Magellan Healthcare

ORGANIZATION PROVIDER APPLICATION

If you respond "yes" to any of the liability questions, please submit documentation describing the incidents or cases involved. Please feel free to delete any patient's names from any such documents. Examples of documents that will help Magellan process your application include:

- 5 year claim history from your insurance carrier (Required)
- Sanction letters and related documents from any licensing, certifying or credentialing entity naming the organization.
- Settlement agreements, petitions, complaints, answers, and demand letters regarding malpractice claims naming the organization.
- A chronology of the events involved in the sanction or lawsuit, settlement, etc., including: the actions taken by you and date(s), assessments and diagnostic information related to the incident and how it was managed, and a description of any policies and procedures that were changed as a result of the event(s) or incident(s).
- Description of relevant quality assurance activities.

Please note that these documents will be reviewed in order to determine the applying organization's network status, including acceptance or denial of this application. Submitting complete information will facilitate a more informed decision.

DECLARATIONS AND CONSENT

Declarations And Consent:

The Applicant hereby warrants and represents that all information supplied to Magellan Health, including, but not limited to, licensure, insurance and malpractice history, is true, accurate, and complete. The Applicant further understands that any information entered in this document by Applicant which subsequently is found to be false could result in removal from the network and/or termination of any agreement with Magellan and/or its affiliated companies (Magellan). The Applicant agrees to maintain professional and general liability coverage as stated in this document.

The Applicant grants permission and consent for Magellan, and/or its designee, to obtain and verify information contained on the application and consents to the release by any person, organization, or other entity to Magellan, and /or its designee, of all information that may be reasonably relevant to an evaluation of, including, but not limited to, the Organization's ability to render clinical services, character and moral and ethical qualifications. The Applicant expressly waives any privilege, confidentiality right or privacy right to which the Organization may be entitled. The Applicant agrees to hold harmless any such person, organization or other entity from any cause of action based on the release of such information, in good faith, to Magellan and /or its designee pursuant to this consent. The Applicant releases Magellan and its designees from any liability for any reports, records, recommendations, claims information and claims history, or any other information related to the Organization that are provided to Magellan or its designee by a third party, including otherwise privileged and confidential information given in good faith and related to the credentialing process. The Organization further understands that participation as a provider for Magellan is dependent upon successful completion of the credentialing process. A photocopy of this authorization shall be deemed equivalent to the original.

Applicants serving the Texas Medicaid population: Applicant agrees to comply with applicable state and federal regulations, rules, policies, and procedures relating to mental health targeted case management and mental health rehabilitative services.

I certify that I am authorized to make the above warranties, representations, authorizations and releases on behalf of this provider organization and to sign this application on behalf of this organization.

______________________________	______________________________
Name of Provider Organization (*Please print*)	Name of Authorized Representative (*Please print*)
______________________________	______________________________
Date	Signature of Authorized Representative

PLEASE RETAIN A COPY OF THIS APPLICATION FOR YOUR FILES

RETURN THIS APPLICATION BY:

MAIL: MAGELLAN HEALTH
ATTN: ONS NETWORK SERVICES
14100 MAGELLAN PLAZA DRIVE
MARYLAND HEIGHTS, MO 63043

FAX: 888-656- 6795