



<lookup_key> <line_unique_id>

Ph: <send_phone>

Fax: <send_fax>

<Date>

<First_Name> <Last_Name>, <Degree_Type>

<Send_Address1> <Send_Address2>

<Send_City>, <Send_State> <Send_Zip>

Dear Dr. <Last_Name>:

The biannual recredentialing review is pending. Please forward as soon as possible information needed for this process.

Recredentialing package includes:

- Reappointment profile - any one of the following may be used (Current California Participating Physician Application or CPPA Reapplication or CHG brief Reappointment Application, which is attached)
- Current Medical License
- Current DEA Certificate
- Current Malpractice Insurance Certificate
- Summary of malpractice activity in the last two years

To assist in the quick processing of this information, please FAX THE ABOVE INFORMATION directly to our Credentialing Staff at (619) 213-1033 or (619) 213-1026. PLEASE USE THIS LETTER AS YOUR FAX COVER PAGE (for identification purposes).

We will contact you should additional information or documents be required to update your credentials file and/or when action is taken on this application. If this provider is no longer associated with your group, please contact Teresa at (619) 498-6441. Thank you for your cooperation.

Sincerely,

Elizabeth

Elizabeth Micklus
Credentialing Specialist

Community Health Group, Credentialing Dept., 740 Bay Boulevard,
Chula Vista, CA 91910

Phone: (619) 498-6521 · Fax: (619) 213-1033 · Email:
credentialing@chgsd.com

<lookup_key>

Practitioner Profile Summary

Please make changes as necessary.

Name: <first_name> <middle_name> <last_name>, <degree_type>

Specialty: <primary_specialty> **Sub-Specialty(ies):** <sub_specialty> <SUB_SPECIALITY>

Original Appointment: <Active_Date>

Next Reappointment Due: <Primary_End_Date>

Group/ Practice

<group_detail>

Practitioner's Language (Other than English): <Language1> <Language2>

Site Language (if different from practitioner):

Licensing Data

State Medical License: <State_License>

Expires: <License_Date>

DEA Certificate: <Dea_License>

Expires: <Dea_Date>

Board Certification

<board_detail>

Hospital Privileges

(If more than 1, please circle main admitting facility)

<appoint_facility_detail>

Insurance

<insurance_detail>

Attestation
Questions

1. Has your license to practice in any jurisdiction, DEA, Medicare, Medicaid or Board Certification been challenged, limited, suspended, reduced or revoked (voluntarily or involuntarily) or is there any investigations or challenges pending. Yes__ No__

2. Have you been denied staff membership, clinical privileges, plan participation, or the renewal thereof, been subject of disciplinary action or investigation, or had your privileges, participation, or medical staff membership restricted, reduced or otherwise challenged at any hospital, medical organization/facility or health plan or is any such investigation/challenge pending? Yes__ No__

3. Have you resigned from, or chosen not to renewal clinical privileges at, any medical staff or outpatient facility? Yes__ No__

4. Have you had any malpractice claims, judgments, settlements filed against you since your last reappointment? Has your professional liability coverage been reduced, denied or otherwise changed since your last appointment? Yes__ No__

5. Have you completed less than the required CME to maintain your CA medical license? Yes__ No__

6. Do you have any mental or physical health condition that would prohibit you from continuing to provide appropriate care to your patients? Yes__ No__

If the answer is yes to any question above, please provide detailed explanation below or on separate sheet.

Reappointment Application - cont'd
<first_name> <last_name>, <degree_type>
Print Date: <date>

RELEASE / ACKNOWLEDGEMENTS

I hereby request reappointment to the provider panel of community Health Group, with practice status as show above. I acknowledge that I have been given access to Community Health groups' current policies, and hereby agree to abide by them.

I release from liability and consent to the communication and release of information and documents between Community Health Group and health plans/medical groups/IPAs/hospitals and any and all individuals, business entities, medical staffs, training programs, medical societies, professional associations, professional liability insurance companies and licensing authorities for the evaluation of my professional training, experience, character, conduct, judgement, ethics, ability to work with others, and willingness to abide with and conform to regulatory and practice norms and standards.

I hereby affirm that the information submitted in this reappointment application and any addendums thereto is true and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of my application and/or termination from participation with Community Health plan.

Signature: _____ **Date:**

Printed Name: <first_name> <last_name>, <degree_type>