Keystone First Credentialing Forms
Fax Cover Sheet

To:	Keystone First Credentialing Department	From:	
Fax:	1-215-863-6369	Pages:	
Phone:		Date:	
Re:		Cc:	

Requesting the following Participation Status:

Print contact name and telephone number:_____

____ Joining an existing Keystone First Provider Group_____

____ New to Keystone First _____

This fax includes the following documents:

____Warranty Attestation

____W-9**

____ Other _____

Comments:

_____

_____

_____

_____

** The most current W-9 can be downloaded from the Internal Revenue Service, www.irs.gov

Completed forms can be faxed to the Credentialing Department at 1- 215-863-6369 or signed documents may be scanned and submitted with electronic signature by secure email provider.credentialing@keystonefirstpa.com

CREDENTIALING WARRANTY ATTESTATION

I agree that the following plans (the "Plans") may use the information that I have provided and this credentialing attestation for credentialing purposes: Keystone First (KF), AmeriHealth Caritas Pennsylvania (ACP), AmeriHealth Northeast (ANE) and any other corporation or entity directly or indirectly owned or controlled by, or under common control with the Plans.

I represent and warrant to the Plans that the information contained in the foregoing application is correct and complete to the best of my knowledge and belief, and I agree to inform the Plans promptly if any material change in **such information occurs, whether before or after my entering an agreement with a Plan for the provision of medical** services. By my signature below, I certify that have read, understood and agree to adhere to the Code of Medical Ethics of the American Medical Association, the Code of Ethics of the American Osteopathic Association, or the standards of ethics of another professional organization applicable to my licensure category.

To facilitate compliance with the credentialing requirements of regulatory and accrediting agencies and organizations, I hereby authorize the Plans to inspect all records and documents and to verify with individuals, **organizations and other health providers, all information concerning my professional competence, character, and** moral and ethical qualifications. I release the Plans and their employees and agencies 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 also hereby authorize and request all individuals and institutions to promptly reply to all requests from the Plans for information or verification of information as described above. I release from any and all liability all individuals and institutions furnishing such information to the Plans, their respective agents, employees and representatives.

I authorize and agree that any Plan, and its respective agents, employees and representatives may disclose to another Plan any information, including otherwise privileged or confidential information, concerning my ability and **personal and professional qualifications for the purpose of credentialing, recredentialing or peer review.**

I understand that I have the right, unless prohibited by law or peer review protection, to:
- review information that I submitted in support of my application
- **review the information that was obtained from outside sources regarding my application**
- **correct any erroneous information in my application**

I authorize the Plans to use the information provided in their selection, credentialing and recredentialing process, and to verify such information as being appropriate. I further understand that each of these Plans has its own criteria for acceptance, and that I may be accepted or rejected by each independently. I agree that a photocopy of my signature below may be relied upon by any person or entity receiving a copy of this authorization.

I agree that until I am fully credentialed, I will not treat the Plans' members. If credentialed by the Plans, I agree that I will not refer Plan members to an out of network provider unless the member requires urgent/emergent care, or the Plan pre-certifies such a referral.

I understand that the Plans are performing this credentialing under delegation of Independence Blue Cross or its affiliates. Accordingly, Independence Blue Cross or such affiliate has ultimate responsibility and authority for credentialing determination for the Plans and may have access to credentialing information.

Signed_____

Printed Name_____

Date_____

Revised 4/08/13