

# Optima Health Credentialing Packet

Thank you for your interest in becoming a participating provider in the Optima Health Network. Please review the following instructions to ensure acceptance of your application for processing:

1. **Please inform Optima Health directly of the Provider's intent to participate in the Optima Health Network by contacting your assigned Network Educator at 877-865-9075.**
2. **Visit [www.CAQH.org](http://www.CAQH.org) to complete an application.** Optima Health uses the online Council for Affordable Quality Healthcare (CAQH) application exclusively for all Providers. Please contact the CAQH Provider Help Desk (1-888-599-1771 or [caqh.updhelp@acsgs.com](mailto:caqh.updhelp@acsgs.com)) for assistance with the CAQH application.

3. **Once your CAQH application is complete, with all supporting documentation attached, please complete and submit this packet, which includes the following:**
  - **Optima Health Provider Information form**
  - **Optima Health Application Checklist** – please review and complete to confirm your CAQH application contains all required information. (*Optima Health Credentialing will not accept or process an incomplete application. Omission of any information or supporting documentation will result in your application being returned to your office for correction.*)
  - **Optima Health Authorization and Release**

**PLEASE EMAIL PACKET TO:**

**Hampton Roads, Eastern Shore, NC: Linda Winebrenner - [LKWINEBR@SENTARA.COM](mailto:LKWINEBR@SENTARA.COM)**  
**All other areas: Ebonie Grady - [ELGRADY@SENTARA.COM](mailto:ELGRADY@SENTARA.COM)**

Complete applications are forwarded to the Optima Health Credentialing Department for review, verification, and presentation to the Medical Director and Credentialing Committee for final determination. **The credentialing process typically takes between 60-90 days upon receipt of a complete and correct application.**

Upon approval by the Optima Health Credentialing Committee, Providers will be notified by their assigned Network Educator of their Optima Health participation effective date. **Providers should not begin scheduling or treating Optima Health members on an in-network basis until they are notified of their Optima Health effective date.**

If you have any questions about the Optima Health credentialing process, please contact Provider Services at 800-648-8420. We look forward to working with you.

**OPTIMA HEALTH CREDENTIALING**  
**PROVIDER INFORMATION FORM**  
*(All fields are required.)*

Provider Name: \_\_\_\_\_ CAQH Number \_\_\_\_\_

Individual NPI: \_\_\_\_\_

Provider Type: \_\_\_\_\_ Provider Specialty: \_\_\_\_\_

If Family Practice, Geriatrics, Internal Medicine, or Pediatrics, will provider be a PCP with members attached?     Yes     No

If yes, please select panel status listed below:

- 0 Provider is open and accepting members
- 1 Not accepting new patients; will continue providing services for existing patients, siblings, and spouses switching plans with verification from physician's office
- 3 Not accepting new patients; accepting newborns and siblings.
- 4 Age restriction: Provide ages: \_\_\_\_\_
- 5 Non MD: Membership should be paneled to valid MD in practice
- 7 Covering physician only

Practice Name \_\_\_\_\_

Tax Id # \_\_\_\_\_ Group NPI # \_\_\_\_\_

Vendor Number(s) to be Attached to Provider (if known) : \_\_\_\_\_

Practice Address \_\_\_\_\_  
\_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Practice Email \_\_\_\_\_

Office Credentialing Contact: \_\_\_\_\_

Credentialing Contact Phone: \_\_\_\_\_

Credentialing Contact Email: \_\_\_\_\_

# APPLICATION CHECKLIST

**Provider Name:** \_\_\_\_\_

**Please initial to confirm each of these items has been completed:**

<b>Provider Office</b>	<b>Optima Use</b>
_____	_____ All questions answered on CAQH application
_____	_____ Optima Authorization & Release Form with signature date no more than 6 months old at the time Optima receives all required documents
_____	_____ Seven years of malpractice insurance history in CAQH application (Two years for NPs, PAs, CNMs)*
_____	_____ Explanation for gaps in malpractice insurance noted in CAQH*
_____	_____ Copy of current malpractice insurance face sheet showing \$2,200,000 per incident/\$4,400,000 per aggregate for Virginia or \$1 million/\$3 million minimum for other states.
_____	_____ Explanation for any malpractice suits noted in CAQH
_____	_____ Education history, including applicable internship/residency/fellowships noted in CAQH
_____	_____ All past and current state licenses and DEA information noted in CAQH
_____	_____ ECFMG number noted in CAQH (if applicable)
_____	_____ Board Certification information or date when taking boards noted in CAQH
_____	_____ Hospital Privileges listed in CAQH (if applicable)
_____	_____ Covering colleagues or partners/associates noted in CAQH
_____	_____ Work history for past 10 years noted in CAQH
_____	_____ Explanation of work history gaps > 6 months noted in CAQH*
_____	_____ Professional references from 2 providers with contact phone number noted on CAQH Application*
_____	_____ Copy of Curriculum Vitae or Resume in month and year format attached to CAQH
_____	_____ Foreign languages spoken noted in CAQH
_____	_____ Completed W-9 form (for newly contracted practices only)
_____	_____ National Provider Identification Number

Provider Office Representative (Print Name) \_\_\_\_\_ Date \_\_\_\_\_

**OPTIMA HEALTH USE ONLY:**

CA/Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Medicare Opt Out List Date \_\_\_\_\_

Credentialing Department \_\_\_\_\_ Date \_\_\_\_\_

Comments \_\_\_\_\_

\* Information not included on North Carolina CAQH application and must be supplied separately.

# Sentara Healthcare

## Authorization and Release

### A. General Conditions of Application

In return for my application being considered and processed, I agree to be legally bound by the following terms and conditions:

1. I know that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I will also provide the Sentara Hospital(s) to which I am applying (hereinafter referred to as "the applicable Sentara Hospital(s)") and Sentara Health Plan, Inc., provided that I am seeking participation in a Sentara Affiliated Health Plan(s) (hereinafter referred to as "the applicable Sentara Affiliated Health Plan(s)") with any additional information that the applicable Sentara Hospital(s), the applicable Sentara Affiliated Health Plan(s) or their respective representatives may request. Failure to provide any requested information will cause my application to be incomplete, so that it cannot be processed.
2. I will keep this application current by informing the applicable Sentara Hospital(s), through the Site Administrator(s) or his/her designee(s) and/or the applicable Sentara Affiliated Health Plan(s) through the Sentara Health Plan, Inc. Medical Director, of any changes in the information provided.
3. I will be available for interviews with regard to this application.
4. As applicable, I will accept committee assignments, emergency service call obligations, and other reasonable Medical Staff duties and responsibilities assigned to me.
5. I will provide timely and continuous care for all my patients treated at the applicable Sentara Hospital(s).
6. My appointment to the Medical Staff(s) and exercise of clinical privileges at the applicable Sentara Hospital(s) and/or my participation in the applicable Sentara Affiliated Health Plans are dependent upon my continued demonstration of professional competence and cooperation and acceptable performance of all related responsibilities.
7. I have had an opportunity to read a copy of the Medical Staff Bylaws, Rules and Regulations, and/or Credentials Policy of the applicable Sentara Hospital(s) and the contract of the applicable Sentara Affiliated Health Plan(s), and I specifically agree to abide by the bylaws, policies, rules and regulations, and directives that are in force during the time I am appointed to the Medical Staff(s) at the applicable Sentara Hospital(s).
8. I will abide by the applicable Sentara Hospital(s)' and applicable Sentara Affiliated Health Plan(s)' Corporate Compliance Policy and any laws, regulations and standards of conduct applicable to my profession, participation in any federal health program, or activities at the applicable Sentara Hospital(s) and/or applicable Sentara Affiliated Health Plan(s) and will report any known or suspected violation to the Site Administrator(s), Compliance Officer(s), or Sentara Health Plan, Inc. Medical Director.
9. All information provided in or attached to this application is accurate and complete. I know that any misrepresentation, misstatement or omission from this application shall constitute cause to stop the processing of my application. If my misrepresentation, misstatement, or omission is discovered after I have been appointed, that discovery may be an automatic relinquishment of my appointment and clinical privileges. Neither situation entitles me to any of the hearing or appeal rights contained in the Medical Staff Bylaws and/or the Credentials Policy(s) at the applicable Sentara Hospital(s) or any of the hearing or appeal rights contained in the policies at the applicable Sentara Affiliated Health Plan(s).

### B. Information Sharing, Release, and Immunity

1. I understand that the entities to which I am applying for appointment and clinical privileges and/or participating provider status are members of, or affiliated with, Sentara Healthcare. I also understand that my Confidential Peer Review Information will be shared among the Sentara Hospital(s) at which I am granted, or seek, Medical Staff appointment and clinical privileges and each Sentara Affiliated Health Plan at which I am granted, or seek, participation and Sentara Health Plan, Inc.. "Confidential Peer Review Information" includes information and/or documentation regarding my clinical competence and/or professional conduct that is obtained or produced as part of the credentialing, quality assessment, and/or peer review processes conducted by the Sentara Hospital(s) and their Medical Staff(s), Sentara Health Plan, Inc., and/or the Sentara Affiliated Health Plan(s). Such sharing is solely for the purposes of credentialing and peer review and will be treated in the same confidential manner as within a single Sentara Hospital or Sentara Affiliated Health Plan and/or Sentara Health Plan, Inc..
2. The Sentara Hospital(s) at which I am granted, or seek, appointment and clinical privileges, the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, and Sentara Health Plan, Inc. may

release to one another, and to the Sentara Healthcare Medical Affairs Committee, Confidential Peer Review Information regarding my practice.

3. Confidential Peer Review Information that is released shall be used solely for credentialing and peer review purposes and all Confidential Peer Review Information will be handled in confidence, in accordance with the protections and privileges afforded to peer review information under state and/or federal law.
4. I accept the following conditions and intend to be legally bound by them:
  - (a) To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue Sentara Healthcare, the Sentara Healthcare Medical Affairs Committee, the Sentara Hospital(s) at which I am granted, or seek, Medical Staff appointment and clinical privileges and their Medical Staff(s), Sentara Health Plan, Inc., the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, their respective representatives, or any third parties for any matter relating to appointment, reappointment and clinical privileges, and participation in the Sentara Affiliated Health Plan(s), or my qualifications for the same.
  - (b) I authorize the Sentara Hospital(s) at which I am granted, or seek, Medical Staff appointment and clinical privileges and their Medical Staff(s), Sentara Health Plan, Inc. and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for appointment to the Medical Staff(s) at the Sentara Hospital(s) or participation in the Sentara Affiliated Health Plan(s). This authorization includes the right to inspect or obtain communications, reports, records, recommendations or disclosures that may be relevant to such questions. I specifically authorize these third parties to release the information to the Sentara Hospital(s) at which I am granted, or seek, Medical Staff appointment and clinical privileges and their Medical Staff(s), Sentara Health Plan, Inc. and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives upon request.
  - (c) I also authorize the Sentara Hospital(s) at which I am granted, or seek, Medical Staff appointment and clinical privileges and their Medical Staff(s), Sentara Health Plan, Inc. and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to release such information to other hospitals, health care facilities and managed care entities and their agents, who seek such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges and participating provider status or other credentialing matter.
  - (d) I agree that the hearing and appeal procedures set forth in the Hospital(s)' Medical Staff Bylaws and/or Credentials Policy(s) and/or the hearing and appeal procedures set forth in the Sentara Affiliated Health Plan(s)' policies are my sole and exclusive remedy with respect to any professional review action taken at the Sentara Hospital(s) and Sentara Affiliated Health Plan(s).
- (5) In the event that the terms and conditions of this release conflict with the terms and conditions of the Coalition for Affordable Healthcare's (CAQH) release, the terms and conditions of this release shall control as they relate to Sentara Healthcare.

\_\_\_\_\_  
Signature of Practitioner

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date