

## CERTIFICATION, AUTHORIZATION AND RELEASE

In submitting this application for credentialing (or recredentialing) by **Maine Network for Health** (formerly Health Net, Inc.) and any contracting Payor for health care services including but not limited to health maintenance organizations (as defined in the Maine Network for Health written Physician Agreement to provide services to Covered Persons under Agreements between Maine Network for Health and various Payors), I understand that it is my responsibility to produce the required information for the proper evaluation of my application and that failure to produce this information will prevent my application from being reviewed and acted upon and may result in a termination of my participation.

1. I hereby certify under pains and penalties of perjury that the information contained herein, including all supporting materials, is correct and complete to the best of my knowledge and belief. I understand that my application will be reviewed based upon the information I have provided and other information obtained in accordance with other credentialing programs. I further understand that information which is found to be false could result in a denial or termination of participation.
2. I authorize Maine Network for Health and contracting Payors to consult with any person or entity who has information bearing on my competence, character and ethical qualifications and to inspect such records which may be material to the evaluation of my professional qualifications and competence.
3. I authorize all professional licensing agencies in any state in which I am licensed to practice, and my health care facility, health care organization or professional organization with whom I have had employment, practice, association or privileges, to release information to Maine Network for Health and contracting Payors regarding my professional skills, any pending or final disciplinary action or malpractice action, and any other information relevant to my character or professional competence and/or ability to perform.
4. I authorize and request my malpractice liability insurance carrier to release information to Maine Network for Health and contracting Payors regarding any claims or actions for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
5. I release from liability (a) any person or entity who, in good faith and without malice, provides information for the purpose of evaluating my application, credentials and qualifications; and (b) Maine Network for Health and contracting Payors for any acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications.
6. I agree to notify Maine Network for Health and all contracting Payors as soon as I become aware of any event which might reasonably affect my credentialing status, including the initiation of any disciplinary action by any health care facility or regulatory authority.

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

**Name:** \_\_\_\_\_  
Applicant's name (printed)

Please return this application to:  
**Maine Network for Health**  
80 Exchange Street, Suite 603  
Bangor, ME 04401