Driscoll Health Plan

EXPEDITED CREDENTIALING REQUEST
Provisional Status Addendum

Provider NPI: _____

Provider Name: _____

Group NPI: _____

Group Name: _____

This is in support of my request to be given Expedited Credentialing and Provisional Status with Driscoll Health Plan (DHP). I hereby warrant, represent, and agree as follows:

1. The DHP Participating Medical Group I am joining endorses my request and agrees to the terms hereof by executing this Addendum in the space provided below.

2. I am licensed in the State of Texas by, and am in good standing with, the Texas Medical Board, with no history of disciplinary action, and have an active Texas Medicaid Provider Enrollment.

3. If Provisional Status is granted, I agree to comply with the terms of the Medical Group Agreement as if I were a Medical Group Provider, including, without limiting the foregoing, its provisions requiring Medical Group Providers and Medical Group to hold enrollees of Health Plans harmless and prohibiting billing such enrollees, subject to the terms and conditions of the Medical Group Agreement. In addition, if Provisional Status is granted I agree to comply with the provisions of all applicable Laws, including, without limiting the foregoing, those requiring that enrollees of Health Plans be held harmless and prohibiting the billing of such enrollees by me or the Medical Group for any amounts that may become payable by me to DHP in the event that DHP determines that I fail to meet its credentialing standards and my Provisional Status is terminated, or otherwise, both during and after any termination of my Provisional Status.

4. I acknowledge and fully understand that the granting to me of Provisional Status: (a) is not the result of any credentialing of me by DHP and that DHP will review and make a determination on my credentialing based on my application and other information in accordance with its standard credentialing processes and procedures; and (b) does not constitute an acceptance by DHP of me as a Medical Group Provider as defined in the Medical Group Agreement or qualify me in any way as a participating provider in a DHP network of providers until such time as I successfully complete all credentialing requirements and am approved by the DHP credentialing committee.

I agree with the above statements and understand that DHP will notify me of the decision to grant Provisional Status, as well as the final Credentialing determination.

Provider Agreement:

Provider Signature: _____ Date: _____

Group Agreement:

Authorized Signature: _____ Date: _____

Authorized Name: _____

Authorized Title: _____

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