Mississippi Division of Medicaid / Centralized Credentialing Verification Organization (CVO)
Facility Attestation / Authorization and Release

As part of my application for credentialing submitted to the CVO (my "Application"), I hereby acknowledge, understand, consent, and agree as follows:

1. Consistent with my Application, I have the obligation to and burden of submitting all information useful and necessary for proper evaluation of my Application.

2. I am responsible for addressing and resolving any and all issues, questions, and concerns regarding information provided to the CVO in my Application. I agree to provide information related to my Application and requested by CVO, including updated information. My failure to produce any information requested by the CVO may result in the CVO electing not to evaluate my Application or denying my Application.

3. The CVO may investigate any information included in my Application and I consent to all aspects of such investigation as part of the credentialing process. More specifically, I authorize the CVO to request, obtain, and act upon any information regarding my competence, qualifications, education, training, professional and clinical ability, character, conduct, ethics, judgment, mental and physical health, emotional stability, utilization practices, professional licensure or certification, and other matter related to my qualifications or other information associated with my Application (my "Qualifications").

4. I hereby authorize any and all individuals, institutions, schools, programs, entities, facilities, hospitals, societies, associations, corporations, agencies, licensing authorities, boards, plans, insurers, and other organizations of any type, including, but not limited to, those with which I have been associated, who have information which may bear on my Qualifications to consult with, report to, and release, exchange and share information and documents with the CVO for the purpose of the CVO's evaluation of my Application and my Qualifications.

5. I consent to and hereby authorize the CVO's inspection of records and documents (including medical records and peer review information) that may be material to the CVO's evaluation of my Application and Qualifications and my ability to carry out the services which I may perform in the event my Application is approved. I hereby authorize each and every individual and organization with custody of those records and documents to permit the CVO's inspection and copying of them as may be reasonably necessary for the CVO's evaluation of my Application. I agree to appear before the CVO for interviews regarding the CVO's evaluation of my Application.

6. I consent to and hereby authorize the CVO's release of records, documents, and related information to healthcare entities, care management organizations and interested persons on their request for such information concerning my Qualifications (including, but not limited to, peer review information), provided that the CVO's release of such information is done in good faith and without malice. I hereby release the CVO and its authorized representatives and agents from liability for any claim for damages of any nature for the good faith release of records, documents, or other related information.

7. I hereby release the CVO and its authorized representatives and agents from liability for their acts when performed in a reasonable manner with respect to the investigation and evaluation of my Application and my Qualifications, and I hereby waive any and all claims of any nature against the CVO and its authorized representatives and agents acting in good faith and without malice in connection with the evaluation of my Application and my Qualifications.

8. I acknowledge and understand that any investigations, actions, and recommendations by the CVO (including the CVO's Credentialing Committee) with respect to the evaluation of my Application and my Qualifications and any further reappraisals or evaluations will be undertaken by the CVO as a medical review and/or peer review committee are consistent with the CVO's obligations (under applicable law or otherwise) to conduct such reviews and are, therefore, entitled to application protections provided by law.

9. I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating practitioner by CVO, DCH or a Care Management Organization under contract with DCH.

10. I understand that I have the right to review and correct erroneous information obtained by the CVO to evaluate my Application. This includes information obtained from primary sources (e.g., malpractice insurance carriers, state licensing boards and National Practitioner Data Bank). The review must take place within six (6) months of the date of this Application and my proposed corrections must be submitted in writing to the CVO within thirty (30) days of commencement of the review. The CVO is not

required to allow a practitioner to review references or recommendations or other information that is peer-review protected.

11. I understand that if my Application is rejected for reasons relating to my professional conduct or competence, CVO may report the rejection to the appropriate state licensing board, the National Practitioner Data Bank, and/or the Health Care Integrity and Protection Data Bank.

12. I certify that (i) the information provided in or attached to my Application is accurate and complete; (ii) I have adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements; (iii) I hold a full, unrestricted license to practice in the state(s) in which I practice or I have indicated on this application the limitations and/or restrictions imposed; and (iv) I have reported any loss or limitation of hospital privileges or any disciplinary activity to the CVO.

Select the appropriate option:

☐ **As a physician, I attest that I will continue to maintain active admitting and staff privileges at a CVO-participating hospital or I have otherwise indicated on this application.**

☐ **As a health care professional requiring a supervising physician relationship, I attest that I have a written agreement with a physician who oversees my clinical decision in compliance with the professional licensing laws in the state(s) in which I practice.**

☐ **I am not a physician or a health care professional who is required to have a supervising physician relationship.**

13. The CVO does not discriminate on the basis of race, color, national origin, sex, religion, age or disability.

14. I have read and fully understand this Authorization and Release, which constitutes my written authorization and request to provide and release any and all relevant information (including supportive records and documents) regarding my Application and any further reappraisals and evaluations by the CVO. I agree to execute any additional releases as may be reasonably required by the CVO in connection with any further reappraisal and evaluations.

15. By signing below, I attest that I am the duly authorized representative of the Facility and have the proper authorization to execute this attestation with the intent to fully bind Facility to the truthfulness of its answers. I attest that all the information on this entire application is complete, accurate and current.

***Your Signature**

Date