EmblemHealth®

CREDENTIALING APPLICATION ADDENDUM FOR REGISTERED PHYSICIAN ASSISTANT

Applicant name:	**Applicant title:**

Required Documents

Each applicant must submit the original application form in addition to this Registered Physician Assistant addendum. Each application must be accompanied by a collaborative Registered Physician Assistant practice agreement with an EmblemHealth participating provider.

Collaborative Practice Agreement

The undersigned agree to work in a collaborative practice within their scope of practice, including hospital admissions and dispensing of controlled substances as needed. ☐ Separate agreement attached.

EmblemHealth Physician

Name:			
Address:	City:	State:	ZIP code:
Phone:	License #:	NPI#:	Directory ID #:
Signature:		Date:	

Physician Assistant Consent and Release Form

I understand and acknowledge that as an applicant for EmblemHealth (plan):

A. It is my responsibility to provide sufficient information upon which a proper evaluation can be undertaken of my current licensure, relevant training and/or experience, current competence, health status, character ethics and any other criteria adopted by the plan.

B. I agree to abide by EmblemHealth's administrative guidelines, applicable laws, rules and regulations, and agree to be bound by them.

The plan will investigate the information in this application, disciplinary reporting and information exchange activities as part of its credentialing program, as follows:

1. **Authorize investigation and release of information concerning appointment.** I hereby authorize all individuals, institutions, and entities, including but not limited to schools, colleges, university administrators and members of the professional staff of facilities or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance who have knowledge concerning information requested in this application, to consult with and release relevant information to the plan or its agents.
2. **Release from liability.** I hereby, fully, absolutely and unconditionally release from all liability the plan, its agents and all other individuals, institutions and entities providing information in accordance with the authorization contained herein for all acts performed in good faith and without malice in connection with the investigation of this application, including but not limited to, the acts of preparing or completing any verifications, evaluations, recommendations, information request or forms that are provided by the applicant, hospitals or third party payers. This release is in addition to any other applicable immunities provided by law.

The authorization and release given by me herein shall be irrevocable so long as I am an applicant for credentialing or have clinical privileges at the plan.

The investigation of information in this application is true and complete to the best of my knowledge and belief and any materials misstatement or omission from this application may constitute rounds for denial or revocation of clinical privileges with the plan. The plan shall be solely responsible for all decisions concerning granting clinical privileges.

I have read and understand the foregoing Authorization and Release.

Name (Print or Type):	
Signature:	Date: