9. ATTESTATION/PARTICIPATION STATEMENT

For purposes of making this application for participation in the Beacon Health Options, Inc. provider network, I certify that all information provided to Beacon Health Options, Inc. is complete and correct to the best of my knowledge and belief. I agree to notify Beacon Health Options, Inc. promptly if there are any material changes in the information provided, whether prior to or after my acceptance as a Beacon Health Options, Inc. participating provider. I understand and agree that if Beacon Health Options, Inc. discovers that my application contains any significant misstatement, misrepresentations, or omissions, Beacon Health Options, Inc. may void, in its sole discretion, this application and any related participating provider agreements.

I authorize Beacon Health Options, Inc. and its Credentialing Verification Organization (CVO) to consult with the National Practitioner Data Bank, and associated Data Banks, State licensing board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Commission for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competence, character, moral and ethical qualifications. I also authorize all of them to release such information to Beacon Health Options, Inc. I release Beacon Health Options, Inc., its CVO, employees, and agents and all those whom Beacon Health Options, Inc. contacts from any and all liability for their acts performed in good faith and without malice in obtaining and verifying such information and in evaluating my application.

I understand that Beacon Health Options, Inc. may be required by the Federal government or its clients to perform a criminal records check as a condition for participation and that Beacon Health Options, Inc. has the right to obtain a copy of a criminal history report and share such record with the account for which members are being treated. I also understand that I have the right to challenge the accuracy and completeness of any information contained in such a report.

I consent to the release by any person to Beacon Health Options, Inc. and its CVO, all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I further understand and agree that: (a) I am responsible for producing all information required or requested by Beacon Health Options, Inc. in connection with this application; (b) Beacon Health Options, Inc. shall not complete the processing of this application until such information is provided by me. In the event that Beacon Health Options, Inc. decides not to accept me as a participating provider and I desire to have the decision reviewed, I will appeal such determination to the Beacon Health Options, Inc. Provider Appeals Committee (“PAC”). By signing this Attestation/Participation Statement I am not precluded from pursuit of any separate rights that I may have under state or federal laws.

____ Date (mm/dd/yy):____/____/____

Signature of Applicant

____

Name (Please Print)

RETURN COMPLETED APPLICATION WITHIN 30 CALENDAR DAYS TO:
Beacon Health Options, Inc.
National Network Operations
PO Box 41055
Norfolk, VA 23541
(800) 397-1630

Beacon Health Options, Inc. is an equal opportunity organization, which does not discriminate on the basis of race, color, sex, national origin, religion, age, disability, or veteran status in admission or access to, or treatment or employment in, its programs and activities. Applicants who may have inquiries regarding our policy and procedures should contact the National Networks Department.