



## Become an Independent Reviewer

Thank you for your interest to become an independent reviewer with PMSCO Healthcare Consulting (PMSCO). PMSCO is a URAC-accredited independent review organization who provides medical reviews and appeals/grievance services to organizations and healthcare providers who want an independent, objective review of case files. To comply with URAC standards, each reviewer must:

- ◆ have 5 year post residency experience
- ◆ be active in clinical practice
- ◆ be board certified in specialty, if applicable

To begin the process of becoming a reviewer for PMSCO, please complete the following:

- ◆ an application with attestation
- ◆ a general conflict of interest statement
- ◆ a confidentiality statement
- ◆ an independent contractor agreement
- ◆ a HIPAA Business Associate Agreement

Your application and supporting documentation will be verified and then forwarded to our Credentialing Committee for review. The Credentialing Committee meets once a month; therefore, it may take 4-6 weeks after we receive your application and required documentation before you are notified of the Committee's decision. Again, thank you for your interest.

Please return all documents to:

Credentialing Coordinator  
PMSCO Healthcare Consulting  
777 East Park Drive  
Harrisburg, PA 17111



**PMSCO**  
HEALTHCARE CONSULTING

Specialists in the Business of Medicine

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## Independent Reviewer Application Instructions

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Please type or print all responses on the attached Independent Reviewer Application.

Please return the following documents:

1. Signed Independent Reviewer Application
2. Current copies of:
  - a. State License
  - b. DEA Certificate (if applicable)
  - c. CDS Certificate (if applicable)
  - d. Curriculum Vitae or Resume
  - e. ECFMG Certificate (if applicable)
  - f. Board Certification (letter or certificate)
  - g. Current Malpractice Cover Sheet (if applicable)
  - h. Professional Liability Claims History (any malpractice cases with details, if any)
  - i. Evidence of CME or continuing education credits (last three (3) years) (if not required by state for licensure)

NOTE: If your degree is other than MD or DO, please complete those sections of the application that apply.
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If you have questions please phone 1-888-294-4336.

Please return the application to:

PMSCO Healthcare Consulting  
Attention: Credentialing Coordinator  
777 East Park Drive  
Harrisburg, PA 17111

# Independent Reviewer Application

This form should be typed or legibly printed in black or blue ink. Please answer all questions completely and fully. If more space is needed than provided on this application, attach additional sheets and reference the question being answered. If a question is not applicable to you, please respond with N/A. Incomplete applications cannot be processed. **Please initial and date the bottom of each page of the application.**

## 1. PERSONAL INFORMATION

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Degree and/or Title: \_\_\_\_\_ Social Security Number \_\_\_\_\_ Email: \_\_\_\_\_

Any other name under which you have been known: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender: (Optional) Male: \_\_\_\_\_ Female: \_\_\_\_\_ Ethnicity (Optional): \_\_\_\_\_

If you are not a US Citizen, do you have authorization to work in the US?  Yes  No  N/A

**Primary Office Address**  Preferred for contact/ mailing

Name of Practice/ Company: \_\_\_\_\_ Street Address: \_\_\_\_\_

Suite/Bldg#: \_\_\_\_\_ City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

**Home Address**  Preferred for contact/ mailing

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Contact Person: \_\_\_\_\_

**Specialty:** \_\_\_\_\_

**Additional Boards and Interests:** \_\_\_\_\_

Are you a member of the Pennsylvania Medical Society?  Yes  No

Please indicate your minimum Hourly Salary Requirement. \$ \_\_\_\_\_

Are you actively practicing? Yes  No

Are you actively teaching? Yes  No

**Medical Licensure/Registration (if applicable)**

Medical License Number:	Issue Date:	Expiration Date:
CDS/BNDD Number (If Applicable):		Expiration Date:
Federal DEA Reg. Number (s):		Expiration Date:
EPSDT Provider Number:		Expiration Date:
Medicare Provider Number:		Expiration Date:
Medicaid Provider Number:		Expiration Date:
UPIN/NPI Number:		Expiration Date:

**Additional State Licenses and Numbers**

State:	License Number:	Expiration Date:
State:	License Number:	Expiration Date:

**2. EDUCATION / TRAINING / HOSPITAL PRIVILEGES**

**Undergraduate/Professional Training**

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date of Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Graduation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Medical School / Dental School / Postgraduate**

Institution: \_\_\_\_\_ Degree: \_\_\_\_\_ Date of Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Graduation Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**International Medical Graduates (if applicable)**

ECFMG Number: \_\_\_\_\_ Issue Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Internship/Residency (if applicable)**

Institution: \_\_\_\_\_ Type of Training: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Date of Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Program Completed:  Yes Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Specialty: \_\_\_\_\_  
 No Explain: \_\_\_\_\_

**Residency/Fellowship (if applicable)**

Institution: \_\_\_\_\_ Type of Training: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Date of Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Program Completed:  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Specialty: \_\_\_\_\_  
 Explain: \_\_\_\_\_

**Residency/Fellowship (if applicable)**

Institution: \_\_\_\_\_ Type of Training: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Date of Entry: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Program Completed:  Yes  No Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Specialty: \_\_\_\_\_  
 Explain: \_\_\_\_\_

**Other Experience or Training (i.e., allied health, public service, or military)**

Institution: \_\_\_\_\_ Type of Training Program: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Country: \_\_\_\_\_ Dates of Attendance: \_\_\_\_\_  
 Program Completed:  Yes  No Supervised Clinical Hours: \_\_\_\_\_  
 Additional Information: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Work History**

Starting with your current practice, list all employment since completion of post-graduate training. Explain any gaps in the chronology. (CV or Resume is acceptable)  Attached

Employer/Practice	Location: City and State	Dates (inclusive): Month and Year
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Primary Hospital Affiliation (if any)**

Primary Hospital: \_\_\_\_\_ Street Address: \_\_\_\_\_  
 Department: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Staff Category: \_\_\_\_\_ % of Admissions: \_\_\_\_\_ Dates of Affiliation: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Do you currently admit and care for patients on your own hospital service?  Yes  No  
 If yes:  Adult  Child  Infant If no, please explain: \_\_\_\_\_  
 \_\_\_\_\_

**Additional Hospital Affiliation (if any)**

Hospital: \_\_\_\_\_ Street Address: \_\_\_\_\_

Department: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Staff Category: \_\_\_\_\_ % of Admissions: \_\_\_\_\_ Dates of Affiliation: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Additional Hospital Affiliation (if any)**

Hospital: \_\_\_\_\_ Street Address: \_\_\_\_\_

Department: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Staff Category: \_\_\_\_\_ % of Admissions: \_\_\_\_\_ Dates of Affiliation: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Previous Hospital Affiliations (within the last 10 years) (if applicable)**

Hospital: \_\_\_\_\_ Dates of Affiliation: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City, State: \_\_\_\_\_

Hospital: \_\_\_\_\_ Dates of Affiliation: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City, State: \_\_\_\_\_

Hospital: \_\_\_\_\_ Dates of Affiliation: From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 City, State: \_\_\_\_\_

**Board Certification**

Board Certified:  Yes  No Certifying Board: \_\_\_\_\_

Are you pursuing Board Certification?  Yes  No If yes, give details of plans to take Board Exam or if no, please explain:

\_\_\_\_\_

Certificate Number: \_\_\_\_\_ Original Certification Date: \_\_\_\_\_

Most Recent Recertification Date: \_\_\_\_\_ Certification Expiration Date: \_\_\_\_\_

**Additional Board Certifications / Other Certifications**

Board Certified:  Yes  No Certifying Board: \_\_\_\_\_

Certificate Number: \_\_\_\_\_ Original Certification Date: \_\_\_\_\_

Most Recent Recertification Date: \_\_\_\_\_ Certification Expiration Date: \_\_\_\_\_

Are you pursuing Board Certification?  Yes  No

If yes, give details of plans to take Board exam: \_\_\_\_\_

\_\_\_\_\_

### 3. CONFIDENTIAL INFORMATION

IF YOU HAVE A “YES” ANSWER TO ANY QUESTION IN THE SECTIONS BELOW, REFERENCE THE QUESTIONS ON A SEPARATE SHEET, GIVE FULL DETAILS, AND ATTACH.

**Have any of the following at any time been, or are they currently in the process of being denied, revoked, not renewed, suspended, limited, restricted, placed on probation, or placed under other disciplinary action, either voluntarily or involuntarily in this or any other state?**

Medical or professional license	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DEA or CDS/BNDD registration	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hospital medical staff membership	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clinical privileges or other rights on any hospital medical staff	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Employment by any hospital, institution, or the military	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Professional society memberships	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Participation in any private, federal, or state health insurance program (i.e., Medicare, CHAMPUS, Medicaid)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Participation in an HMO, PPO, or any other managed care organization	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Board Certification	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**At any time, have you ever been:**

Convicted of a criminal offense	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convicted of a felony	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Convicted of a misdemeanor relating to a health profession, or received probation without a verdict, disposition in lieu of trial, or an accelerated rehabilitation disposition in the disposition of felony charges in any state, territory or country	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Have you ever at any time or are you currently:**

Under indictment for any crime	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The subject of an investigation by any private, federal or state health insurance program or state licensing board	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Under investigation by any state licensing board or federal agency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
The subject of any adverse action reports to a state or federal databank	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Have you ever either voluntarily or involuntarily:**

Withdrawn your application for medical staff membership at any facility	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Withdrawn your request for any clinical privileges at any facility	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Health Status**

Is there any reason that you can't perform the professional duties of the position with or without reasonable accommodation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you currently using illegal substances or illegally using substances?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Professional Liability History**

In the past 10 years, has your liability insurance ever been canceled or denied?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any malpractice judgments against you including arbitration in the last 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any claim settlements not involving litigation or arbitration paid by you or on your behalf in the last 10 years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you now a defendant in a pending malpractice suit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**4. PROFESSIONAL LIABILITY CARRIER INFORMATION**

Current Insurance Carrier: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Suite/Bldg #: \_\_\_\_\_ Date of Coverage: \_\_\_\_\_ Coverage expiration: \_\_\_\_\_

Coverage Amount \_\_\_\_\_ Policy Number: \_\_\_\_\_ Type of coverage: \_\_\_\_\_

Individual: \_\_\_\_\_ Procedures excluded from coverage: \_\_\_\_\_

Aggregate: \_\_\_\_\_

**Previous Insurance Carrier(s)** (For the last 5 years, if you have not been with your current carrier for 5 years.)

Previous Insurance Carrier: \_\_\_\_\_ Type of coverage: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite/Bldg#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Coverage: To: \_\_\_\_\_ From: \_\_\_\_\_

Procedures excluded from coverage: \_\_\_\_\_

Previous Insurance Carrier: \_\_\_\_\_ Type of coverage: \_\_\_\_\_

Street Address: \_\_\_\_\_ Suite/Bldg#: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Coverage: To: \_\_\_\_\_ From: \_\_\_\_\_

Procedures excluded from coverage: \_\_\_\_\_

**Applicant's Signature:** \_\_\_\_\_

## 5. CONDITIONS OF APPLICATION

**BY COMPLETING THIS CREDENTIALS FORM I HEREBY:**

- authorize all representatives of PMSCO, and its staff to consult with my prior associates and others who may have information bearing on my professional competence, character, ethical qualifications, and ability to work cooperatively with others; and,
- consent to the inspections by all representatives of PMSCO and its staff of all documents that may be material to an evaluation of my qualifications and competence; and,
- release from liability all representatives of PMSCO and its staff for acts performed and statements made concerning my credentials and qualifications; and,
- release from liability any and all individuals and organizations who provide information to PMSCO and its staff concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges; and,
- certify that the Work History statement is accurate and complete; and,
- acknowledge that I, as an applicant for participation with PMSCO, have the burden of producing adequate information for a proper evaluation of my professional, ethical, and other qualifications for such participation and for resolving any doubts about such qualifications; and,
- acknowledge that any misstatements in or omissions from this credentials form constitute cause for denial of participation or cause for summary dismissal from PMSCO; and,
- certify all information given by me to the foregoing questions and statements on this credentials form is true and correct without omissions of any kind; and,
- acknowledge, as an applicant for participation with PMSCO, the release of my utilization and quality of care data, compiled in the Medis Groups database or other similar utilization databases, at each hospital where I hold staff appointments and clinical privileges; and,
- acknowledge that PMSCO under the terms of the Health Care Improvement Act of 1986, may query the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, and the Federation of State Medical Boards, in reviewing credentials of its applicants or physicians; and,
- understand and agree that nothing in this credentials form is intended to imply or create an employment relationship or contract for employment, nor does it guarantee approval of a contract for service; and,
- understand and agree all information provided becomes the property of PMSCO, and that PMSCO may use the information secured in connection herewith to facilitate my credentialing application with managed care payors. However, the extent of this facilitation will be to pre-print credentialing forms sent to me – this information will only be provided to the managed care payors when (and if) I complete the balance of the credentialing materials and return the executed form to PMSCO or the managed care payor.
- understand and agree that once I've agreed to be presented as a PMSCO candidate for a Clinical Consultant/Medical Director position for a particular client, I may only accept the position (if offered) through PMSCO.

**Name** \_\_\_\_\_ **Date** \_\_\_\_\_  
 (Please print)

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 (No signature stamps accepted)

# **Confidentiality and Disclosure Statements**

## **CONFIDENTIALITY AGREEMENT**

PMSCO Healthcare Consulting has determined that all consultants performing any type of reviews or evaluations during the course of their assigned duties with PMSCO Healthcare Consulting must sign a confidentiality agreement (see attached). Breach of this agreement will result in immediate termination of the consultant's current duties with PMSCO Healthcare Consulting and will prohibit any future contractual arrangements between the consultant and PMSCO Healthcare Consulting.

### **Definition**

**CONFIDENTIAL INFORMATION**– Confidential information means information that is not public knowledge, or available to the public on request, disclosure of which would give an unfair, unethical, or illegal advantage to another desiring to contract with the Commonwealth.

### **Confidential Business Information**

It is understood that all information to which the consultant has access during their assigned course of duties with PMSCO Healthcare Consulting, including discussions and written materials is considered confidential and proprietary to PMSCO Healthcare Consulting and/or the referring entity. The consultant should not make any unauthorized disclosure of this information.

### **Confidential Patient Information**

It is understood that all patient information to which the consultant has access during their course of assigned duties with PMSCO Healthcare Consulting, is considered confidential and proprietary to PMSCO Healthcare Consulting. This information includes, but is not limited to, information contained in the patient's medical record, such as the identity, diagnosis, prognosis or course of treatment for the patient. This information will be used strictly for the purpose of evaluation, training, education, rehabilitation, treatment or research. The consultant should not make any unauthorized disclosure of this information.

### **Consultant's Confidentiality Agreement**

I understand that during the course of my assigned duties with PMSCO Healthcare Consulting, I will be provided access to confidential patient and/or business information. I agree to be bound by all state and federal requirements concerning confidentiality of medical records requirements.<sup>1</sup> I agree that all business material, written or otherwise, obtained pursuant to performing my duties for PMSCO Healthcare Consulting, is considered strictly confidential and

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<sup>1</sup>Confidentiality of Communications, 42 Pa. C.S.A. §§5929, 5944  
Access to Medical Records, 42 Pa. C.S.A. §§6151-6159; 42 Pa. Code §16.61 (18)  
Confidentiality of Patient Records, 42 United States Code §290dd-2 & §290ee-3  
Mental Health Procedures Act, Confidentiality of Records, 50 P.S. §7111

the property of the PMSCO Healthcare Consulting and/or the referring entity. I will not make any unauthorized disclosure of this information.

If my services are terminated for any reason, I agree to protect the confidential information shared with me from unauthorized use and disclosure, and will abide by the terms of this agreement.

I understand that breach of this confidentiality agreement will result in immediate termination of my current duties with PMSCO Healthcare Consulting and will prohibit any future contractual arrangements between myself and other agencies of PMSCO Healthcare Consulting.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Witness** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

<sup>1</sup>Confidentiality of Communications, 42 Pa. C.S.A. §§5929, 5944  
Access to Medical Records, 42 Pa. C.S.A. §§6151-6159; 42 Pa. Code §16.61 (18)  
Confidentiality of Patient Records, 42 United States Code §290dd-2 & §290ee-3  
Mental Health Procedures Act, Confidentiality of Records, 50 P.S. §7111

## DISCLOSURE STATEMENT

PMSCO Healthcare Consulting has determined that all consultants performing any type of reviews or evaluations during the course of their assigned duties with PMSCO Healthcare Consulting must sign a general disclosure statement (see attached).

It is the on-going responsibility of consultants to disclose, on a case-by-case basis, any situations that could be identified as potential conflicts of interest. Breach of this agreement will result in immediate termination of the consultant's current duties with PMSCO Healthcare Consulting and will prohibit any future contractual arrangements between the consultant and agencies of PMSCO Healthcare Consulting.

### Definition

CONFLICT OF INTEREST-a conflict of interest may exist when an employee is involved in an activity or has a personal interest that might interfere with the employee's objectivity in performing PMSCO Healthcare Consulting duties and responsibilities.

### **Examples of Conflict of Interest Situations**

Not all outside interests and financial relationships place the consultant in conflict with his/her obligations to PMSCO Healthcare Consulting and the referring entity. Not all of the conflicting interests are necessarily impermissible. Complete disclosure of potential conflicts of interest protects the consultant from suspicion and accusations of breach of professional integrity.

Below are some examples of situations, which should be disclosed because they may be viewed as potential conflicts of interest:

- Providing privileged or otherwise special access to information gained by the consultant in the course of his/her consultancy to an agency in which the consultant has a political or financial interest.
- Performing reviews for medical necessity of cases from an agency which the consultant has a personal or professional affiliation.
- Use of the consultant's role to obtain employment, contracts or other benefit.
- Use of the consultant's role to lobby for a particular policy or legislative outcome (Hatch Act.)<sup>1</sup>
- Use of the consultant's role to advance the case of self or related agency in regulatory matters before the state government or other related agencies.

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<sup>1</sup> The Federal Hatch Act, Chapter 15, Title 5, United States Code, restricts the political activity of employees of the Federal Government as well as state and local agencies.

**NOTE: Current voting membership on the Board of Trustees of the Pennsylvania Medical Society constitutes a conflict of interest that disqualifies you from serving as an independent reviewer of any case file from Pennsylvania pursuant to URAC accreditation standards. Voting membership does not disqualify you from serving as an independent reviewer of case files from other states.**

Please list any current jobs, contracts, and staff appointments that may be regarded as a potential conflict of interest with your expected duties for PMSCO Healthcare Consulting. (Please use additional sheets if necessary). The consultant is responsible to notify PMSCO Healthcare Consulting when an addition or deletion to this list occurs.

**JOBS/POSITIONS**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**CONTRACTS/NETWORK PARTICIPATION**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

**STAFF APPOINTMENTS**

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_

Breach of the general disclosure policy will result in immediate termination for cause of the undersigned's contractual relationship with PMSCO Healthcare Consulting and may affect the undersigned's ability to enter into future contracts with agencies of PMSCO Healthcare Consulting.

<sup>1</sup> The Federal Hatch Act, Chapter 15, Title 5, United States Code, restricts the political activity of employees of the Federal Government as well as state and local agencies.

## **Consultant's General Disclosure Agreement**

I have read the examples of conflict of interest situations and have reviewed my own situations and actions in light of the illustrations. I have identified any situations, which could be viewed as a potential conflict of interest. I agree to notify PMSCO Healthcare Consulting on an on-going case-by-case basis of any potential conflict of interest situations that may occur during the course of my assigned duties with PMSCO Healthcare Consulting.

I understand that a breach of this disclosure agreement will result in immediate termination of my current duties with PMSCO Healthcare Consulting and will prohibit any future contractual arrangements between myself and PMSCO Healthcare Consulting.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Witness** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

<sup>1</sup> The Federal Hatch Act, Chapter 15, Title 5, United States Code, restricts the political activity of employees of the Federal Government as well as state and local agencies.

## CLINICAL CONSULTANT AGREEMENT

THIS AGREEMENT, effective the \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, by and between PennMed Member Services Company, a Pennsylvania corporation located at 777 East Park Drive, PO Box 69067, Harrisburg, Pennsylvania 17106-9067 ("PMSCO"), and \_\_\_\_\_. ("Consultant"), located at \_\_\_\_\_. PMSCO and Consultant may hereafter be referred to individually as a "Party" and collectively as the "Parties."

### Recitals

WHEREAS, PMSCO desires to contract with Consultant to provide professional medical director/clinical advisor and related administrative services, and Consultant desires to render such services to PMSCO; and

WHEREAS, the Parties desire to enter into this Agreement in order to provide a full statement of their respective responsibilities as they exist in connection with the provision of medical director/clinical advisor services during the term of this Agreement;

NOW, THEREFORE, it is mutually agreed as follows:

#### 1. CONTRACT FOR SERVICES

PMSCO hereby contracts with Consultant to provide the full range of professional services, as well as related administrative services as a medical director/clinical advisor, and Consultant hereby agrees to provide such services under such terms and conditions as are hereinafter stated and as the Parties may from time to time mutually agree.

#### 2. APPOINTMENT AND SERVICES TO BE PROVIDED

2.1 Independent Contractor. Consultant shall, at all times, be an independent contractor and not an employee of PMSCO, and shall not hold himself out as an employee of PMSCO.

2.1.1. Consultant shall be liable for his own debts, obligations, acts, and omissions, including the payment of all required withholding, social security, and other taxes or benefits.

2.1.2. PMSCO shall not withhold, on behalf of Consultant, any sums for income tax, unemployment insurance, social security, or any other withholding or benefit pursuant to any law or requirement of any governmental body.

2.1.3. Nothing in this Agreement is intended, nor shall be construed, to create an employer/employee relationship, or a joint venture relationship.

2.1.4. In the event that the Internal Revenue Service or any other governmental agency shall, at any time, question or challenge the independent contractor status of Consultant, both PMSCO and Consultant, upon receipt by either of them of notice from the Internal Revenue

Service or any other governmental agency, shall promptly notify the other Party and afford the other Party the opportunity to participate in any discussion or negotiation with the Internal Revenue Service or other governmental agency, irrespective of whom or by whom such discussions or negotiations are initiated. The other Party shall participate in any such discussions or negotiations to the extent permitted by the Internal Revenue Service or other governmental agency. The provisions of this Section (2.1.4.) shall apply only to issues arising from the independent contractor relationship described herein and not to any other tax matter involving either Party.

2.2. Cooperation. Consultant will cooperate with and assist PMSCO employees in preparation of clinical reports and will use best efforts to maintain and elevate the performance of PMSCO in the field of medical management.

### 3. **CONSULTANT REPRESENTATIONS**

3.1 Representations. Consultant hereby makes the following representations, the continuing validity of which shall be a prerequisite to the obligations of PMSCO hereunder:

3.1.1. Consultant shall be licensed to practice medicine in accordance with the laws of an appropriate state agency and shall be Board certified in their respective specialty if applicable.

3.1.2. Consultant shall at all times conduct himself in compliance with all applicable federal, state and local laws, rules and regulations.

3.1.3. Consultant shall not compete with PMSCO during the term of this Agreement or for a period of one year thereafter. Specifically, Consultant agrees not to (i) solicit or independently contract with a PMSCO client which was introduced to Consultant by PMSCO, or (ii) solicit or independently contract with a PMSCO client utilizing Consultant's services pursuant to this Agreement or (iii) directly or indirectly contract with any other current PMSCO client. A list of current PMSCO clients will be provided to Consultant upon request.

3.1.4 Consultant shall provide PMSCO with complete credentialing materials, as reasonably requested by PMSCO, and shall update such materials on an annual basis.

3.1.5 Consultant shall collaborate with PMSCO and PMSCO clients in the process of integration of Consultant with the PMSCO and client staff including, but not limited to, orientation to the work site and to PMSCO and client standards and values.

3.1.6 Consultant shall participate in any remedial non-clinical (e.g., computer) training reasonably required by PMSCO or a PMSCO client.

3.1.7 Consultant shall participate in and abide by PMSCO's Peer Review and Quality Improvement Programs.

3.1.8 Consultant shall hold all information received pursuant to this Agreement, including, without limitation, the compensation paid to Consultant and the identity of PMSCO clients, in strictest confidence, and shall not disclose, or allow disclosure of, such information to

any third party.

3.1.9 Consultant acknowledges and agrees that a breach of this Agreement would result in irreparable harm to PMSCO, the extent of which would be difficult to ascertain, and in any event, money damages would be an inadequate remedy in the event of such a breach. Accordingly, PMSCO shall be entitled to specific performance and injunctive or other equitable relief as a court may deem appropriate in the event of such a breach, and Consultant agrees to waive any requirement for the securing or posting of any bond in connection with such remedies. Such remedies shall not be deemed to be exclusive, but shall be in addition to all other remedies available at law or in equity to PMSCO.

#### 4. **PMSCO REPRESENTATIONS**

4.1 Representations. As consideration for the obligations and responsibilities of Consultant pursuant to this Agreement, PMSCO shall, at no cost to Consultant, and within the limits of its fiscal capabilities, and in accordance with PMSCO policy:

4.1.1. Make available such supplies and materials as mutually agreed to by PMSCO and Consultant as being necessary for the proper operation and conduct of medical management activities.

4.1.2. Make available to Consultant such information in patient records or otherwise in PMSCO's control as shall reasonably enable Consultant to perform his services hereunder.

4.1.3. Hold information concerning the compensation paid to Consultant in strictest confidence, and shall not disclose, or allow disclosure of, such information to any third party.

#### 5. **FINANCIAL**

Consultant shall be paid \$250 per standard case file review; \$350 per expedited case file review (48 hours response time); \$150 per hour for any other clinical consulting services performed hereunder; and \$150 for professional services rendered with respect to each drug protocol reviewed performed by Consultant pursuant to the Agreement.

#### 6. **TERM**

This Agreement shall commence as of the date first above written, and shall continue for one year thereafter. The Agreement shall automatically renew for consecutive one-year terms, unless terminated as set forth in Section 7.

#### 7. **TERMINATION**

7.1 Right of PMSCO to Terminate. PMSCO shall have the right to terminate this Agreement at any time upon the occurrence of any of the following events. Such termination shall be effective ten days after the giving of such written notice if the occurrence of the event is

not corrected within the notice period.

7.1.1. The insolvency/bankruptcy of Consultant that prevents Consultant from performing his duties and obligations under this Agreement.

7.1.2. Consultant cannot perform for a consecutive 30-day period the duties and obligations required by this Agreement.

7.1.3. Consultant fails to have the qualifications, training, and licenses necessary to perform the duties and obligations under this Agreement.

7.1.4. Consultant is not licensed to practice medicine by an appropriate state agency or has his license revoked or suspended for any reason.

7.1.5. Consultant is determined by a court of law to have criminally violated the Medicare or Medicaid laws or reimbursement regulations and is prohibited from participating in the Medicare or Medicaid programs as a result thereof.

7.1.6. Consultant is guilty of any immoral conduct.

7.1.7. Consultant fails in any manner to abide by the provisions of this Agreement.

7.1.8. If the consultant is an MD or DO, and Consultant does not become a member in good standing with the Pennsylvania Medical Society, if practicing in Pennsylvania, within 30 days after being assigned to provide medical director/clinical advisor services or fails to maintain such membership.

7.2 Right of Either Party to Terminate. Either party may terminate this Agreement upon 30 days' written notice to the other Party.

## 8. GENERAL PROVISIONS

8.1 Assignment. Consultant shall not assign, sell or transfer this Agreement, his obligations hereunder or any interest herein without the prior written consent of PMSCO. This Agreement may be assigned in whole or in part by PMSCO to any entity that is the successor in interest to substantially all of the assets of PMSCO.

8.2 Offers. Recognizing (i) the special nature of the relationships existing, or which will exist, between PMSCO and the personnel which it employs or retains, and between Consultant and employees which he retains and (ii) that the recruiting and training of personnel by PMSCO and Consultant is a costly and time-consuming endeavor, both parties agree that they will not, during the term of this Agreement or any renewals hereof, or for a period of one year following the termination of this Agreement, directly or indirectly, through any manner or means, impair or initiate any attempt to impair the relationships which exist between PMSCO and personnel employed or retained by PMSCO or between Consultant and the employees retained by Consultant through offers of employment or offers of contracts for services to be rendered by such personnel or otherwise, unless PMSCO and Consultant agree to such employment or

retention. Without limiting other possible remedies to the non-breaching Party for a breach of this covenant, each Party agrees that injunctive or other equitable relief shall be available to enforce this covenant, such relief to be without the necessity of posting a bond, cash or otherwise. Each Party further agrees that if any restriction contained in this Section is held by any court to be unenforceable or unreasonable, a lesser restriction shall be enforced in its place and the remaining restrictions contained herein shall be enforced independently of each other.

8.3 Governing Law. This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the Commonwealth of Pennsylvania, without regard to principles of conflicts of law.

8.4 Severability. If any term or provision of this Agreement or the application thereof to any person or circumstance shall to any extent be invalid or unenforceable, the remainder of this Agreement or the application of such term or provision to persons or circumstances other than those to which it is held invalid or unenforceable shall not be affected thereby, and each term and provision of the Agreement shall be valid and enforceable to the fullest extent permitted by law.

8.5 Integrated Agreement. This Agreement constitutes the entire understanding and agreement between the Parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements, or understandings existing between the Parties concerning the subject matter hereof.

8.6 Captions. Captions contained in this Agreement are inserted only as a matter of convenience and in no way define, limit, or extend the scope or intent of this Agreement or any provision hereof.

8.7 Arbitration. The Parties shall in good faith attempt to resolve any controversy, dispute or disagreement arising out of or relating to this Agreement, or the breach thereof, by negotiation. If any such controversy, dispute, or disagreement is not resolved within 30 days of the earliest written notice which sets forth the issues involved, that controversy, dispute, or disagreement shall be settled by arbitration, which shall be conducted in Harrisburg, Pennsylvania in accordance with the American Health Lawyers Association Alternative Dispute Resolution Service Rules of Procedure for Arbitration, and judgement on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. Each Party shall bear its own attorneys fees and costs in connection with the arbitration; however, all other costs of the arbitration shall be borne equally by the Parties.

8.8 Gender. Any noun or pronoun used in this Agreement shall be construed in masculine, feminine, or neuter as its sense and use may require.

8.9 Waivers and Amendments. No waiver of any term, provision, or condition of this Agreement, whether by conduct or otherwise, in any one or more instances, shall be deemed to be or construed as a further and continuing waiver of any such term, provision or condition of this Agreement. No amendment to any provision of this Agreement shall be effective unless in writing and signed by each Party.

8.10 Notices. Notices under this Agreement shall be in writing and shall be served to the Parties at the address first above written.

8.11 No Discrimination. Each Party agrees that, in the performance of this Agreement, services will be provided without discrimination towards any patients, employees, or other persons regardless of their race, age, sexual preference, color, or ethnic background. Both Parties are equal opportunity employers. Both Parties shall comply with all requirements and provisions of the Civil Rights Act of 1964, 42 U.S.C.A. Section 2000 et seq. and of the Pennsylvania Human Relations Act.

8.12 Binding Agreement. All of the terms and provisions of this Agreement shall be binding upon, inure to the benefit of and be enforceable by each of the Parties hereto, their respective legal representatives and their permitted successors and assigns.

8.13 Further Assurances. The Parties agree to execute such other documents as may be required to implement the terms and provisions and fulfill the intent of this Agreement.

IN WITNESS WHEREOF, the Parties have caused their duly authorized representatives to execute this Agreement as of the date first above written.

Consultant: \_\_\_\_\_

Date: \_\_\_\_\_

**“PMSCO”: PennMed Member Services Company**

By: \_\_\_\_\_  
David A. Hess

Title: President and COO

Date: \_\_\_\_\_

## **HIPAA Business Associate Agreement**

This Health Insurance Portability and Accountability Act (“HIPAA”) Business Associate Agreement (“Agreement”) between \_\_\_\_\_ (“Consultant”), and PMSCO is effective as of the date the last party signs this Agreement.

PMSCO intends to ensure that its privacy and security policies and practices meet or exceed the standards set by state and federal law, especially HIPAA, for the protection of individual health information. Therefore, PMSCO intends to protect the privacy and provide for the security of protected health information (“PHI”) seen by Consultant pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 and regulations promulgated there under by the U.S. Department of Health and Human Services (the “HIPAA Regulations”) and other applicable state and federal laws.

According, in consideration of PMSCO’s grant of access to such information for the Consultant to fulfill obligations of the agreement, and intending to be legally bound, the parties hereto agree as follows:

- Definitions.
  - a. Terms used, but not defined, in this Agreement shall have the same meaning as those terms in 45 CFR Sections 160.103 and 164.501.

- Description of Services.

Consultant shall provide to PMSCO Clinical Consulting Services.

- Obligations of Consultant.

Except as otherwise limited in this Agreement, Consultant may use or disclose PHI to perform functions, activities or services for, or on behalf of PMSCO as specified in this Agreement provided that such use or disclosure would not violate the Privacy Rule if done by PMSCO or PMSCO’s client.

- a. Nondisclosure. Consultant shall not use or further disclose PMSCO’s PHI other than as permitted or required by this Agreement or as required by law.
- b. Safeguards. Consultant shall use appropriate safeguards to prevent use or disclosure of PMSCO’s PHI other than as provided for by this Agreement.
- c. Mitigation. Consultant shall mitigate, to the extent practical, any harmful effect that is known to Consultant of a use or disclosure of PHI by Consultant in violation of the requirements of this Agreement.
- d. Reporting of Disclosures. Consultant shall report to PMSCO any use or disclosure of PMSCO’s PHI not provided for by this Agreement.
- e. Consultant Agents. Consultant shall ensure that any agent, including a subcontractor, to whom Consultant provided PHI received from and/or created or received by Consultant on behalf of PMSCO, agrees to the same restrictions and conditions that apply to this Agreement with Consultant with respect to such PHI.

- f. Amendments to PHI. Consultant agrees to make any amendment(s) to PHI that PMSCO directs or agrees to, at the request of PMSCO or PMSCO's client, and in the time and manner designated by PMSCO.
  
- g. Availability of Records and Accounting of Disclosures. Consultant agrees to make internal practices, books, and records relating to the use and disclosure of PHI received from, or created or received by the Consultant on behalf of, PMSCO available to PMSCO, or at the request of PMSCO to PMSCO's client or the Secretary of the Department of Health and Human Service (Secretary), in a time and manner reasonably designated by PMSCO, PMSCO's client or the Secretary, for purposes of the Secretary determining PMSCO's or PMSCO's client's compliance with the Privacy Rule.
  
- h. Return or Destruction of PHI. Upon termination of this Agreement, Consultant shall return or destroy all PHI received from, or created or received by Consultant on behalf of PMSCO, that Consultant still maintains in any form and retain no copies of such information.
  
- Ownership of PHI. All work product generated or acquired by Consultant in performing Consultant's duties hereunder shall be the exclusive property of PMSCO. Work product shall include, without limitation, all claims data, clinical data, and supporting records and information. All such work product shall be and continue to remain confidential pursuant to Sections 3(h) and 5 of this Agreement.
  
- Termination and Material Breach. A violation of a material term of the Agreement by Consultant as determined by PMSCO shall provide grounds for immediate termination of the Agreement by PMSCO.
  
- Survival of Consultant Obligations. The obligations of Consultant under this Agreement shall survive the termination of this Agreement.
  
- Indemnification. Consultant will indemnify, hold harmless and defend PMSCO from and against any and all claims, losses, liabilities, costs and other expenses incurred as a result of, or arising directly or indirectly out of or in connection with any breach of this Agreement.
  
- Interpretation. Any ambiguity in this Agreement shall be interpreted in favor of a meaning that permits PMSCO and PMSCO's client to comply with HIPAA Regulations and other applicable federal and state laws.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement.

**PMSCO**

**CONSULTANT**

David A. Hess

\_\_\_\_\_  
 President and Chief Operating Officer

\_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_