Doula Credentialing Application

This application is to be utilized exclusively by Doula Practitioners who do not have an application available via CAQH.

Instructions:

Please type or print legibly when completing this form. If you need more space, attach additional sheets, and reference the question being answered. To assist in the timely processing of your application, we have provided the following checklist of documents necessary to complete your application packet for review.

Application Checklist:

- ☐ Valid, current Doula certification
- ☐ Current malpractice coverage
- ☐ Curriculum Vitae which includes work history for the past 5 years (month/year must be included)
- ☐ Completed and signed Meridian application and attestation forms
- ☐ Completed W-9 Form
- ☐ Disclosure of Ownership Statement

If information is missing, Meridian will notify the applicant of receipt of missing or incomplete application elements. Applicants have thirty (30) days from the date of submission to provide all missing elements to Meridian. If all elements have not been submitted within the 30-day timeframe, the application will be closed as incomplete. Once your credentials have been verified, the Meridian Credentialing Committee will review your application and you will be notified of our decision in writing.

During the credentialing and recredentialing process, Meridian obtains information from various outside sources to evaluate your application. You have the right to review any primary source information that Meridian collected during this process such as the National Practitioner Data Bank (NPDB), Licensing and Board Certification. However, this does not include references or recommendations or other information that is peer review protected.

You also have the right to request the status of your application at any time during the credentialing/recredentialing process.

I. General Information

Last Name: _____ First Name: _____ MI: _____

Maiden or Other Names Used: _____ DOB: _____

Gender: ☐ Male ☐Female Email Address: _____

Medicaid Provider #: _____ Federal Tax ID #: _____

Individual NPI: _____ Group NPI: _____

Degree: _____ Specialty: _____

Does the provider support electronic prescribing? ☐Yes ☐No

II. Practice Information

Practice Name: _____ Email: _____

Address: _____

City: _____State: _____ County: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Credentialing Contact Name: _____ Email: _____

Accepting new patients? ☐Yes ☐No List in Provider Directory? ☐Yes ☐No

What gender or age restrictions do you have?

Gender: ☐No Restrictions ☐Female Only ☐Male Only

Age: ☐No Restrictions ☐Age Limits: Lowest Age _____ Highest Age_____

Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

III. Accessibility

Please specify which accessibility options you have for individuals with physical disabilities:

Accessibility	Yes	No
Parking spaces, curb ramps, or loading zones at building entrance	☐	☐
Doorways wide enough to ensure safe passage by individuals using mobility aids	☐	☐
Wheelchair accessible restrooms with grab bars and accessible lavatories	☐	☐
ASL signage and raised tactile text characters at office, elevator, and restroom doors	☐	☐
Medical equipment accessible to patients using mobility aids	☐	☐
Exam rooms accessible to patient using mobility aids	☐	☐
Other	☐	☐

Is the provider's location on an accessible public transportation route?

Transportation	Yes	No
Bus	☐	☐
Rail	☐	☐
Other	☐	☐

Does this location offer non-English languages (including ASL) on-site by qualified healthcare interpreters? ☐ Yes ☐ No

If the answer is yes, which non-English languages are provided on-site by qualified healthcare providers, office staff and/or interpreters at this location?

Non-English Language	Yes	No	Non-English Language	Yes	No
American Sign Language (ASL)	☐	☐	Korean	☐	☐
Arabic	☐	☐	Mandarin	☐	☐
Cantonese	☐	☐	Polish	☐	☐
French	☐	☐	Portuguese	☐	☐
German	☐	☐	Russian	☐	☐
Haitian	☐	☐	Spanish	☐	☐
Hindi	☐	☐	Tagalog	☐	☐
Italian	☐	☐	Vietnamese	☐	☐
Japanese	☐	☐	Other	☐	☐

Does the provider supply translation services for written materials? ☐Yes ☐No

IV. Cultural Competency

Has the provider completed cultural competency training? ☐Yes ☐No

Meridian seeks to increase network developments' capacity to recruit providers of diverse racial and ethnic backgrounds. Please check the applicable boxes best describing your ethnicity, culture and race.

Ethnicity	**Culture**		**Race**
☐ African American	☐ African American	☐ Greek	☐ Black
☐ Hispanic American	☐ Arabic	☐ Haitian	☐ White
☐ Asian American	☐ Asian or Pacific Islander	☐ Hindi	☐ Other_____
☐ Native American	☐ Black	☐ Hispanic	
☐ American Woman	☐ Black (Non-Hispanic)	☐ Indian	
☐ Other_____	☐ Caucasian	☐ White (Non-Hispanic)	

Does the provider have specialized training and experience in treating the following?

Specialized Training	**Yes**	**No**
Physical Disabilities	☐	☐
Intellectual and Developmental Disabilities	☐	☐
Chronic Illness	☐	☐
HIV/AIDS	☐	☐
Serious Mental Illness	☐	☐
Substance Abuse	☐	☐
Homelessness	☐	☐
Deafness or hard-of-hearing	☐	☐
Blindness or Visual Impairment	☐	☐
Co-occurring Disorders	☐	☐
Other	☐	☐

V. Malpractice Insurance – attach current copy of declaration page

Current Professional Carrier: _____

Carrier Address: _____

Carrier Phone #: _____

$ Amount per Occurrence: _____ $ Amount per Aggregate: _____

Date of Coverage from: _____ Date of Coverage to: _____

VI. Professional Training

Complete School Name _____

City: _____ State: _____ Course of Study/Major: _____

Degree(s) Received: _____ Graduation Date (mm/yy): _____

Did you complete the program? ☐ Yes ☐ No
(If you did not complete the program, please attach Explanation Form(s)

VII. Certification (Please attach a copy of your current Board Certificate)

Are you certified by any board in your profession? ☐ Yes ☐ No
List all current and past board certifications.

Name of Issuing Board	Specialty	Certification Date (mm/yy):	Recertification Date (mm/yy):	Expiration Date (mm/yy):

VIII. Work History

List all work history/military experience in chronological order from most current to oldest for a five (5) year period beginning with the current year. Please explain fully any gaps of six months or more in the space provided below. A current Curriculum Vitae (must specify month and year) may be substituted.

From (Month/Year)	To (Month/Year)	Name & Address of Employer	Position Held

IX. Disclosure Questions

Please provide a complete explanation if any of the following questions are answered in the affirmative. Use a separate sheet to continue, if necessary. Answer all questions. If you do not believe a question is applicable to you, you should answer the question "No."

	Licensure
1	Has your license, registration or certification to practice in your profession, ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or have you ever been subject to a fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? ☐ Yes ☐ No
2	Has there been any challenge to your licensure, registration or certification? ☐ Yes ☐ No
	Hospital Privileges and Other Affiliations
3	Have your clinical privileges or medical staff membership at any hospital or healthcare institution, voluntarily or involuntarily, ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical record when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board? ☐ Yes ☐ No
4	Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation? ☐ Yes ☐ No
5	Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ☐ Yes ☐ No
	Education, Training and Board Certification
6	Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? ☐ Yes ☐ No
7	Have you ever, while under investigation or to avoid an investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ☐ Yes ☐ No
8	Have any of your board certifications or eligibility ever been revoked? ☐ Yes ☐ No
9	Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ☐ Yes ☐ No

DEA or State Controlled Substance Registration	
10	Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) while under investigation? ☐ Yes ☐ No
Medicare, Medicaid or Other Governmental Program Participation	
11	Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare of Medicaid program, or in regard to other federal or state governmental healthcare plans or programs? ☐ Yes ☐ No
Other Sanctions or Investigations	
12	Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program. Medicare or Medicaid program, or any other private, federal or state health program or a defendant in any civil action that is reasonably related to your qualifications, competence, functions, or duties as a medical professional for alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No
13	To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ☐ Yes ☐ No
14	Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ☐ Yes ☐ No
15	Have you ever been convicted or, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? ☐ Yes ☐ No
16	Have you ever been convicted of, pled guilty to, pled nolo contendere to, sanctioned, reprimanded, restricted, disciplined or resigned in exchange for no investigation or adverse action within the last ten years for sexual harassment or other illegal misconduct? ☐ Yes ☐ No
Professional Liability Insurance Information and Claims History	
17	Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history? ☐ Yes ☐ No
18	Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your individual liability history? ☐ Yes ☐ No
Malpractice Claims History	
19	Have you had any professional liability actions (pending, settled, arbitrated, mediated or litigated) within the past 10 years? If yes, provide information for each case. ☐ Yes ☐ No

	Criminal/Civil History
20	Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony? ☐ Yes ☐ No
21	In the past ten years have you been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations) or been found liable or responsible for any civil offense that is reasonably related to your qualifications, competence, functions, or duties as a medical professional, or for fraud, an act of violence, child abuse or a sexual offense or sexual misconduct? ☐ Yes ☐ No
22	Have you ever been court-martialed for actions related to your duties as a medicinal professional? ☐ Yes ☐ No
	Ability to Perform Job
23	Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drugs may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to rugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal Law." The term does include, however, the unlawful use of prescription-controlled substances). ☐ Yes ☐ No
24	Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ☐ Yes ☐ No
25	Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? ☐ Yes ☐ No
26	Are you unable to perform the essential functions of a practitioner in your area of practice even with reasonable accommodation? ☐ Yes ☐ No

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organization, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, and Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provider another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information *including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules, and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

_____ _____

Signature* Name (print)*

_____

Date Signed*

Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has ownership interest of 5% or more in a disclosing entity, is an officer or directory of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this Statement, an updated Statement should be completed and submitted within 30 days of the change. Please attach a separate sheet if necessary to provider complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Check one that describes you: ☐Individual Provider ☐Group Practice ☐Disclosing Entity	
Name of Individual Provider, Group Practice, or Disclosing Entity ("Provider")	
DBA Name:	
Address:	
TIN or SSN:	NPI:

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the provider (e.g., an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. – refer to the definition of "person with ownership or control interest" in the instructions), list the name, address, date of birth (DOB), and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the provider, list the name, Tax Identification Number (TIN), and address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	**DOB (if an individual)**	**Address**	**SSN (if an individual) TIN (if an entity)**

Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the provider has an ownership or control interest of 5% or more?
☐Yes ☐No

If "yes," list the name, address, DOB, and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

Name	**DOB (if an individual)**	**Address**	**SSN (if an individual) TIN (if an entity)**

Section III: Relationships

Are any of the individuals listed in Section I or Section II above related to each other? ☐Yes ☐No

If "yes," list the individuals who are related to each other, and the type of relationship (i.e., spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Name	Type of Relationship

Section IV: Convictions

Has any person who has an ownership or control interest in the provider, or has an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid or Title XX program? ☐Yes ☐No (verify through OIG website)

If "yes," please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

Section V: Business Transactions

Has the provider had any financial transactions with any subcontractors totaling more than $25,000 with any subcontractors during the pre
months? ☐Yes ☐No

Has the provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previo
years? ☐Yes ☐No

If "yes," list the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous twelve-month period, and any significant business transactions between the Provider and any wholly owned supplier or between the provider and any subcontractor during the past five-year period. (42 CFR 455.105. Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI: Managing Employees

Does the provider have any managing employees? ☐Yes ☐No

If "yes," list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and the percent of interest. (42 CFR 455.104) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	% Interest

Disclosure of Ownership and Control Interest Statement Attestation

If “Group Practice” or “Disclosing Entity” is checked in the Practice Information section above, the undersigned hereby represents that he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate, and on behalf of each provider and provider listed on Exhibit A attached to this Statement, and the undersigned represents that he, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed provider and provider.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading, inaccurate, or incomplete data may result in a denial of participation for the affected providers.

_____ _____

Signature Title (or indicate if authorized Agent)

_____ _____

Name (please print) Date