Regence
P.O. Box 1106
Lewiston, ID 83501

Regence BlueCross BlueShield of Utah Practitioner Credentialing Application

Regence contracts with physicians and other health care professionals to form provider networks essential for the delivery of health care services to our members. If you are a dentist or dental professional do not complete this application. Visit **regencedental.com** to complete an application and the onboarding process.

Regence requires all providers to meet credentialing criteria prior to contracting and remain in compliance with those criteria at all times. Please refer to the *Practitioner Credentialing Criteria for Participation and Termination* for details.

You will receive an email when your agreement documents are available for signature. **Note**: If you are joining an existing group, you will be added to the group's agreement and you will not need to sign any additional documents.

To begin the credentialing verification process, please:

1. Provide the email address and name of the individual who is responsible for reviewing and electronically signing agreement documents on your behalf:

All agreement documents are sent electronically. Not completing this portion will delay processing of your documents.	
First Name:	
Last Name:	
Email:	

2. Complete the application online in its entirety and print it.
3. Sign pages 10, 11 and 12 and return them along with a copy of your CP 575 or 147C letter and required documents via Email or fax to 1 (888) 335-3002.
4. Use our onboarding resources to complete required tasks.
5. Check the status or receipt of your new credentialing application in the Onboarding Tracker, available in Availity Essentials: Payer Spaces. Please allow at least 10 business days from the application submission date to see the status in the Onboarding Tracker. If the information you need is not available in the Onboarding Tracker, call our Provider Contact Center at 1 (888) 349-6558.
6. View additional information about credentialing and contracting in our Self-Service Tool, on our provider website, **regence.com**.

You have the right to review information submitted to support your credentialing application, including review of information submitted from outside sources, e.g., malpractice insurance and state licensing boards. Information that is allowed to be shared includes the current status, outstanding requests and process timeframes. Peer-protected and confidential information prohibited by law cannot be disclosed.

In the event that erroneous or conflicting information is discovered in a credentialing application, you will be notified in writing of the right to dispute and/or correct the information (subject to any restrictions provided by a verification source, or otherwise prohibited by law). You must submit a detailed explanation of all clarifications and corrections in writing, within fifteen (15) business days of the request. Receipt of corrected credentialing information is documented in your credentialing file.

Regence BlueCross BlueShield of Utah is an Independent Licensee of the Blue Cross and Blue Shield Association

Application addendum questionnaire

The following **optional** questions are included to meet National Committee for Quality Assurance (NCQA) standards.

Race:	
Language(s):	
Ethnicity:	

No aspect of network participation shall be denied based on origin, religion, national identity, gender, age or sexual orientation. Regence does not discriminate or base credentialing and re-credentialing decisions on an applicant's race, ethnicity or language.

Please acknowledge receipt of this addendum by signing below.

_____	_____	_____
Applicant signature (Stamp is not acceptable)	Printed name	Date

Regence BlueCross BlueShield of Utah

An Independent Licensee of the Blue Cross and Blue Shield Association

Utah Practitioner Credentials Verification Application

- Complete the application in its entirety using black or blue ink. Please document any YES responses on the Attestation Question page.
- Please include information on **all** current practice locations. Failure to do so can result in delay of payments.
- If changes must be made to the completed application, strike out the information and write in the modification, initial and date.
- If a section does not apply to you, please check the provided box at the top of the section.

I. Instructions

This form should be **typed or legibly printed in black or blue ink**. If more space is needed than provided, attach additional sheets and reference the question being answered. *Please do not use abbreviations*. **Current copies of the following documents must be submitted with this application** (all are required for MDs, DOs; as applicable for other health practitioners). If not available, indicate why.

- A copy of your CP 575 or 147C
- State Professional License(s)
- DEA Certificate with Utah address
- Face Sheet of Professional Liability Policy or Certificate
- Résumé/Curriculum Vitae (Not an acceptable substitute for completing the application.)

**** All sections must be completed in their entirety.****

II. Practitioner Information

Last name (include suffix; Jr., Sr., III)	First (do not abbreviate)	Middle (do not abbreviate)	
Other name(s) under which you have been known by reference, licensing and or educational institutions?		Degree(s)	
Birth date	Birth place (city, state, country)	Social security number	Citizenship
Languages spoken by practitioner	Type of Provider ☐ PCP ☐ Urgent Care ☐ Specialist	Gender ☐ Male ☐ Female	
NPI	Specialty	Subspecialty	
Name as it should appear in the Provider Directory	E-mail Address	Have you voluntarily opted-out of Medicare? ☐ Yes ☐ No	

III. Practice Information

Effective Date at Primary Practice location _____ **Days per week at this location** _____

Practice Setting:
☐ Clinic/Group ☐ Sole Practice ☐ Home Based ☐ Hospital Based ☐ Other (please specify) _____

Name of practice, affiliation, or clinic name		Department name (if hospital based)	
Primary office street address	City	State	Zip code
Patient appt. phone number / Fax number	Name affiliated with tax ID number		Federal tax ID number
Mailing address (if different from above)	City	State	Zip code
Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Administration fax number	
Credentialing contact (if different from above)	Credentialing telephone number	Credentialing fax number	
Office/Administrator e-mail address	Credentialing e-mail address		
Traditional Medicare number (for this location)	Railroad Medicare number (for this location)	DME Medicare number (for this location)	
Other Medicare number (for this location)	Do not print this location in Provider Directory ☐	Location wheelchair accessible? ☐ Yes ☐ No	

QI Sent: QI Date: IND: ☐ GRP: ☐ HOS: ☐

Modification to the wording or format of the Utah Practitioner Application may invalidate the application.

III. Practice Information (continued)

Effective Date at Secondary Practice location _____ **Days per week at this location** _____

Practice Setting:
☐ Clinic/Group ☐ Sole Practice ☐ Home Based ☐ Hospital Based ☐ Other (please specify) _____

Name of secondary practice, affiliation or clinic name			Department name (if hospital based)
Secondary office street address	City	State	Zip code
Patient appt. phone number / Fax number	Name affiliated with tax ID number		Federal tax ID number
Mailing address (if different from above)	City	State	Zip code
Billing address (if different from above)	City	State	Zip code
Office manager / Administrator name	Administration telephone number	Administration fax number	
Credentialing contact (if different from above)	Credentialing telephone number	Credentialing fax number	
Office/Administrator e-mail address	Credentialing e-mail address		
Traditional Medicare number (for this location)	Railroad Medicare number (for this location)	DME Medicare number (for this location)	
Other Medicare number (for this location)	Do not print this location in Provider Directory ☐	Location wheelchair accessible? ☐ Yes ☐ No	

List other office locations with above information on a separate sheet.

IV. Professional Licensure

Utah State professional license/registration/certificate number	Status ☐ Active ☐ Inactive ☐ Temporary	
Issue date / Expiration date	**Name of sponsor if required by licensure, (i.e. Physician's Assistant).**	
Drug Enforcement Administration (DEA) registration number	Issue date	Expiration date
State controlled substance certificate number	Issue date	Expiration date
ECFMG number (applicable to foreign medical graduates)	Date issued	

V. All Other Professional Licenses

State	License/registration/certificate number	Date issued
Expiration date	Year relinquished	Reason
State	License/registration/certificate number	Date issued
Expiration date	Year relinquished	Reason
State	License/registration/certificate number	Date issued
Expiration date	Year relinquished	Reason

VI. Undergraduate Education

Name of college or university			**Does Not Apply** ☐
Degree received	Graduation date		
Mailing address	City	State	Zip code
Name of college or university			
Degree received	Graduation date		
Mailing address	City	State	Zip code

(*Do not abbreviate*) (Attach additional sheet if necessary)

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VII. Medical/Professional Education

Medical/Professional school

Start date	Graduation date	Degree received

Mailing address	City	State	Zip code
	Phone	Fax	

Medical/Professional School

Start date	Graduation date	Degree received

Mailing address	City	State	Zip code
	Phone	Fax	

(*Do not abbreviate*) (Attach additional sheet if necessary)

VIII. Graduate Education

Institution **Does Not Apply** ☐

Program or course of study	Faculty director

Mailing address	City	State	Zip code
Dates attended ( ) - ( )	Phone	Fax	

(*Do not abbreviate*) (Attach additional sheet if necessary)

IX. Internship/PGYI

Institution **Does Not Apply** ☐

Program director

Mailing address		City	State	Zip code
Start date	Completion date	Phone	Fax	
Type of internship		Specialty		

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

(*Do not abbreviate*) (Attach additional sheet if necessary)

X. Residencies

Institution **Does Not Apply** ☐

Program director

Mailing address		City	State	Zip code
Start date	Completion date	Phone	Fax	
Type of residency		Specialty		

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution **Does Not Apply** ☐

Program director

Mailing address		City	State	Zip code
Start date	Completion date	Phone	Fax	
Type of residency		Specialty		

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

(*Do not abbreviate*) (Attach additional sheet if necessary)

XI. FELLOWSHIPS

Institution — **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

Institution — **Does Not Apply** ☐

Program director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Course of study

Did you successfully complete the program? ☐ Yes ☐ No (If "No", please explain on separate sheet.)

(*Do not abbreviate*) (Attach additional sheet if necessary)

XII. PRECEPTORSHIP

Institution — **Does Not Apply** ☐

Department chairman

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Training

(*Do not abbreviate*) (Attach additional sheet if necessary)

XIII. FACULTY APPOINTMENT

Institution — **Does Not Apply** ☐

Faculty director

Mailing address	City	State	Zip code

Start date	Completion date	Phone	Fax

Position

(*Do not abbreviate*) (Attach additional sheet if necessary)

X. BOARD CERTIFICATION

Are you board or otherwise professionally certified? **Does Not Apply** ☐

☐ **Yes** If "Yes", please complete below ☐ **No** If "No", describe your intent for certification, if any, and dates of testing for Certification on separate sheet.

Issuing Board/Entity	State Issued	Specialty	Date Certified	Date Recertified	Expiration Date (if any)

Have you applied for certification other than those indicated above? ☐ Yes ☐ No

If so, list certification and date

If you participate in a specialty which does not have board certification, please indicate specialty

(*Do not abbreviate*) (Attach additional sheet if necessary)

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XV. Other Certifications

ACLS, BLS, ATLS, PALS, NRP, NALS
(i.e., Fluoroscopy, Radiography, etc. – Attach certificate if applicable)

Does Not Apply ☐

Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date
Type	Number	Expiration date

XVI. Hospital and Other Institutional Affiliations

Does Not Apply ☐

Please list in **reverse chronological order (with the current affiliation(s) first)** all institutions where you (A) have current affiliations, (B) applications in process, (C) have had previous affiliations or, if no current affiliation, (D) have a current coverage plan. This includes hospitals, surgery centers, institutions, corporations, military assignments, or government agencies. If more space is needed, attach additional sheet(s). List only affiliations here, list employment in section XVII, Work History.

(*Do not abbreviate*) (Attach additional sheet if necessary)

A. Current Affiliations

Name of primary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No)**

Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	

Name of secondary facility (Do you have admitting privileges? ☐ **Yes** ☐ **No)**

Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	

Name of other facility (Do you have admitting privileges? ☐ **Yes** ☐ **No)**

Department	Department / Clinical Chair	Status (active, provisional, courtesy, temporary, etc.)	
Mailing address	City	State	Zip code
Phone number	Fax number	Appointment date	

(*Do not abbreviate*) (Attach additional sheet if necessary)

B. Applications In Process

Hospital/Institution

Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	

Hospital/Institution

Mailing address	City	State	Zip code
Phone number	Fax number	Date application submitted	

(*Do not abbreviate*) (Attach additional sheet if necessary)

C. Previous Affiliations

Name of facility — **Does Not Apply** ☐

Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	

Name of facility

Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	

Name of other facility

Department		Department / Clinical Chair	
Mailing address	City	State	Zip code
Phone number	Fax number	Previous status (active, provisional, courtesy, temporary, etc.)	
Reason for leaving		Appointment date (from– to)	

(for those without admitting privileges)

D. Inpatient Coverage Plan

Please attach signed letter of agreement from the physician or group representative that admits and manages the inpatient care for your patients. **Does Not Apply** ☐

Name of admitting physician/practice/clinic/group	Hospital where privileged

(*Do not abbreviate*) (Attach additional sheet if necessary)

XVII. Work History

Chronologically list all work history activities since completion of professional training (use extra sheets if necessary). This information must be complete. A curriculum vitae is <u>not</u> sufficient.

Name of current practice/employer

Contact name	Telephone number	Fax number	From	To
Mailing address	City	State	Zip code	

Name of practice/employer

Contact name	Telephone number	Fax number	From	To
Mailing address	City	State	Zip code	

Reason for leaving

XVII. Work History (Continued)

Name of practice/employer				
Contact name	Telephone number	Fax number	From	To
Mailing address	City	State	Zip code	
Reason for leaving				

Please account for all gaps in time between date of medical / professional school graduation to present not covered elsewhere within this application. Include dates, activity and names where applicable.

Activity / Name	From	To

(*Do not abbreviate*)

XVIII. Military Status & Affiliations

List all Military affiliations (current and previous), including Military reserves (use extra sheets if necessary). **Does Not Apply** ☐

Name of Primary Base				
Division	Telephone number	Fax number	From	To
Address	City	State	Zip code	

Name of Primary Base				
Division	Telephone number	Fax number	From	To
Address	City	State	Zip code	

Are you an Active Duty Service Member (ADSM)? ◯ Yes ◯ No

Are you currently employed at a Military Treatment Facility (MTF)? ◯ Yes ◯ No

In the past twelve (12) months have you been employed in a managerial, accounting, auditing, or similar capacity by an agency or organization which is responsible, directly or indirectly for decisions regarding Department of Defense payments? ◯ Yes ◯ No

(*Do not abbreviate*)

XIX. Professional Affiliations

Please list membership in all professional societies. Complete Name of Society	Date Joined	Current Member	
		Yes	No
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐
		☐	☐

X. Peer References

List **three** professional references, from your specialty area, not including relatives, who have worked with you in the past two years. References must be from individuals who through recent observation, are directly familiar with your work and can attest to your clinical competence in your specialty area. One reference must be from same discipline.

Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number (optional)
Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number (optional)
Name of reference		Title and specialty	
Mailing address	City	State	Zip code
E-mail address	Telephone number	Fax number	Cell phone number (optional)

XXI. Professional Liability

(*Do not abbreviate*)

Current insurance carrier		Policy number	
Mailing address	City	State	Zip code
Phone number	Fax number	Origination (retroactive) date	
Per claim amount	Aggregate amount	Effective date	Expiration date

Please list **ALL** professional liability carriers within the past ten years

Name of carrier		Policy number	
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier		Policy number	
Mailing address	City	State	Zip code
Phone number	Fax number	From	To
Name of carrier		Policy number	
Mailing Address	City	State	Zip code
Phone number	Fax number	From	To

XXII. PROFESSIONAL LIABILITY ACTION DETAIL – CONFIDENTIAL

Practitioner name(print or type)

Does Not Apply ☐

Please list any past or current professional liability claim(s) or lawsuit(s), in which allegations of professional negligence were made against you, whether or not you were individually named in the claim or lawsuit. Please do not include patient names or other HIPAA protected health information (PHI). Photocopy this page as needed and submit a separate page for EACH claim/event. A legible signed practitioner narrative that addresses all of the following details is an acceptable alternative.

Date and clinical details of the incident, with preceding events

Date	Details

Your role and specific responsibility in the incident

Subsequent events, including patient's clinical outcome

Date suit or claim was filed

Name and Address of Insurance Carrier that handled the claim

Your status in the legal action (primary defendant, co-defendant, other)

Current status of suit or other action

Date of settlement, judgment, or dismissal

If case was settled out-of-court, or with a judgment, settlement amount attributed to you? **$**

UTAH PRACTITIONER ATTESTATION QUESTIONS - *To be completed by the practitioner*

Please answer **all** of the following questions. If your answer to any of the following questions is 'Yes", provide details as specified on a separate sheet. *If you attach additional sheets, sign and date each sheet.*

			Yes	No
A.	**PROFESSIONAL SANCTIONS**			
①	Have you ever been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily or involuntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?			
	a.	License to practice any profession in any jurisdiction	☐	☐
	b.	Other professional registration or certification in any jurisdiction	☐	☐
	c.	Specialty or subspecialty board certification	☐	☐
	d.	Membership on any hospital medical staff	☐	☐
	e.	Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.	☐	☐
	f.	Medicare, Medicaid, FDA, governmental, national or international regulatory agency or any public program	☐	☐
	g.	Professional society membership or fellowship	☐	☐
	h.	Participation/membership in an HMO, PPO, IPA, PHO or other entity	☐	☐
	i.	Academic Appointment	☐	☐
	j.	Authority to prescribe controlled substances (DEA or other authority)	☐	☐
②	Have you ever been subject to review, challenges, and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?		☐	☐
③	Have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?		☐	☐
④	Have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?		☐	☐
B.	**CRIMINAL HISTORY**		**Yes**	**No**
①	Have you ever been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?		☐	☐
	a.	Do you have notice of any such anticipated charges?	☐	☐
	b.	Are you currently under governmental investigation?	☐	☐
C.	**AFFIRMATION OF ABILITIES**		**Yes**	**No**
①	Do you presently use any drugs illegally?		☐	☐
②	Do you have, or have you ever had, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or could affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.		☐	☐
③	Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?		☐	☐
D.	**LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section,** please document in Section XXII. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)			
①	Have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?		☐	☐
②	Have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?		☐	☐
③	Are there any such claims being asserted against you now?		☐	☐
④	Have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?		☐	☐
⑤	Are any of the privileges that you are requesting not covered by your current malpractice coverage?		☐	☐
E.	**ATTESTATION**			
	I warrant that all the statements made on this form and on any attached information sheets are complete, accurate, and current. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.			

Typed or printed name _____ Signature _____ Date _____

Modification to the wording or format of the Utah Practitioner Application may invalidate the application.

XXIII. ATTESTATION	I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. 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 _____

Review dates and initials

Provider Release/Authorization

(Modified releases will not be accepted)

By submitting this application I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the Healthcare Organization(s)** indicated in this application (initial credentialing/recredentialing), I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and certification of CPR training. I have provided peer references familiar with my professional competence and ethical character if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.

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

3. I authorize all individuals, institutions and entities of other hospitals or institutions with which I have been associated, and all professional liability insurers with which I have had or currently have professional liability insurance who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated Healthcare Organization(s), 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/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 investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the Healthcare Organization(s) designated herein, unless revoked by me in writing.

7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by the medical staff bylaws, rules, regulations and policies.

8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

9. 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.

10. I grant permission for the release of the credentials information contained in the practitioner application to the entities listed below.

Signature: _____ **Date:** _____

Name: _____

**Entity Release Name: Regence BlueCross BlueShield of Utah