

Practitioners

List of therapists to be authorized to practice under the group's contract:

Check here and attach a separate sheet if necessary.

Name & Degree:			NPI:
	Date of birth:	SSN:	
Name & Degree:			NPI:
	Date of birth:	SSN:	
Name & Degree:			NPI:
	Date of birth:	SSN:	
Name & Degree:			NPI:
	Date of birth:	SSN:	
Name & Degree:			NPI:
	Date of birth:	SSN:	
Name & Degree:			NPI:
	Date of birth:	SSN:	

Please note: **Separate credentialing applications are required for all individual therapists.**

Certification, authorization and release

Contract/Legal Entity Name:

DBA/Practice Name (*if applicable*):

In submitting this application for credentialing (or recredentialing) by CarePartners of Connecticut, Inc., or any CarePartners of Connecticut affiliate (as defined in your written agreement to provide services to CarePartners of Connecticut members) (collectively "Plan") I understand that it is the Provider's responsibility to produce the required information for the proper evaluation of its application and that failure to produce this information will prevent its application from being reviewed and acted upon. The undersigned hereby acknowledges that he or she is authorized and empowered to complete this application and enter into contracts on behalf of the Provider. By submission of this application for membership in the Plan Provider Network, the undersigned hereby:

1. Certifies under pains and penalties of perjury that the information contained herein, including all supporting materials, is true and complete to the best of his/her knowledge and belief. The Provider understands that its application will be reviewed based upon the information it has provided and other information obtained by Plan in accordance with its credentialing program. The Provider further understands that information which is found to be false could result in a denial or termination of Provider's network privileges.
2. Acknowledges and agrees that Plan or its agents may solicit information from past and former associates, health care organizations and any other relevant sources and review documents which Plan, in its discretion, deems relevant in assessing Provider's qualification for membership in the Plan provider network.
3. Authorizes the release of all such relevant information by any individual or organization and release from liability Plan and any such individuals or organizations which in good faith and without malice provide information bearing on the Provider's qualifications for the Plan provider network and/or credentialing status.
4. Authorizes the licensing agencies in any state in which the Provider is or has been licensed, to release information to Plan regarding any licensure information, any pending or final disciplinary action, and any other information relevant to the Provider's professional competence or status.
5. Agrees that all employed and/or contracted clinical staff and associates have been appropriately credentialed consistently with all applicable laws, requirements and standards.
6. Authorizes and requests Provider's professional liability insurance carrier to release information regarding any claim or action for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
7. Agrees to notify Plan as soon as Provider becomes aware of any event which might reasonably affect Provider's Plan credentialing status, including the initiation of any disciplinary action by any certification or accreditation entity, any health care facility or regulatory agency.
8. Understands that it may not provide healthcare services to Plan members until it is credentialed and contracted by Plan.
9. Authorizes and releases from liability Plan for the good faith disclosure of credentialing information by Plan to the extent required by law, regulations, court order or other standards or requirements applicable to Plan.

Authorized representative's signature

Date

Authorized representative's name (*please print*)

Authorized representative's title