) of the facility in which you primarily practice and maintain staff privileges for confirmation of such privileges. ****This release must be completed by all applicants in order to ensure authorized release of confidential information.****
4. **Email this completed application along with your CV to acentracredentialing@acentra.com**

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Acentra Health CREDENTIALING / RE-CREDENTIALING APPLICATION

IDENTIFICATION INFORMATION		
(Click on the *TAB* key to move to next field)		
Date		
Last Name		
First Name		
Middle Initial		
Prefix		
Suffix (Jr., Sr., etc.)		
Title (e.g., MD, RN, MSW)		
SSN #		
NPI #		
Tax ID #		
Is Tax ID business or personal? Business ☐ Personal ☐		

HOME INFORMATION		
Do you prefer to be contacted at home? Yes ☐ No ☐		
Preferred Method of Contact (email, cell phone, other phone)		
Address 1		
Address 2		
City	**State**	**Zip Code**
County		
Phone		
Fax	**Pager**	**Cell Phone**
Email		

OFFICE INFORMATION		
Do you prefer to be contacted at your office? Yes ☐ No ☐		
Preferred Method of Contact (email, cell phone, other phone) --		
Business Name		
Contact Person		
Contact Title		
Email Address		
Address 1		
Address 2		
City	**State**	**Zip Code**
Phone	**Cell Phone**	

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LICENSURE INFORMATION	
☐ **Physician** ☐ **Allied Health**	
License Number **Type** **State** **Expiration Date**	☐ Expired, not renewing ☐ This is a restricted License
License Number **Type** **State** **Expiration Date**	☐ Expired, not renewing ☐ This is a restricted License
For additional Licenses, please list information below	

BOARD CERTIFIED SPECIALTIES (MDs and DOs only)	
Specialty **Effective Date**	☐ This is a time-limited certification that expires ☐ This is a lifetime certification ☐ I am willing to review this specialty
Subspecialty	☐ This is a time-limited certification that expires ☐ This is a lifetime certification
Specialty **Effective Date**	☐ This is a time-limited certification that expires ☐ This is a lifetime certification ☐ I am willing to review this specialty
Subspecialty	☐ This is a time-limited certification that expires ☐ This is a life-time certification

SPECIAL QUALIFICATIONS: *Please provide a list of your special qualifications*	
For **Allied Health** professionals, please identify your certifications.	
For all applicants, please identify expertise you offer Acentra Health (Examples: languages other than English, expertise with particular settings, experience in specific contracts, such as HRSA or BFCC areas). Type as many as you have, separated by commas.	

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GENERAL QUESTIONS	
Are you currently involved in active practice?	☐ **Yes** ☐ **No** If yes, please estimate your average hours per week:
Are you currently involved in clinical teaching?	☐ **Yes** ☐ **No** If yes, please estimate your average hours per week:
Have you ever provided direct patient care?	☐ **Yes** ☐ **No** If yes, enter the date you started providing direct patient care: *Note: If your direct patient care has had periods of interruption, please enter the date that you most recently started providing direct patient care.*
Do you currently provide direct patient care?	☐ **Yes** ☐ **No** If yes, please estimate your average hours per week: If no, please indicate month and year you stopped providing direct patient care:
Do you have any gaps in work history?	☐ **Yes** ☐ **No** If yes, please explain. Please specify the amount of time that lapsed in work history, if greater than three months:
Have your privileges to practice been abridged or suspended in any way, or is any action now pending?	☐ **Yes** ☐ **No** If yes, please explain:
Do you currently have any charges or sanctions filed against you in a criminal, civil, or administrative proceeding, or do you have reason to believe that such charges or sanctions will be filed?	☐ **Yes** ☐ **No** If yes, please explain:
Have you ever entered a plea of guilty or nolo contendere where the offense involved the use or delivery of a controlled substance? If your conviction has been expunged, please answer No.	☐ **Yes** ☐ **No**
Have you ever been enrolled in any Professional Health Monitoring Program (PHMP)?	☐ **Yes** ☐ **No** If *Yes*, please provide the reason for your participation and the dates in which you were in PHMP. If yes, *h*ave you successfully completed the program? ☐ **Yes** ☐ **No**
Do you have utilization/quality assurance or peer review experience?	☐ **Yes** ☐ **No** If yes, give area of expertise and number of years' experience:
Are you willing to testify?	☐ **Yes** ☐ **No**
Do you have ABQAURP certification?	☐ **Yes** ☐ **No** Date of certification:
Are you willing to complete Expedited Reviews?	☐ **Yes** ☐ **No**

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REVIEW AGREEMENT

My signature at the conclusion of this agreement indicates my willingness to participate as a peer reviewer when requested by Acentra Health or its subsidiaries and to conduct reviews in accordance with the applicable contract, URAC, or state-mandated time frames.

I understand that Acentra Health is relying upon the current accuracy of the information contained in my Peer Reviewer Application and will continue to rely upon its accuracy in deciding whether to request my services as a reviewer.

I further understand that I will be compensated for my peer review services based on the type of review or service and/or amount allowed by the individual contract and that compensation to me as a peer reviewer for any provision of the services required hereunder does not contain direct or indirect incentives to make inappropriate review decisions.
I agree to maintain and safeguard the confidentiality of all medical records and data received by me relevant to the performance review activities. I further agree to promptly advise Acentra Health of any issue with respect to a conflict of interest or perceived conflict of interest in connection with review activities.

I also agree to fully cooperate with Acentra Health and client personnel in connection with preparation of all time logs, administrative forms, review reports, depositions, and other oral or written testimony, which may be required in connection with my review activities.

I agree to notify Acentra Health within three (3) business days of any changes regarding my credentials or contact information noted within this application as well as any changes or restrictions to licensure, Drug Enforcement Administration (DEA) registration, and professional board certifications. Except to the extent specifically modified by this Agreement, I hereby ratify and affirm all authorizations, applications, consents, and agreements executed by me in connection with my acceptance by Acentra Health as a reviewer under the Social Security Act and other applicable regulations.

AUTHORITY TO RELEASE INFORMATION

In applying for appointment as a peer reviewer or consultant to Acentra and/or its subsidiaries, I, hereby authorize Acentra Health, or its representatives, to contact any healthcare facilities with which I have been associated and with others who may have information bearing on my professional qualifications, clinical competence, credentials, behavior, or any other matters which may be relevant to my appointment as a peer reviewer. I release from any liability all representatives of Acentra Health for their acts performed in good faith and without malice in connection with evaluating me and my credentials and release from liability all individuals and organizations who provide information to Acentra Health, or its designees, including otherwise privileged or confidential information.

Peer Reviewer Acknowledgement	
I acknowledge that all information provided in this application and disclosure is true, correct, and complete to the best of my knowledge and belief. I will notify Acentra Health within three (3) business days of any material changes to the application. I understand and agree that any material misstatement or omission in this application may constitute grounds for denial or revocation of participation. I acknowledge that I have read this application in its entirety. I further agree that a photocopy of this document may serve as a duplicate original. Facsimile signatures or signatures imprinted in an electronic medium, such as .pdf format, shall be deemed to be original signatures.	
I have reviewed and agree to the Peer Reviewer Acknowledgement as outlined above.	☐ **Yes** ☐ **No**
By typing my name, I acknowledge that I have read and understood this application/document in its entirety and agree to the content of this document.	
Date signed	

Note: *Any firm that has misrepresented its status in the above listed categories in order to obtain a subcontract from Keystone Peer Review Organization, LLC, will be subject to the punishments as defined in 115 U.S.C.645(d) and FAR 52-219-9 (e).*

Signature of this form constitutes certification of compliance with all provisions within this form.

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PEER REVIEWER APPLICATION POTENTIAL EXCLUSION

A peer reviewer applicant, at the time of initial credentialing or recredentialing, may be declined participation for the following:

1. Evidence of incompetence, meaning the gross or repeated deviation from the standard of care by failing to conform to minimal standards of acceptable and prevailing medical practice or failure to maintain appropriate professional boundaries.
2. Evidence that the applicant has engaged in any unethical conduct, including actions likely to deceive, defraud, or harm patients or the public.
3. Evidence that the applicant has been sanctioned or has sanctions pending by federal, state, or local government programs.
4. Evidence that the applicant has personally engaged in or otherwise contributed to the submission of claims for payment that were false, negligently incorrect, intentionally duplicated, or indicated other abusive billing practices.
5. Evidence that the applicant has engaged in any conduct resulting in a felony or gross misdemeanor conviction. For purposes of this provision, a plea of guilty or a plea of no contest to a felony or gross misdemeanor charge constitutes a conviction.
6. Evidence that the applicant has engaged in any sexual misconduct or in any behavior toward a patient that could be reasonably interpreted by the patient as physical, emotional, or sexual abuse or harassment.
7. Evidence of using or prescribing for self or self-administration of any controlled substance, dangerous drug (as specified in law), or alcoholic beverages, which are dangerous or injurious to the applicant, any other person public, or that the practitioner's ability to practice safely is impaired by that use.
8. Evidence of repeated acts of clearly excessive prescribing, furnishing, administering of controlled substances, repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and the medical reason for prescribing (note that in no event shall a physician or surgeon who is lawfully treating intractable pain be reported for excessive prescribing).
9. Evidence that the applicant has had hospital privileges suspended or revoked for other than the failure to sign medical records.
10. Evidence that the applicant does not hold an active, unrestricted license or certification to practice medicine or a health profession in a state or territory of the United States. Thank you for your interest in participating as a peer reviewer.