Credentialing Guidelines

***** NEW as of 6/1/2023*** Please note for Mid-Level providers (Nurse Practitioners and Physician Assistants) if you mark yes to being a PCP or Yes to Showing in Molina's Directory then a full packet and the credentialing process is required. If the Mid-Level is acting as a specialist and they do not wish to show on the Molina Online Directory for members, then you will just need to complete an Attachment C. See below for additional instructions.**

The supervising physician **must be credentialed with Molina**. Please provide the MD's name and NPI. Please use this checklist to ensure the information needed by our Credentialing Department is present.

For Providers to be Affiliated with Practice: The below items MUST be included

- CAQH ID: current Attestation, current practice(s) listed, authorize Molina access
- An incomplete package will delay or term the credentialing process

- If MID-LEVEL Provider is acting as a specialist and does **NOT** wish to show in the Molina online Directory for members then omit all forms except Attachment C and send that to: SCNetworkAdministration@MolinaHealthCare.com
- If the Med-Level **is** acting as a PCP or **would** like to appear in Molina's Provider Online Directory – please indicate so on the Attachment C form. In both cases, we would need the below.
    - Attachment C Provider Roster – include all location and provider information
        - Full protocols signed/dated within 1 year by Mid-Level and Supervising Physician
            - Supervising Physician must be PAR with Molina Healthcare of SC
                - Provide Effective Date for Group affiliation

***** Please note If the PCP box is checked, the provider will be assigned members. *****

- Include SC Medicaid Number. **Provider must have an active SC Medicaid number**.
- If provider(s) have completed application(s) on CAQH, ensure all information is current and practice location(s) are included within the application.
    - Please note, our Credentialing Department requires attestations in **CAQH not to be within 60 days of expiration.**
        - Ensure Molina is authorized to access the CAQH profile
- If the provider(s) does not have a current CAQH profile, please complete SC Uniform Credentialing Application.
    - All pages must be completed, mark "N/A" where not applicable and ensure all pages are initialed and dated where required.
    - Work history information includes 5 years, any gaps of 6 months or more must include an explanation documented/attached.
        - Malpractice Insurance Limits: **MUST NOT expire within the next 60 days**
            - 1/3 mil, MD, DO, Oral Surgeon, and Podiatrist
        - 1/1 mil, non-physician BH, Naturopath, and Optometrist
    - 200/600 Acupuncturist, Chiropractor, Massage Therapist, NP, PA, PT, SLP
        - TORT (if applicable)
    - Patient Compensation Fund (if applicable)
- Additional Insurance if the above limits are not met, **MUST NOT expire within the next 60 days**

Please contact your Provider Service Representative (PSR) with questions about Credentialing.

Submit completed credentialing applications to MSC-Credentialing@MolinaHealthCare.com and copy your PSR.

Please note the Credentialing and provider load process can take up to 60 days.

ATTACHMENT C PROVIDER ROSTER

Please note the three sections of this form: 1. Practice Contact Information 2. Practice Name, Location and Important Information 3. Provider Details

Contract Entity Type ☐ Solo Practice ☐ Group Practice ☐ IPA ☐ FQHC/RHC

Practice Credentialing contact person:

Name: _____ Title: _____

Phone: _____ Email: _____

1. _____ _____ _____-_____
   Group Name Group NPI Group TIN
2. _____ _____ _____-_____
   Group Name Group NPI Group TIN
3. _____ _____ _____-_____
   Group Name Group NPI Group TIN

Practice Names and Locations Affiliated with Contract
(for Members' Provider Directory) - *Please list 'Same' if the Name is the same as the Group listed above.*

1. _____ _____
   Practice Name Address including Bldg, Suite #

   _____ _____
   City, State, Zip County

   _____ _____
   Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

2. _____ _____
   Practice Name Address including Bldg, Suite #

   _____ _____
   City, State, Zip County

   _____ _____
   Practice Phone Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

3. _____ _____

Practice Name | Address including Bldg, Suite #

_____ _____

City, State, Zip | County

_____ _____

Practice Phone | Practice Fax

Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From – To							

In Order for Providers to be Affiliated with Practice, these items must be included:

- o CAQH ID - current Attestation, current practice listed, authorize Molina access
- o Must have active SCDHHS Medicaid ID
- o An incomplete package will delay or term the credentialing process

If the PCP box is checked, Provider will be credentialed, listed in Molina Directory and assigned members.

1. _____ _____ _____ _____

Last Name | First Name | Degree | CAQH ID and DOB (mm/dd/yyyy)

_____ _____

Primary Specialty | Individual NPI

Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3

Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N

Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Do you intend to show, and be searchable in Molina's online directory for members? ☐ Y ☐ N

Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

Supervising MD (for Mid-level) Name: _____

Supervising NPI: _____

If more space is needed to capture information, please print a copy of this roster and submit the copy with your Agreement for submission. Thank you!

2._____ _____ _____ _____

Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____

Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Do you intend to show, and be searchable in Molina's online directory for members? ☐ Y ☐ N

Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

Supervising MD (for Mid-level) Name: _____

Supervising NPI: _____

3._____ _____ _____ _____

Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____

Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Do you intend to show, and be searchable in Molina's online directory for members? ☐ Y ☐ N

Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

Supervising MD (for Mid-level) Name: _____

Supervising NPI: _____

If more space is needed to capture information, please print a copy of this roster and submit the copy with your Agreement for submission. Thank you!

4. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Do you intend to show, and be searchable in Molina's online directory for members? ☐ Y ☐ N

Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

Supervising MD (for Mid-level) Name: _____

Supervising NPI: _____

5. _____ _____ _____ _____
Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____
Primary Specialty Individual NPI Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3 Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Do you intend to show, and be searchable in Molina's online directory for members? ☐ Y ☐ N

Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

Supervising MD (for Mid-level) Name: _____

Supervising NPI: _____

If more space is needed to capture information, please print a copy of this roster and submit the copy with your Agreement for submission. Thank you!

6. _____ _____ _____ _____

Last Name First Name Degree CAQH ID and DOB (mm/dd/yyyy)

_____ _____

Primary Specialty Individual NPI

Medicaid ID # _____

Provider Practice Locations (Check all that apply): ☐ 1 ☐ 2 ☐ 3

Medicare ID # _____

Do you intend to serve as a primary care provider? ☐ Y ☐ N

Effective Date: _____

Do you intend to serve as a specialist? ☐ Y ☐ N

Do you intend to show, and be searchable in Molina's online directory for members? ☐ Y ☐ N

Do you solely see members in the inpatient setting, i.e., do NOT take appointments in office? ☐ Y ☐ N

Accepts New Patients? ☐ Y ☐ N Current Molina Members? ☐ Y ☐ N

Other Member Enrollment Limitations? _____

Supervising MD (for Mid-level) Name: _____

Supervising NPI: _____

If more space is needed to capture information, please print a copy of this roster and submit the copy with your Agreement for submission. Thank you!

Please Note:

The following pages are only needed if the provider doesn't have an updated CAQH profile

SC Uniform Managed Care Provider Credentialing Application

I. PERSONAL INFORMATION

☐ Solo Practice ☐ Group Practice

Name: Last _____ First _____ M.I. _____ Suffix _____ Degree _____

Maiden and/or other name _____ List W-9 name if different _____

Place of birth: City _____ State _____ Date of birth _____

If you are not a U.S. citizen, do you have authorization to work in the U.S.? ☐ Yes ☐ No

(OPTIONAL) ☐ Male ☐ Female *This information will not be used by the Managed Care Organization in making its determination regarding your participation.*

Social Security number _____ NPI _____ UPIN number _____

Practice name _____

Tax ID number _____ Group NPI _____

E-mail address of practitioner _____

II. MEDICAL LICENSE/REGISTRATION

A. If you are a family practitioner, do you offer OB care? ☐ Yes ☐ No

B. Do you speak any foreign language fluently that you would like added to the directory? ☐ Yes ☐ No

If yes, please specify _____

C. ECFMG number _____

Current professional license number(s) *(indicate if not applicable):* ☐ NA

1. SC Medical License number _____ Issue date _____ Exp. date _____

2. Additional medical state licences and numbers:

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

3. DEA # _____ Exp. date _____ SC Cont. Drug Perm. # _____ Exp. date _____

History of previous licensure in all jurisdictions *(indicate of not applicable):* ☐ NA

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

State _____ License number _____ Issue date _____ Exp. date _____

III. EDUCATION, TRAINING AND HOSPITAL PRIVILEGES

A. Medical school institution _____

City _____ State _____ Country _____

Date of entry _____ Graduation date _____ Degree _____

Internship institution _____ Speciality _____

City _____ State _____ Country _____

Program completed ☐ Yes ☐ No Date of entry (MMYY) _____ Completion date (MMYY) _____

Residency institution _____ Speciality _____

City _____ State _____ Country _____

Program completed ☐ Yes ☐ No Date of entry (MMYY) _____ Completion date (MMYY) _____

Fellowship institution _____ Speciality _____

City _____ State _____ Country _____

Program completed ☐ Yes ☐ No Date of entry (MMYY) _____ Completion date (MMYY) _____

B. CME Requirements

Number of CME credits completed in the last two years _____

C. Hospital Staff Privileges

Hospital name _____

Address _____

Department _____ Dates of affiliation (MMYY): From _____ To _____

Status of privileges _____ % of admissions _____

Additional hospital name _____

Address _____

Department _____ Dates of affiliation (MMYY): From _____ To _____

Status of privileges _____ % of admissions _____

Additional hospital name _____

Address _____

Department _____ Dates of affiliation (MMYY): From _____ To _____

Status of privileges _____ % of admissions _____

If you do not admit, please describe arrangements to provide hospital care _____

_____

Provider initials _____ Date _____

IV. MEDICAL SPECIALITIES

Medical Specialities	Certifying Board	Date Certified	Expiration Date
Primary:			
If not Board certified, do you plan to take certifying exam?	☐ Yes (Date:)	☐ No	
Secondary:			
If not Board certified, do you plan to take certifying exam?	☐ Yes (Date:)	☐ No	

Under which specialty do you wish to be listed in the directory? _____

Are you applying for participation as: ☐ Primary care physician ☐ Specialist ☐ Non-Physician practitioner

V. MALPRACTICE INFORMATION

You are required to maintain malpractice insurance of an adequate and acceptable amount reflective of your specialty as a prerequisite for participating in a managed care organization. Please ***attach*** a copy of your most recent malpractice insurance binder.

List current and previous malpractice insurance carriers for the past five years:

Carrier Name & Address	Policy Number	Effective Date	Expiration Date	Amount of Coverage

VI. FIVE YEAR WORK HISTORY *(CV cannot be used in lieu of completing this section)*

	Name of Current/Previous Employer(s)	Dates of Employment (MMDDYY)		
1.			to	
2.			to	
3.			to	
4.			to	
5.			to	

Please provide an explanation of any gaps in employment _____

_____

_____

Signature _____ Printed name _____ Date _____

Rubber-stamped and electronic signatures are not acceptable.

VII. BACKGROUND INFORMATION: PLEASE ANSWER THE FOLLOWING QUESTIONS

This section must be completed by the practitioner. This information will be held strictly confidential.

Managed Care Organizations must have complete liability information and written explanations to begin the credentialing process. (If you answer "Yes" to any of the questions listed below, please enclose a detailed explanation.)

1. Do you have any pending misdemeanor or felony charges? ☐ Yes ☐ No

2. Have you ever been convicted of a felony? ☐ Yes ☐ No

3. Has your license to practice medicine in any jurisdiction ever been voluntarily or involuntarily denied, restricted, suspended, challenged, revoked, conditioned or otherwise limited? ☐ Yes ☐ No

4. In the past five years and up to and including the present, have you had any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others? ☐ Yes ☐ No

5. Considering the essential functions of a practitioner in your area of practice, in the past five years and up to and including the present, have you suffered from any communicable health condition that could pose a significant health and safety risk to your patients? ☐ Yes ☐ No

6. Have you ever been publicly reprimanded or disciplined by a professional licensing agency or board? ☐ Yes ☐ No

7. Has your DEA certification or state controlled drug permit ever been restricted, suspended, revoked, voluntarily relinquished or otherwise limited? ☐ Yes ☐ No

8. Have any of your privileges or memberships at any hospital or institution ever been denied, suspended, reduced, revoked, not renewed or otherwise limited? ☐ Yes ☐ No

9. Has your participation in Medicare, Medicaid or any other government program ever been limited or curtailed, or have you voluntarily excluded yourself from any of these programs? ☐ Yes ☐ No

10. Has your participation in an insurance company network ever been limited or terminated? ☐ Yes ☐ No

11. In the past five years and up to the present, have you had a history of chemical dependency or substance abuse that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ Yes ☐ No

12. In the past five years and up to and including the present, have you had or do you have any mental or physical condition or do you take any medications that might affect your ability to competently and safely perform the essential functions of a practitioner in your area of practice? ☐ Yes ☐ No

13. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment of a medical malpractice claim on your behalf or are any medical malpractice suits pending against you? ☐ Yes ☐ No

14. Has your professional liability insurer ever placed conditions or restrictions on your coverage or ability to obtain coverage? ☐ Yes ☐ No

VIII. AUTHORIZATION

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL ITS ATTACHMENTS ARE ACCURATE, COMPLETE AND TRUE.

I understand that:

A. Any misrepresentation, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;

B. It is my responsibility to promptly advise the Managed Care Organization in writing within 30 days of any changes or additions to the information contained in this application;

C. All the information contained in this application, or its attachments, is subject to the Managed Care Organization's investigation and review and;

D. This is an application only and my submission of this application does not automatically result in participation with the Managed Care Organization.

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to The National Practitioner Data Bank.

I authorize the Managed Care Organization to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Managed Care Organization of all documents that may be material to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Managed Care Organization and all representatives of the Managed Care Organization for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Managed Care Organization in good faith and without malice or negligence concerning my professional competence, character and ethics. I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension, or curtailment of participation status, membership and/or privileges of any type to or from the Managed Care Organization.

Signature of applicant _____ Date _____

Name of applicant (print or type) _____

Must be signed in ink

EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE.

Rubber-stamped and electronic signatures are not acceptable.

Practitioners have the right to review information obtained to evaluate their credentialing and recredentialing applications.

SC Uniform Managed Care Provider Office Information

I. GENERAL INFORMATION

A. Do you accept Medicaid patients?

☐ Yes (Medicaid ID # _____) ☐ No

B. Have you signed an agreement to participate with Medicare in the past twelve months?

☐ Yes (Medicare Group ID # _____) ☐ No

C. Are you accepting new patients? ☐ Yes ☐ No

D. Are there any age limitations? ☐ Yes (Minimum age _____ Maximum age _____) ☐ No

E. Are there gender restrictions? ☐ Males only ☐ Females only ☐ Both/no restrictions

F. Please describe any other patient limitations: _____

_____

II. OFFICE INFORMATION

A. Office address (physical)

1. Practice name _____ EIN # _____

2. Street _____ City _____ County _____ State _____ Zip _____

3. Appointment phone _____ Fax _____

4. Office contact person _____ 5. Credentialing contact phone _____

6. List all practitioners (including physician extenders) who are at this location. Indicate their status as (P) for Participating or (A) for Applying by each name. If you need more room, attach a separate sheet.

Status	Practitioner

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Describe: _____

_____

8. List physicians who are not a part of your practice with whom you share calls: _____

_____

9. What hours are you available to see patients in this office?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From-To							

10. After-Hours phone number(s) _____

11. Is your office equipped with telecommunications devices for the deaf (TDD)? ☐ Yes ☐ No

12. Is sign language assistance available? ☐ Yes ☐ No

13. List languages spoken by office staff: _____

14. Is your office handicap accessible? ☐ Yes ☐ No

B. Billing address (if different)

1. Name claims payable to _____

2. Street/PO Box _____ City _____ State _____ Zip _____

3. Phone _____ Fax _____

C. Mailing address (if different)

1. Street/PO Box _____ City _____ State _____ Zip _____

2. Phone _____ Fax _____

D. Office e-mail address (if any) _____

E. Practice Website address (if any) _____

III. SATELLITE OFFICE INFORMATION *(Duplicate this page for each satellite office location)*

A. Satellite office address (physical)

1. Practice name _____ EIN # _____

2. Street _____ City _____ County _____ State _____ Zip _____

3. Appointment phone _____ Fax _____

4. Office contact person _____ 5. Credentialing contact phone _____

6. List all practitioners (including physician extenders) who are billing at this location. Indicate their status as (P) for Participating or (A) for Applying by each name. If you need more room, attach a separate sheet.

Status	Practitioner

Status	Practitioner

7. Do you offer 24-hour/7-day coverage? ☐ Yes ☐ No Describe: _____

_____

8. List physicians who are not a part of your practice with whom you share calls: _____

_____

9. What hours are you available to see patients in this office?

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From-To							

10. After-Hours phone number(s) _____

11. Is your office equipped with telecommunications devices for the deaf (TDD)? ☐ Yes ☐ No

12. Is sign language assistance available? ☐ Yes ☐ No

13. List languages spoken by office staff: _____

14. Is your office handicap accessible? ☐ Yes ☐ No

B. Billing address (if different)

1. Name claims payable to _____

2. Street/PO Box _____ City _____ State _____ Zip _____

3. Phone _____ Fax _____

C. Mailing address (if different)

1. Street/PO Box _____ City _____ State _____ Zip _____

2. Phone _____ Fax _____

D. Office e-mail address (if any) _____

E. Practice Website address (if any) _____

Molina Healthcare of South Carolina

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

By submitting this authorization and release of information form in conjunction with the Standardized Credentialing form, I understand and agree as follows:

1) I understand and acknowledge that, as an applicant for participating status with Molina Healthcare of South Carolina indicated on the Practitioner Application for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications in a timely manner. I understand that the application will not be processed until the application is deemed complete by Molina Healthcare of South Carolina.

2) I further understand and acknowledge that Molina Healthcare of South Carolina or a designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to information exchange activities of Molina Healthcare of South Carolina as part of the verification and credentialing process.

3) I authorize all individuals, institutions and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information Molina Healthcare of South Carolina, their staffs and agents.

4) I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5) I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with providing information, investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Molina Healthcare of South Carolina or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

6) I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations, contractual agreements, and policies of Molina Healthcare of South Carolina.

7) I acknowledge that I am responsible for notifying Molina Healthcare of South Carolina of any changes/challenges to licensure, DEA, malpractice claims, criminal convictions, hospital privileges or other disciplinary actions.

8) I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Molina Healthcare of South Carolina where I have participation status before initiating judicial action.

9) I understand that completion and submission of the Authorization and Release does not automatically grant me membership or participating status with Molina Healthcare of South Carolina.

10) I hereby further authorize and consent to the release of information and/or reporting by Molina Healthcare of South Carolina to medical associations, licensing boards, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and other similar organizations regarding any pertinent information which Molina Healthcare of South Carolina may have concerning me as long as such release of information and/or reporting is done in good faith and without malice, and I hereby release from liability Molina Healthcare of South Carolina and its staff and representatives for so doing.

11) I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

a) Have you ever been convicted of, pled guilty to, or pled nolo contender to any felony?

☐ **YES** ☐ **NO** **(If yes, please provide a statement below explaining your answer.)**

b) Are you currently engaged in illegal drug use?

☐ **YES** ☐ **NO** **(If yes, please provide a statement below explaining your answer.)**

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this applications constitute cause for denial or summary dismissal. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name Here: _____

Signature: _____

(Stamped signature is not acceptable)

Date: _____