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Credentialing Application

PERSONAL INFOMATION			
LAST NAME	FIRST NAME		MIDDLE
E-MAIL	PHONE	SPOUSE/PARTNER'S NAME	
SOCIAL SECURITY #	DATE OF BIRTH	PLACE OF BIRTH (City & State)	
PRIMARY SPECIALTY		FORMER ALIASES Years Associated (YYYY-YYYY)	
NPI #	FCVS LOGIN		
Are you a citizen of the United States? □ YES □ NO		If no, are you authorized to working the U.S.? □ YES □ NO	

CURRENT/PREVIOUS HOME ADDRESS		
Please provide a chronological history in MM/YYYY format for the last 10 years (Attach additional sheet(s) as needed).		
CURRENT ADDRESS		
CITY	STATE	ZIP
START DATE	END DATE	
STREET ADDRESS		
CITY	STATE	ZIP
START DATE	END DATE	
STREET ADDRESS		
CITY	STATE	ZIP
START DATE	END DATE	
CITY	STATE	ZIP
STREET ADDRESS		

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START DATE	END DATE	
STREET ADDRESS		
CITY	STATE	ZIP
START DATE	END DATE	
❒ **Please check this box if you have additional addresses**		

UNDERGRADUATE EDUCATION

INSTITUTION NAME		
ADDRESS		
DATES ATTENDED FROM: TO:	Did you graduate? □ YES □ NO	If no, please provide explanation
PHONE:	FAX:	DEGREE AND MAJOR
INSTITUTION NAME		
ADDRESS		
DATES ATTENDED FROM: TO:	Did you graduate? □ YES □ NO	If no, please provide explanation
PHONE:	FAX:	DEGREE AND MAJOR

MEDICAL SCHOOL

INSTITUTION NAME		
ADDRESS		
DATES ATTENDED MM/YYYY FROM: TO:	Did you graduate? ■ YES □ NO	If no, please provide explanation:
PHONE:	FAX:	DEGREE AND MAJOR
ADDITIONAL INSTITUTION NAME ***(if applicable***		

FOREIGN MEDICAL EDUCATION

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ARE YOU A GRADUATE OF A FOREIGN MEDICAL SCHOOL? □ YES □ NO		
IF YES, ARE YOU CERTIFIED BY THE EDUCATION COMMISSION FOR FOREIGNMEDICAL GRADUATES (ECFMG)? □ YES □ NO		
ECFMG ISSUE DATE (MM/DD/YYYY)	ECFMG NUMBER:	

INTERNSHIP

INSTITUTION NAME		
ADDRESS		
PHONE	FAX	PROGRAM DIRECTOR
DATES ATTENDED FROM: TO:	TYPE OF INTERNSHIP ☐ ROTATING ☐ STRAIGHT ☐ OTHER	
Did you successfully complete the program? □ YES □ NO	If no, please provide explanation:	
ADDITIONAL INSTITUTION NAME ***(if applicable)***		
ADDRESS		
PHONE	FAX	PROGRAM DIRECTOR
DATES ATTENDED FROM: TO:	TYPE OF INTERNSHIP? ☐ ROTATING ☐ STRAIGHT ☐ OTHER	
Did you successfully complete the program? □ YES □ NO	If no, please provide explanation:	

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RESIDENCY		
All applicants that have completed Residency Training within the last five years or is currently in training **MUST** provide a current Program Director.		
INSTITUTION NAME		
ADDRESS		
PHONE	FAX	PROGRAM DIRECTOR
DATES ATTENDED FROM: TO:	LIST SPECIALTY:	
Did you successfully complete the program? □ YES □ NO	If no, please provide explanation:	
ADDITIONAL INSTITUTION NAME ***(if applicable)***		
ADDRESS		
PHONE	FAX	PROGRAM DIRECTOR
DATES ATTENDED FROM: TO:	LIST SPECIALTY:	
Did you successfully complete the program? □ YES □ NO	If no, please provide explanation:	
FELLOWSHIP		
INSTITUTION NAME		
ADDRESS		
PHONE	FAX	PROGRAM DIRECTOR
DATES ATTENDED FROM: TO:	SPECIALTY:	
Did you successfully complete the program? □ YES □ NO	If no, please provide explanation:	
ADDITIONAL INSTITUTION NAME ***(if applicable)***		
ADDRESS		
PHONE	FAX	PROGRAM DIRECTOR

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DATES ATTENDED FROM: TO:	SPECIALTY:
Did you successfully complete the program? □ YES □ NO	If no, please provide explanation:

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EXAMS	
Identify the exams taken.	
□ **FLEX** □ **SPEX** Number of attempts: _____ Year of attempt(s): _____	□ USMLE □ COMLEX □ NBOME/NBME Step 1 - # of attempts: _____ Year of attempt(s): _____ Step 2 - # of attempts: _____ Year of attempt(s): _____ Step 3 - # of attempts: _____ Year of attempt(s): _____

EDUCATIONAL GAPS	
*List all educational gaps. Gaps over **30** days require a more detailed explanation in the box below.*	
GAP DATES	EXPLANATION
GAP DATES	EXPLANATION
GAP DATES	EXPLANATION
GAP DATES	EXPLANATION

EMPLOYMENT/WORK HISTORY		
List employment history for all employment in chronological order. Use MM-YYYY. (Attach additional sheet(s) as needed)		
COMPANY		
ADDRESS		
CONTACT	PHONE	FAX
JOB TITLE	DATES OF EMPLOYMENT FROM: TO:	
REASON FOR LEAVING		

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COMPANY		
ADDRESS		
CONTACT	PHONE	FAX
JOB TITLE	DATES OF EMPLOYMENT FROM: TO:	
REASON FOR LEAVING		
COMPANY		
ADDRESS		
CONTACT	PHONE	FAX
JOB TITLE	DATES OF EMPLOYMENT FROM: TO:	
REASON FOR LEAVING		

WORK HISTORY GAPS

List all work history gaps. Gaps greater than 30 days require a more detailed explanation in the box below.

DATES OF GAP	EXPLANATION
DATES OF GAP	EXPLANATION
DATES OF GAP	EXPLANATION
DATES OF GAP	EXPLANATION

HOSPITAL PRIVILEGES/AFFILIATIONS

List <u>all</u> current and previous hospital affiliations. Use MM-YYYY. (Please attach additional sheet(s) as needed)

PRIMARY HOSPITAL NAME	DATES OF AFFILIATION FROM: TO:
ADDRESS	PHONE

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STAFF STATUS	**FAX/EMAIL**	
HOSPITAL NAME	DATES OF AFFILIATION FROM: TO:	
ADDRESS		PHONE
STAFF STATUS	FAX/EMAIL	
HOSPITAL NAME	DATES OF AFFILIATION FROM: TO:	
ADDRESS		PHONE
STAFF STATUS	**FAX/EMAIL**	
HOSPITAL NAME	DATES OF AFFILIATION FROM: TO:	
ADDRESS		PHONE
STAFF STATUS	**FAX/EMAIL**	

❒ **Please check this box if you will be providing a list of all previous affiliations**

MILITARY SERVICE

BRANCH	SERVICE DATE FROM: TO:
RANK AT DISCHARGE	TYPE OF DISCHARGE
IF OTHER THAN "HONORABLE", PLEASE EXPLAIN:	

BOARD CERTIFICATION

PRIMARY SPECIALTY	ARE YOU BOARD CERTIFIED? □ YES □ NO Name of Certifying Board:	
ORIGINAL CERTIFICATION DATE:	CERTIFICATE #	EXPIRATION DATE: *If applicable*

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

- ❒ I have taken exam, results pending
- ❒ I have taken Part I and am eligible for Part II. I am intending to sit for the Boards on_____(date)
- ❒ I am not planning to take Boards.

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SECONDARY SPECIALTY	ARE YOU BOARD CERTIFIED? □ YES □ NO Name of Certifying Board:	
ORIGINAL CERTIFICATION DATE:	CERTIFICATE #	EXPIRATION DATE: *If applicable*

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY.

- ❒ I have taken exam, results pending
- ❒ I have taken Part I and am eligible for Part II. I am intending to sit for the Boards on_____(date)
- ❒ I am not planning to take Boards.

PEER REFERENCES

*All applicants must provide 4 peer references who can attest to your clinical abilities within the last 12 months. References must be of same discipline (**i.e., Physician to Physician, NP to NP, PA to PA**). Allied Health Professional are required to provide at least one supervising physician/medical director.*

NAME/TITLE	RELATIONSHIP
COMPANY/AFFILIATION	PHONE
ADDRESS	
EMAIL	
NAME/TITLE	RELATIONSHIP
COMPANY/AFFILIATION	PHONE
ADDRESS	
EMAIL	
NAME/TITLE	RELATIONSHIP
COMPANY/AFFILIATION	PHONE
ADDRESS	
EMAIL	
NAME/TITLE	RELATIONSHIP
COMPANY/AFFILIATION	PHONE

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ADDRESS	
EMAIL	

MEDICAL LICENSES					*Check if obtained through the IMLC*
Please list <u>all</u> current and previous medical licensures held. (Please attach additional sheet(s) as needed)					
STATE ***(Primary)***	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
STATE	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
STATE	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
STATE	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
STATE	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
STATE	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
STATE	LIMITATIONS □ YES □ NO	LICENSE NUMBER	ISSUED DATE	EXPIRATION DATE	□
❒ **Please check this box if you have additional medical licenses**					

CONTROLLED SUBSTANCE REGISTRATION				
❒ ***I do not have an active state or federal controlled substance registration***				
CSR/DEA REGISTRATION #	STATE	DATE ISSUED	EXPIRATION DATE	SCHEDULE □ N/A □ LIMITED □ FULL
CSR/DEA REGISTRATION #	STATE	DATE ISSUED	EXPIRATION DATE	SCHEDULE □ N/A □ LIMITED □ FULL
CSR/DEA REGISTRATION #	STATE	DATE ISSUED	EXPIRATION DATE	SCHEDULE □ N/A □ LIMITED □ FULL
❒ **Please check this box if you have additional state or federal controlled substance registrations**				

CERTIFICATIONS		
BLS CERTIFICATION	ISSUED DATE	EXPIRATION DATE
ACLS CERTIFICATION	ISSUED DATE	EXPIRATION DATE

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PALS CERTIFICATION	ISSUED DATE	EXPIRATION DATE
OTHER CERTIFICATION	ISSUED DATE	EXPIRATION DATE

HEALTH RECORDS

INFLUENZA VACCINATION

Have you received an Influenza Vaccination within the current season? □ YES □ NO

DATE RECEIVED:_____ If no, please complete Addendum B- Declination for Influenza Vaccination

TUBERCULOSIS SCREENING

Have you had a Tuberculosis skin test or booster within the last 12 months? □YES □NO

DATE:_____RESULTS: □ Negative □ Positive

If you have had a positive TB in the past, have you had a Chest X-ray within the last 5 years? □ YES □ NO

TEST DATE:_____ RESULTS: □ Negative □ Positive

❒ I received the following COVID vaccinations.

Date of 1st does: Type:

Date of 2nd does: Type:

Date of Booster: Type:

❒ I will be requesting a medical, religious, or telemedicine exemption from the facilities I am seeking privileges.

See Addendum C. *(Note: It is the discretion of the facility to approve your exemption request, not Coaxion Radiology.* ***In effort to reduce paperwork, Addendum C is intended to be a substitute for site-specific exemption forms.)***

MEDICAL LIABILITY COVERAGE

CARRIER			
POLICY NUMBER	LIMITS	RETRO DATE	EXPIRES
CARRIER			
POLICY NUMBER	LIMITS	RETRO DATE	EXPIRES
CARRIER			
POLICY NUMBER	LIMITS	RETRO DATE	EXPIRES

❒ **Please check this box if you have additional sheet(s) for more Malpractice Insurance information.**

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DISCLOSURE QUESTIONS

MEDICAL LICENSURE AND CERTIFICATES	YES	NO
1) Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, refused, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?		
2) Have you ever received a reprimand or been fined by any state licensing board?		
3) Has your professional license or registration ever been investigated or is it currently being investigated?		
4) Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?		

HOSPITAL PRIVILEGES AND OTHER AFFILIATIONS	YES	NO
5) Have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association, faculty position or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?		
6) Have you ever surrendered, allowed to expire, voluntarily or involuntarily withdrawn a request for membership or clinical privileges, terminated contractual participation or employment, or resigned from any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), medical society, professional association, faculty position or other health delivery entity or system) while under investigation for possible incompetence or improper professional conduct, or breach of contract, or in return for such an investigation not being conducted, or is any such action pending?		
7) Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted regarding participation in the Medicare or Medicaid program, or regarding other federal or state governmental health care plans or programs?		
8) Has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g., reduced limits, restricted coverage, surcharged)?		
9) Have you ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your professional liability insurance or its coverage of any procedures?		
10) Have you ever practiced within your profession without professional liability insurance?		

EDUCATION, TRAINING AND BOARD CERTIFICATION	YES	NO
11) Were you ever, or are you currently, placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship, or other clinical education program?		
12) Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?		
13) Have you ever failed any part of your American Board of Radiology exam? If yes, please provide further details and number of attempts to pass.		
14) Have any of your board certifications or eligibility ever been revoked?		

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OTHER SANCTIONS OR INVESTIGATIONS	YES	NO
15) Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare, or Medicaid program, or any other private, federal, or state health program?		
16) To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?		
17) Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?		
18) Have you ever had any malpractice actions or Notice of Intents? (pending, settled, arbitrated, mediated, or litigated)		
19) Have you ever been found liable, guilty, or responsible for sexual impropriety or misconduct or sexual harassment with a patient, co-worker, or other?		
20) Have you ever been arrested, charged with a misdemeanor or felony, indicted, found guilty or entered a plea of guilty or nolo contendere, in a criminal prosecution (other than a minor traffic violation) whether a sentence was imposed? (Minor traffic violations include, but are not limited to, parking violation, speeding, running a red light, failing to yield and failure to obey a traffic device.)		
21) Have you ever been court-martialed for actions related to your duties as a medical professional?		
HEALTH STATUS		
22) Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug 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 drugs 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.)		
23) Does your use (or have you been told that your use) of alcohol or drugs affect your ability, with or without reasonable accommodation to provide appropriate care to patients and otherwise perform essential functions in your area of practice without posing a health risk to your patients? If yes, please describe any accommodations you are seeking with respect to your condition.		
24) Do you have a physical or mental condition that would affect your ability with or without reasonable accommodation, to provide appropriate care to patients and otherwise perform the essential functions of a practitioner in your area of practice without posing a health or safety risk to your patients? If yes, please describe any accommodations you are seeking with respect to your condition.		

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Please use this space to provide an explanation to any YES responses. ***Note, information given in this section may be placed on formal letterhead for use in the privileging and licensing process. Explanations should be as thorough as possible.***

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Authorization, Attestation and Release
PLEASE READ CAREFULLY

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with:

(including all affiliated radiology practices), 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 Coaxion Radiology 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 does not guarantee that Coaxion Radiology will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with Coaxion Radiology 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.

Hospital Credentialing. I acknowledge that, in addition to being credentialed by Coaxion Radiology, I will also need to be credentialed and privileged at each of the hospitals or other sites where I will be providing services. To that end, I consent to appear for interviews with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I will be responsible for staying informed as to all applicable medical staff bylaws, rules and regulations, and policies of the hospitals and other practices sites where I am credentialed and agree that I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, Coaxion Radiology, 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 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 services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data 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 organizations, 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 Coaxion Radiology and any third parties for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Coaxion Radiology 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, any 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 Coaxion Radiology 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 provide 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 true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). 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 Coaxion Radiology and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

INITIAL _____

SIGNATURE _____

NAME. _____

(PLEASE PRINT OR TYPE) _____

DATE. _____

(MM/DD/YYYY)

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DISCLOSURE OF INTENT TO OBTAIN
CONSUMER REPORTS OR INVESTIGATIVE CONSUMER REPORTS

For employment purposes, Coaxion Radiology may obtain or facilitate obtaining consumer reports on you as an applicant or from time to time during employment. “Consumer reports” are reports from consumer reporting agencies and may include driving records, criminal records, etc. and are sometimes referred as a “background check”.

For such employment purposes, Coaxion Radiology may also obtain investigative consumer reports. Some reference checks by a consumer reporting agency fall into this category. An “investigative consumer report” is a consumer report in which information as to character, general reputation, personal characteristics, or mode of living is obtained through personal interviews with neighbors, friends, associates, acquaintances, or others. You have a right to request disclosure of the nature and scope of an investigation and to request a written summary of consumer rights.

❒ Please check here and below if you would like to receive a copy of your completed background check.

- □ **Sent via email** through secure link within 24 hours of background check completion. OR
- □ **Sent via US mail** through hardcopy report. Please allow up to 2 weeks for delivery.

AUTHORIZATION

I authorize Coaxion Radiology to obtain consumer reports and/or investigative consumer reports regarding me from time to time for employment purposes.

Signature:_____Date: _____

Print Name: _____

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Credentialing Application **Addendum A**

MALPRACTICE CLAIM INFORMATION

Instructions: Complete an Addendum A for each pending, dismissed, dropped, and/or settled malpractice lawsuit that you have been named as a defendant. Attach copies of the complaint, answer, release, settlement documents and all other relevant legal documents.

❒ Please check here if this page is not applicable and sign/date below.

Was this claim reported to the NPDB? □ Yes □ No

MALPRACTICE COMPLAINT:

Include name of patient, age, sex, date of occurrence and location, i.e., office or name and address of hospital.

Plaintiff Name: _____ Age: _____ Sex: _____

Place of Occurrence: _____ Date of Occurrence: _____

County & State Claim Filed: _____

FILED AGAINST: □ Individual Doctor □ Group □ Hospital

Indicate your position in case (i.e., resident, primary physician, etc.): _____

Professional Liability Carrier Involved: _____ Policy #: _____

DISPOSITION:

❒ Pending
❒ Jury Verdict
❒ Dropped
❒ Dismissed
❒ Settled

Total amount paid (if any): _____ Amount attributable to you: _____

Date of payment: _____

Allegation:

_____

_____

_____

Provide a narrative description of your participation/level of care:

_____

_____

_____

_____

_____

Signature: _____ Date: _____

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Provider Identification Verification Form

(To be completed by Practice Leader)

In accordance with Coaxion Radiology Credentialing Policy, to ensure that the individual requesting appointment is the same person presenting this identification; the below form must be completed (Option **A** or **B**) and the original document must be presented at the same time. A copy of the completed form and the document must be returned to your credentialing representative or ----------

Provider's full Legal Name (*As shown on your ID)*: _____
Last *First* *Middle*

Provider's Date of Birth: _____ Place of Birth: _____

Personal Email:_____ Height:_____Weight: _____

Eye Color:_____ Hair Color:_____ Ethnicity:_____ Gender:_____

Provider's Signature:_____

A. For Practice Leader Use Only

I certify that I have viewed the original government issued ID and hereby certify the individual above is the actual person hired to provide imaging services for your practice.

Type of Identification: Valid US Government Agency-issued picture identification. (Please check **one**.)

- ❒ Driver's License
- ❒ U.S. Passport
- ❒ Other Government issued photo I.D.: _____

1. Attach a copy of the identification source to this document.

Leader's Name: _____ Leader Signature:_____Date: _____

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TELERADIOLOGY PRIVILEGE FORM

Provider Name: _____ ☐ Initial Reappointment
(Please Print) First, Last Name Title

Please check all requested privileges. Applicants will be required to provide documentation of current clinical competence for a proper evaluation of review and granting privileges.

- Successful completion of an accredited ACGME or AOA accredited post-graduate training program in Radiology
- Procedure list identifying number of cases performed within the last 24 months
- Additional requirements as identified by the specialty/privilege

	Requested	Deferred
TELERADIOLOGY CORE		
➢ Includes the interpretation of diagnostic radiology studies to diagnose patients of all ages		
➢ Plain film interpretation		
➢ Ultrasound interpretation		
➢ CT interpretation of the head, neck, spine, body, chest, abdomen, pelvis, extremities, and vasculature		
➢ Nuclear Radiology interpretation of the head, neck, spine, body, cardiac, abdomen, pelvis, extremities, and vasculature		
➢ MRI interpretation of the head, neck, spine, body, chest, abdomen, pelvis, extremities, and vasculature		
➢ Positron-emission tomography interpretation		
➢ Mammography (in accordance with Mammography Quality System Regulation-required qualifications) interpretation		

I hereby attest that the requested privileges are supported by education, training, and current experience that I am qualified to perform and wish to exercise. I further understand:

- Privileges requested may differ from those approved
- Completion of this form, at the present time, does not preclude me from requesting additional privileges
- Privileges may also be evaluated as deemed necessary based on concerns identified through the peer review process, or during the OPPE/FPPE evaluation processes
- Failure to uphold or noncompliance with Practice Policies or Code of Conduct may constitute grounds for non- renewal or restriction/limitation of privileges
- Any medical condition that could affect the exercise of clinical privileges must be reported immediately

Physician's Signature: _____ Date: _____

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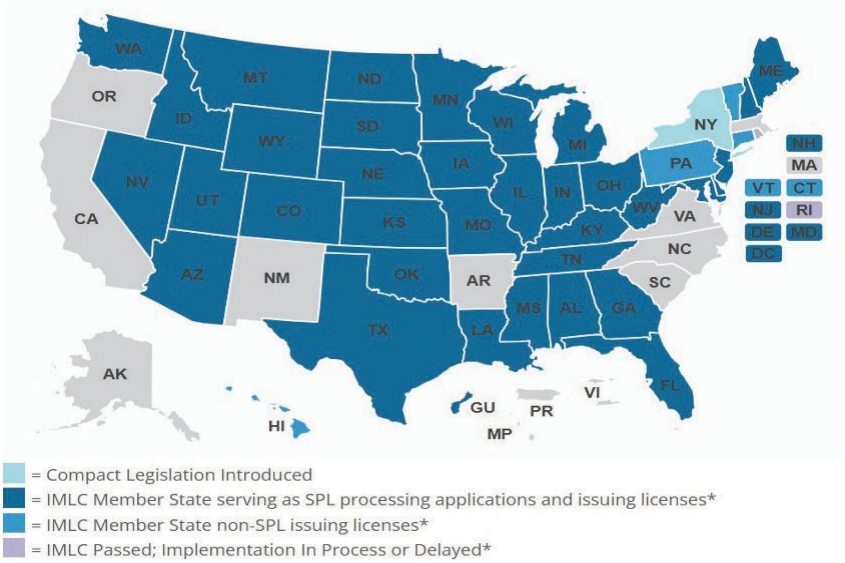
Compact Authorization Request

What is IMLC, you ask? The Interstate Medical Licensure Compact is an agreement among participating U.S. states and territories to work together to significantly streamline the licensing process for physicians who want to practice in multiple states. It offers a voluntary, expedited pathway to licensure for physicians who qualify. To determine if you qualify you must meet the following criteria:



- Have graduated from an accredited medical school, or a school listed in the International Medical Education Directory or its equivalent such as the World Directory of Medical Schools
- Have successfully completed ACGME- or AOA-accredited graduate medical education
- Passed each component of the USMLE, COMLEX-USA, or equivalent in no more than three attempts for each component (Please note that passing the Canadian Licentiate of the Medical Council of Canada, or the LMCC, DOES NOT meet this requirement)
- Hold a current specialty certification or time-unlimited certification by an ABMS or AOABOS board Not have any history of disciplinary actions toward their medical license
- Not have any criminal history
- Not have any history of controlled substance actions toward their medical license
- Not currently be under investigation

☐ I am not eligible to participate in the IMLC.
☐ I may be eligible to participate in the IMLC, but I will need to redesignate my SPL to do so.
☐ I hereby consent to authorize Coaxion Radiology's Licensing Specialist to manage and maintain my IMLC Profile to gain licensure so that I may cover Coaxion Radiology clients in applicable IMLC states.

IMLC Username _____

IMLC Password _____

_____ _____
Signature of Provider Date of Signature

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Interstate Medical Licensure Compact (IMLCC) Questionnaire

Do you have an IMLCC login? YES ☐ NO ☐

If so, please provide your login details below:

IMLCC Login

Username: _____

Password: _____

Please list your State of Principal Licensure (SPL): _____

Which of the following options are relevant to your SPL state?

☐ The physician's primary residence is in the SPL

☐ At least 25% of the physician's practice of medicine occurs in the SPL

☐ The physician is employed to practice medicine by a person, business or organization located in the SPL

☐ The physician uses the SPL as his or her state of residence for U.S. Federal Income Tax purposes.

_____ _____

Signature of Provider Date of Signature

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Credentialing Application **Addendum B**

******Should you choose to decline the seasonal flu vaccine, please complete this form**

DECLINATION FORM FOR SEASONAL INFLUENZA VACCINE

I DO NOT WANT A FLU SHOT.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. [In California, influenza usually begins circulating in early January and continues through February or March.]
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- I have declined to receive the influenza vaccine for the____-_____season. I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community.

Knowing these facts, I choose to decline vaccination currently. I may change my mind and accept vaccination later if vaccine is available. I have read and fully understand the information on this declination form. I am declining due to the following reasons (check all that apply):

- ❒ I believe I will get influenza if I get the vaccine.
- ❒ I do not like needles.
- ❒ My philosophical or religious beliefs prohibit vaccination.
- ❒ I have an allergy or medical contraindication to receiving the vaccine.
- ❒ Other reason – please tell us.

_____

- I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season.
- I understand that I may change my mind at any time and accept influenza vaccination if vaccine is available.

I have read and fully understand the information on this declination form.

Provider Name: _____

Provider Signature: _____ Date: _____

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Addendum C

********Should you choose to seek an exemption from any client/facility-based COVID-19 vaccine requirement as part of the credentialing process, please complete this form.**

COVID-19 VACCINE EXEMPTION REQUEST FORM

Coaxion Radiology has created this form to allow physicians participating in the credentialing process to notify the client/facility that they desire to be exempted from any COVID-19 vaccination requirement.

Basis for Exemption

I wish to request exemption from receiving the COVID-19 vaccination due to one of the following reasons**:**

□ **Medical:** I request exemption from the COVID-19 vaccination due to my current medical condition. (Please have your health care provider execute the Health Care Provider Medical Exemption Request Form attached hereto as Exhibit A and return it with this form.)

□ **Religious**: Receiving the COVID-19 vaccination would conflict with my sincerely held religious, moral, or ethical beliefs. (Please complete Exhibit B attached hereto and return it with this form.)

□ **Telemedicine:** I work remotely in a telemedicine capacity and therefore will not be at risk in transmitting COVID-19 to patients, facility staff, or visitors.

□ **Other (Please explain; use additional pages if necessary)**:

_____

_____

_____

_____

I certify that the information I have provided in connection with my request is accurate and request an exemption from any client/facility-based COVID-19 vaccination requirement. I will agree to comply with any reasonable alternative process, including testing and use of PPE.

Applicant Name: _____

Applicant Signature: _____ Date: _____

***

Disclaimer: The decision as to whether to grant any exemption will be in the sole discretion of the client/facility – and not be determined by Coaxion Radiology or any of its affiliates. Although Coaxion Radiology provides this form to clients/facilities for consideration, it takes no position as to whether any individual exemption request should be granted or denied.

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Exhibit A – Health Care Provider Medical Exemption Request Form

TO BE COMPLETED BY APPLICANT'S HEALTH CARE PROVIDER

Patient Name:

_____ Patient

Date of Birth: _____

The above person should not be immunized for COVID-19 for the following reasons (please check all that apply.):

- □ History of previous allergic reaction to indicate an immediate hypersensitivity reaction to a component of the vaccine.
- □ The physical condition of the person or medical circumstances relating to the person are such that immunization is not considered safe. Please indicate below the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization with the COVID-19 vaccine (use additional pages if necessary).
- □ Other – Please describe below (use additional pages if necessary). Explanation:

_____

_____

_____

_____

_____

_____

_____

- □ I certify that the individual named above should receive a medical exemption from the COVID- 19 vaccine for the reason(s) set forth above.

Medical Provider Signature: _____

Printed Name: _____

Date: _____

Mailing Address: _____

Phone Number/Email Address: _____

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Exhibit B – Religious Exemption Request Form TO BE

COMPLETED BY APPLICANT:

Describe, in your own words, the sincerely held moral, ethical, or religious principles that guide your objection to COVID-19 immunization (use additional pages if necessary).

_____

_____

_____

_____

_____

_____

_____

_____

Identify the religious or spiritual leader(s), if any, from whom you have obtained guidance or counsel with respect to the issue of the COVID-19 vaccination (use additional pages if necessary). Please attach any literature from these leader(s) or their organizations that explains the nature of your sincerely held belief and/or supports your request for an exemption or other accommodation.

_____

_____

_____

_____

_____

I certify that I have the sincerely held moral, ethical or religious beliefs set forth above (and as further referenced in any documentation provided with this request) and therefore seek an exemption on that basis from any Coaxion Radiology client/facility-based COVID-19 vaccination requirement.

Applicant Signature: _____

Printed Name: _____

Date: _____

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A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

    - a person has taken adverse action against you because of information in your credit report.
    - you are the victim of identity theft and place a fraud alert in your file.
    - your file contains inaccurate information because of fraud.
    - you are on public assistance.
    - you are unemployed but expect to apply for employment within 60 days.

    In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

- **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit- worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

- **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

- **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete, or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate. **Consumer reporting agencies may not report outdated negative information.** In most cases, a

consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address form the lists these offers are based on. You may opt out with the nationwide credit bureaus at 1-888-5-OPTOUT(1-888-567-8688).

  - The following FCRA right applies with respect to nationwide consumer reporting agencies:

CONSUMERS HAVE THE RIGHT TO OBTAIN A SECURITY FREEZE

You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent.
However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit.

As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years.

A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

- **Identity theft victims and active-duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learn more.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or

your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	a. Consumer Financial Protection Bureau 1700 G Street, N.W. Washington, DC 20552 b. Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act. c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations d. Federal Credit Unions	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050 b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480 c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106 d. National Credit Union Administration Office of Consumer Financial Protection (OCFP) Division of Consumer Compliance Policy and Outreach 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, S.E. Washington, DC 20590
4. Creditors Subject to the Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street, S.W., Washington, DC 20423
5. Creditors Subject to the Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, S.W., Suite 8200 Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F Street, N.E., Washington, DC 20549

8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	Federal Trade Commission Consumer Response Center 600 Pennsylvania Avenue, N.W. Washington, DC 20580 (877) 382-4357

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Creation Date:

Surrogacy Approval Confirmation for Medicare Individual Provider

Section 1 - Confirmation Purpose and Instructions:

The purpose of this Surrogacy for an Individual Provider Confirmation is for the Individual Provider listed below to confirm that they are aware that the individual or organization identified as the Surrogate below has requested access to act on their behalf. The Individual Provider will approve this individual or organization to act on their behalf when accessing CMS computer systems including but not limited to Provider Enrollment, Chain and Ownership System (PECOS), and the Medicare and Medicaid Electronic Health Records (EHR) Incentive Program Registration and Attestation System (HITECH).

- Authorized Official: An appointed official of the Medicare provider with the legal authority to conduct various actions related to Medicare and abide by Medicare statutes, regulations and instructions.
- Individual Provider: An individual provider that submits claims to the Medicare Part B programs and provides Medicare-covered medical items and services to Medicare beneficiaries.
- Organization Provider: An organization provider (including a group practice) that submits claims to the Medicare Part A and/or Part B programs and provides Medicare-covered medical items and services to Medicare beneficiaries.
- Organization: An Organizational Provider or other organizational entity registered in a CMS computer system for the sole purpose of acting on behalf of an Individual or Organizational Providers with respect to the Medicare Program.
- Surrogate: An Organization or Individual identified by an Individual Provider or Organizational Provider as someone authorized to access CMS computer systems on their behalf and to modify or view any information contained therein that the Individual Provider may have permission or right to access in accordance with Medicare statutes, regulations, policies, and usage guidelines for any CMS system.

When you have completed and confirmed all information below you must submit all pages, and a copy of the Individual Providers Government Issued identification to CMS via CMS External User Services.

Please note: Due to the increased time associated with the manual processing of individual surrogacy confirmations, some delays may be experienced before this request is approved. For more rapid approval, please ask the Provider to log in to CMS' Identity and Access Management System and approve this request online. If approved online by the Provider this confirmation form does not need to be submitted, and access will be granted immediately.

Please contact the CMS External User Services (EUS) Help Desk should you have any questions regarding this confirmation. Please return all pages, completed and signed to: CMS External User Services (EUS) Help Desk, PO Box 792750, San Antonio TX 78279, Phone Number: (866) 484-8049

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Section 2 - CONFIRMATION OF UNDERSTANDING AND PENALTIES FOR FALSIFYING INFORMATION FOR INDIVIDUAL OR ORGANIZATION PROVIDER:

By signing below and submitting or authorizing the submission of this information to CMS all signers of this form confirm and agree to the following:

- The individual identified in Section 3A ("Individual Provider") has: i) a pre-existing and current business relationship with the Surrogate Organization or Surrogate Individual listed in Section 3B and Section 3C respectively below (collectively "Surrogate"); ii) has authorized the Surrogate to access CMS computer systems on their behalf for the sole purpose of modifying or viewing any information contained therein that the Individual Provider may have permission or right to access in accordance with Medicare statutes, regulations, policies, and usage guidelines for that system; iii) has not shared their CMS issued username and password with any 3rd party including the Surrogate.
- The individual identified in Section 3B confirms that they are an Authorized or Access Manager as defined above for the Organization identified in Section 3B ("Surrogate Organization"), and that this Organization has a pre-existing and current business relationship with Individual Provider that grants this Organization the authority to act as a Surrogate, as defined above.
- The individual identified in Section 3C ("Surrogate Individual") confirms that they are an Individual not acting on behalf of any Organization as defined above, and that they have a pre-existing and current business relationship with the Individual Provider that grants this individual the authority to act as a Surrogate, as defined above.
- Surrogates shall only access CMS systems with the username and password issued to them personally as part of the Identity and Access Management Registration process, and not the username and password issued to the Individual Provider indentified in Section 3A.

The signatures below further confirm that all signers: have read, understand, and agree to all statements herein, including the following:

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PENALTIES FOR FALSIFYING INFORMATION ON THE
CONFORMATION FOR MEDICARE INDIVIDUAL OR ORGANIZATION PROVIDER

The signatures below authorize the Medicare program to grant the Surrogate identified in Section 3A access to Medicare information for the Individual/Organization provider identified in Section 2A of this Conformation. The Individual Provider/Authorized Official, agree to the following statements:

18 U.S.C. § 1001 authorizes criminal penalties against an individual who, in any matter within the jurisdiction of any department or agency of the United States, knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious or fraudulent statement or entry. Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000(18 U.S.C. § 3571). Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

Any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplied to Medicare or its contractors, or any deliberate alteration of any text on this conformation, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges and/or imposition of fines, civil damages, and/or imprisonment.

Section 3A- Individual Provider:	**** Indicate Required Fields**
I, the undersigned, certify that I have read and agree to all statements within this conformation, and that all information contained herein is true, correct, and complete. I agree that if I become aware that any information contained herein is not true, correct, or complete, I shall notify the CMS EUS Help Desk of this fact immediately.	
****Individual Provider (First, Middle, Last, Jr., Sr., M.D., D.O., etc.):***	****Provider NPI:***
*** Select the system(s) for which you will be providing surrogate services:* *Note: At least one must be selected.*	
PECOS Yes No Tracking ID:	
EHR Incentive Program Yes No Tracking ID:	
NPPES Yes No Tracking ID:	
*****Signature:***	*****Date Signed (MM/DD/YYYY):***

Section 3B- Surrogate Organization (if applicable):	**** Indicate Required Fields**
Organization's Legal Business Name:	***EIN:***
I, the undersigned, certify that I have read and agree to all statements within this conformation, and that all information contained herein is true, correct, and complete. I agree that if I become aware that any information contained herein is not true, correct, or complete, I shall notify the CMS EUS Help Desk of this fact immediately.	
Surrogate Organization Authorized Official or Access Manager (First, Middle, Last, Jr., Sr., M.D., D.O., etc.):	
Naomi M Cassin	
*****Signature:***	***** Date Signed (MM/DD/YYYY):***

Section 3C- Surrogate Individual (if applicable):	**** Indicate Required Fields**
I, the undersigned, certify that I have read and agree to all statements within this conformation, and that all information contained herein is true, correct, and complete. I agree that if I become aware that any information contained herein is not true, correct, or complete, I shall notify the CMS EUS Help Desk of this fact immediately.	
Surrogate Individual (First, Middle, Last, Jr., Sr., M.D., D.O., etc.):	
*****Signature:***	*****Date Signed (MM/DD/YYYY):***

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CAQH Authorization Request

Welcome to Coaxion Radiology!

We are your CAQH Enrollment Specialist for Coaxion Radiology. The CAQH Enrollment team is responsible for auditing and maintaining your CAQH ProView Profile. The CAQH Enrollment team also facilitates CAQH profile creations, for providers who have never been enrolled.

What is CAQH, you ask? CAQH is an online database that is meant to standardize the enrollment and credentialing process. As a provider all of the data used to complete your enrollment and credentialing process with an Insurance Payer or Medical facility is stored in this database to reduce the time of requesting this data for verification purposes. Due to regulatory requirements, your CAQH ProView Profile must be attested every 120 days to ensure that the data provided is the most current information.

With your permission Coaxion Radiology would like to manage this process on your behalf. If you allow Coaxion Radiology to manage your profile, we ask that you review and provide your CAQH credentials. If you are not aware of your CAQH credentials, we have included an Authorization and Release of Information consent form, that the CAQH enrollment specialist assigned to you will send to CAQH to request access to your profile.

☐ I hereby consent to, authorize Coaxion Radiology's CAQH Enrollment Specialist to manage and maintain my CAQH ProView Profile, as it relates to the credentialing data contained therein, as long as the information is provided in good faith and without malice. Below are my CAQH Credentials

CAQH ID _____

CAQH Username _____

CAQH Password _____

If you are unaware of your CAQH Credentials, please Only Sign, but do not date the attached Authorization and Release of Information to Designated Contacts agreement for CAQH.

_____
Printed Name of Provider

_____ _____
Signature of Provider Date of Signature

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Authorization and Release of Information
To Designated Contacts

I hereby consent to, authorize, and release from liability CAQH, its agents, and CAQH affiliated vendors to release access to my application data, as it relates to the completion and maintenance of the provider credentialing data contained therein, as long as this information is provided in good faith and without malice, unless such acts are due to the gross negligence or willful misconduct of CAQH, its agents, and any CAQH affiliated vendors, to:

1. Coaxion Radiology (Primary Authorized Contact Organization/Practice Name)

Of the information to be released, to the delegated authorized party (or parties) as specified above, includes my CAQH Provider ID number, CAQH ProView Username, and Primary Method of Contact.

I understand that a photocopy or facsimile of this Authorization and Release form shall be as effective as the original when so presented, unless canceled by me in writing.

_____ _____

Printed Name of Provider **CAQH ID Number**

_____

Signature of Provider **Date of Signature**

Expiration of Authorization

Valid for up to 3 years

(Providers please note, if an expiration date is not included, your letter will expire three years from the date the letter was received by CAQH.)