# Credentialing Consulting Agreement

___________________________________________ ("Name of Practice") hereby designates ChoiceHealth, Inc., as its nonexclusive agent to perform credentialing services for the following Payors:

1. ________________________ 2. ______________________ 3. ___________________________
4. ________________________ 5. ______________________ 6. ___________________________
7. ________________________ 8. ______________________ 9. ___________________________
10. _______________________ 11. _____________________ 12. __________________________

This list may be updated at any time either in writing or by verbal notice.

I hereby give permission to ChoiceHealth, Inc. to gather and maintain credentialing information on the above named group. I agree to provide ChoiceHealth, Inc. with completed copies of the North Carolina standard HMO credentialing application for all group members. I hereby attest that to the best of my knowledge, the information supplied in the North Carolina standard HMO credentialing application is completed and accurate. I understand the information requested includes privileged or confidential material applicable to the credentialing process.

By means of this agreement ChoiceHealth notifies "Provider" and "Group" of rights to review any information that is submitted during (re)credentialing, correct erroneous information, and request status of (re)credentialing.

I release from liability all representatives of ChoiceHealth, Inc. for their acts performed in good faith and without malice in evaluating my application, credentials, professional competence, ethics, character, and other qualifications. I hereby consent to the release and exchange of information related to any disciplinary action, suspension, or curtailment of medical-surgical privileges to ChoiceHealth, Inc.

Confidentiality

ChoiceHealth, Inc. agrees that it shall not disclose any privileged or confidential information about "Provider" or "Group" to any individual or entity, except as where necessary to perform Credentialing responsibilities or required by state and federal laws and regulations.

Term and Termination

Termination without Cause. This Agreement may be terminated by either party for any reason upon at least thirty (30) days' prior written notice to the other party.

_____________________________________________ ____________________

*Name of Practice* *Date*

_____________________________________________________________________

*Address Street* *City* *County* *State* *Country* *Zip*

Practice Representative:_____________________________________________

*Last Name* *First* *Middle* *Maiden*

_____________________________________________

*Signature* *Title* *Phone Number*

ChoiceHealth Representative:_________________________________________

*Last Name* *First* *Middle*

_____________________________________________

*Signature* *Title* *Phone Number*

ChoiceHealth membership is granted to providers at the sole discretion of ChoiceHealth staff. ChoiceHealth conducts all business practices in compliance with federal, state and local civil rights legislation. Accordingly, ChoiceHealth considers all applicants for membership equally, without regard to race, color, religion, sex, national origin, age, or disability.

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