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TESTIMONY OF THE AMERICAN MEDICAL ASSOCIATION

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Standard Provider Enrollment Form

The American Medical Association (AMA) would like to thank the National Committee on Vital and Health Statistics' (NCVHS) Standards Subcommittee (Subcommittee) for the opportunity to provide our comments on the issue of provider enrollment forms. These forms are critical to physicians with respect to both the Medicare program and to commercial health plans, as they serve as the gateway for physician and other health care provider participation in these programs.

Medicare enrollment

Before physicians can bill Medicare they must submit an enrollment application to their Medicare contractor and have it successfully processed. Unfortunately, there have been significant problems with the Medicare enrollment process over the past several years. The Centers for Medicare & Medicaid Services (CMS) made significant changes to the enrollment process in 2006, 2009, and again in 2011. The earlier changes created significant challenges for physicians by imposing numerous burdensome requirements and frequent changes such that Medicare contractors and physicians alike were unable to keep up with the ever changing enrollment processing landscape. This resulted in massive application backlogs and processing delays, and ultimately many claims processing interruptions for physicians. Beginning in 2010, however, CMS began making significant changes in order to streamline what has become a bureaucratic nightmare for doctors. **While significant strides have been made during the past two years to make the process work more smoothly, even greater efficiencies could be realized if one national format existed to handle all provider enrollment**.

Below is a discussion of where these efficiencies could be realized in the context of the current Medicare enrollment process.

Completion of Multiple 855 Enrollment Applications: Reducing Number of Applications Submitted

In order for a provider or supplier to enroll in Medicare, they must complete a form known as the 855. There are various versions of the 855 and a provider completes the version most appropriate for them. In some cases, a provider must complete more than one version of the 855. For example, a physician who is a Durable Medical Equipment (DME) supplier must complete the version of the 855 for individuals (855-I) and the version for suppliers (855-S). Until very recently, a solely owned practitioner organization like a group practice had to complete three

versions – the 855-I, 855-B, and the version for reassigning benefits, the 855-R. Physicians who reassign benefits, meaning, they ask Medicare to send their reimbursement to the organization where they work rather than directly to them, are still required to complete an 855-I and 855-R. In addition, if a physician bills Medicare in more than one Medicare Administrative Contractor (MAC) jurisdiction, they must submit separate enrollment applications for each jurisdiction. Additionally, when a contractor is replaced with another requiring physician reenrollment has been proven to lead to confusion. **Creating an electronic standard for enrollment may reduce the need for physicians and other providers to complete more than one enrollment application.**

Reducing Confusion Over Which 855 Form to Complete

Despite improvements to the Medicare enrollment process over the past few years, unfortunately, confusion remains over which version of the 855 form physicians and other providers must complete. And, while CMS has attempted to provide greater clarification for physicians and others, some confusion remains. In the case of physicians, this generally appears to occur when they call their Medicare contractor seeking advice on which version to complete and are given inaccurate, confusing, or conflicting guidance. This confusion has been exacerbated by poorly trained or ill-equipped customer service representatives. **By standardizing the enrollment process electronically, confusion over which 855 form to complete could also be reduced. In turn, this will reduce the time it takes for physicians and other providers to enroll as well as reduce the amount of time customer service representatives spend responding to enrollment questions.**

Revisions to 855 Forms

From time to time, CMS makes changes to the different versions of the 855 forms. This is generally done to either improve the process or to include additional information that CMS determines is needed by Medicare to maintain the integrity of the program.

CMS has made several changes in the past several years to the 855 forms. For example, CMS revised the 855 enrollment forms in July 2009. Prior to July 2009 the 855-I edition of the form was previously known as version CMS-855I (02/08). The 2009 version of the 855-I was known as CMS-855I (02/08)(EF 07/09). Most recently CMS revised the forms again in 2011 and the current version of the 855-I is known as CMS-855I (07/11).

Confusion in the past has resulted when physicians and others inadvertently have submitted an outdated version of the 855. It is unclear how an industry-wide adopted set of standards for the enrollment process would be affected by the Office of Management and Budget (OMB) approval process. For example, today the CMS 1500 paper claim form as well as the 837 electronic claim standard both collect data and are not subject to the OMB approval process because these are industry-wide standards. In contrast, the process for making changes to an 855, is lengthy as it must undergo approval from the OMB since it involves a request for collection of certain data. In order to collect this information they must be in compliance with the Paperwork Reduction Act of 1995 (PRA) which requires federal "agencies to plan for the development of new collections of information and the extension of ongoing collections well in advance of sending proposals to OMB." If an industry-wide standard for collection of information for purposes of enrollment were developed and utilized by the federal government it is unclear **what impact the PRA will have on a standard electronic enrollment process. If an electronic application standard is developed and adopted industry-wide, it raises questions as to the impact of the OMB PRA process. We recommend NCVHS explore this issue further.**

Who Can Update an Online Enrollment Application

CMS originally launched the online system for submitting enrollment applications known as Internet-based Provider Enrollment, Chain and Ownership System (PECOS) in December 2008. Practice staff and credentialing professionals may now use the Internet-based PECOS on behalf of individual practitioners. CMS, however, reminds individual practitioners that they are ultimately liable for the accuracy of the enrollment information reported to the Medicare program, as well as for any unauthorized disclosures of the information that may occur while the information is being sent to Medicare. Organizations, such as group practices, are also permitted to use Internet-based PECOS to complete the information contained within the CMS-855B application, but additional paper work must be completed and further steps must be taken in order to gain access to the system.

Standardizing Enrollment Deadlines

Medicare has numerous requirements associated with the enrollment process. It is unclear whether an electronic enrollment standard would encompass standard timeframes. Many of these timeframes are required under Medicare enrollment regulations. Provided for NCVHS' consideration below, is a discussion of some of these timeframes.

Provider Start Date

Enrollment applications may only be submitted up to 30 days before a practice or practitioner will begin furnishing services to Medicare patients.

Reporting Changes to Information

Keeping enrollment information up-to-date is required by Medicare. Physicians are required to report the following changes in specified timeframes:

- Changes in ownership or financial or controlling interest (30 days)
- Changes in practice location (30 days)
- Adverse legal actions (see Medicare enrollment application for a complete list) (30 days)
- All others 90 days

Retroactive Billing Period

Prior to January 2009, Medicare permitted physicians to submit claims as far back as 27 months. However, under new rules, Medicare now only allow physicians who are enrolling in Medicare to bill back as far as 30 days prior to the date their application is considered "effective." For physicians this means under the new regulations, they are only permitted to bill Medicare for services furnished to Medicare patients up to 30 days before their billing effective date. The effective date is the later of the date they filed an application that their Medicare contractor ultimately approves; or the date they began furnishing services at a new practice location. The "filing" date is defined as the date their Medicare contractor receives the physician's approvable Medicare enrollment application. In the case of an application submitted using Internet-based PECOS, the filing date is the date the contractor receives all of the following: the electronic enrollment application and the certification statement that is signed with an original signature and mailed to the Medicare contractor.

Appeals Process

There are four possible outcomes to a Medicare provider enrollment application: 1) physician is granted Medicare billing privileges; 2) physician is contacted for missing information; 3) physician's application is returned; and 4) physician application is denied.

Physicians have the right to appeal the "denial" of their Medicare provider enrollment application, as well as the "revocation" of their Medicare billing privileges. In most cases, physicians will have three options when it comes to filing an appeal. They can: 1) file a written appeal within 60 calendar days of the notice's postmark; or 2) file a corrective action plan (CAP) within 30 calendar days of the notice's postmark; or 3) file a written appeal within 60 calendar days and file a CAP within 30 calendar days. If physicians do not pursue one of these options in a timely manner, the agency will argue that they have waived their rights to further administrative review and are precluded from seeking any further relief.

In the event a physician's Medicare billing privileges are revoked, the revocation is effective 30 days from date of the postmark on the envelope containing the notice that has been mailed, except that in the case of a revocation based on a federal exclusion or debarment, revocation is effective with the date of the exclusion or debarment.

Timelines MACs Must Meet[1]

In addition to timeframes and deadlines providers must adhere to, CMS has established certain timeframes that MACs must meet. For example, MACs are required to prescreen a provider's enrollment application within 15 days. MACs are also required to process most electronic enrollment applications within 45 days.

Program Integrity: Decreasing Fraudulent Billing and Preventing ID Theft

The AMA recognizes that CMS has unique needs when it comes to the type of information reported on an enrollment application, as they are charged with protecting the Medicare Trust Fund. In doing so, they must ensure that unscrupulous providers and suppliers are kept out of the program and do not receive reimbursement under fraudulent scenarios. Medicare requires providers and suppliers to report adverse legal actions to the program. While Medicare may need this information, commercial payers may not. Many of these needs are reflected in the aforementioned requirements.

Just as standard transactions may contain situational data elements which allow for a provider to report data when a certain situation applies, a similar concept could be applied to enrollment. By ensuring Medicare has the appropriate data it needs to maintain the integrity of the Trust Fund, providing a single electronic enrollment standard could help protect physicians and other providers from identity theft by making it easier to keep their information up to date.

In addition, CMS has a large initiative underway to "revalidate" or re-verify the enrollment information it has on file for each provider. Such time-consuming initiatives that require hundreds of thousands of providers to submit changes to their enrollment information can place a

[1] For a complete list of all Medicare enrollment deadlines please consult Chapter 10 of the Medicare Program Integrity Manual at: http://www.cms.gov/manuals/downloads/pim83c10.pdf.

tremendous burden on both the providers and the Medicare contractors. **While the AMA is pleased that CMS has indicated that they are extending the revalidation effort through 2015 to allow more time for this process to occur, an electronic standard for enrollment would provide even more efficiency. Physicians and other providers who refer or order services for Medicare patients are also going to be required to be included in PECOS in order for claims to be processed. CMS has not at this time turned on the edits that would reject claims for this reason, but will in the near future. The use of an electronic enrollment standard would streamline this process as well, particularly for those who do not bill Medicare but refer and order services to other providers who do. The AMA does believe, however, that physicians who want to continue submitting their enrollment information on paper, should have the option to do so.**

The Affordable Care Act (ACA) included several program integrity provisions, among them, increased screening requirements for providers and suppliers enrolling in Medicare. CMS established three different tiers of enrollment screening, limited, moderate, and high based upon the perceived risk to the Medicare program. The type of provider generally determines the level of screening a provider will receive. Most physicians, for example, are placed in the limited risk category as CMS has deemed most physicians to pose a low risk to the integrity of the Medicare program. As such, they will be subject to the fewest screening requirements. Providers in the middle and high risk tiers will be subjected in some cases to fingerprinting and background checks. This is another example of information that while required by Medicare, is not needed by commercial payers. **In considering a standard electronic enrollment process, it is clear that the program integrity needs of Medicare must be factored in.**

Form 588 for Electronic Funds Transfer

A part of the Medicare enrollment process involves completing the 588 Form which allows providers to receive their reimbursement electronically through electronic funds transfer (EFT). The 588 form is also a form that was approved by OMB as it involves a collection of data. Since the ACA calls for adopting an EFT standard, we expect that this aspect of the enrollment process will be streamlined as a result. **Once an electronic EFT standard is in place, we presume this would mean that the OMB PRA process for collecting the information on the 588 form would become obsolete and no longer be required. However, we recommend NCVHS explore this issue further.**

Submitting Supporting Statements and Documentation

The Medicare enrollment process often requires that providers submit additional documentation. For example, all providers are required to submit a paper certification statement that essentially allows the provider to "certify" that the information they have provided on their enrollment application is correct and true. They are also asked for different pieces of supporting documentation such as a medical license, a driver's license, a phone or power bill to verify a new address. Generally these types of documents must be mailed in on paper, however, CMS recently announced that they expect to have the functionality to scan and electronically send these documents starting in 2012. **We expect that providing the ability for physicians and others to submit these supporting documents electronically will significantly streamline the process, which presents another standardization opportunity that we urge NCVHS to explore.**

Physicians who opt-out of Medicare are also required to have a signed affidavit on file. It is possible that including a standard electronic method for achieving this would also create efficiencies.

Enrollment Fees

While most physicians are exempt, DME suppliers (including physicians suppliers) and institutions will be required, pursuant to the ACA, to pay an enrollment application fee of $505 online at www.pay.gov. It is unclear whether a standard electronic enrollment process would encompass a standard for making a payment online. While we presume this would be outside the purview of such a process, **we recommend that NCVHS consider a standard process for collecting these fees.**

Where Challenges will Remain

While an electronic enrollment standard would provide a tremendous amount of efficiency, there are still some areas of the process that need to be explored further to determine whether a new standard would work. These largely involve internal CMS operational issues. For example, even if an electronic enrollment standard were required, because Medicare has a separate contractor from the MACs in place to handle DME supplier enrollment, it is very likely that CMS would still require a physician supplier to enroll using an existing standard with the MAC and the National Supplier Clearinghouse (NSC), the DME contractor. Therefore, unless CMS were able to achieve better communication between the NSC and the MACs, it is unlikely that these types of physicians would be permitted to complete a single application.

In addition, one complaint many physicians have had with the Medicare enrollment process is that the changes they make to their enrollment information are not reflected in the NPPES. Since the National Plan and Provider Enumeration System (NPPES) and PECOS are two separate databases and given the complexity behind each of them, it remains unclear to us how physicians and other providers could avoid having to update similar information twice.

Standardized Enrollment Forms in the Commercial Market

Similar Problems Exist in the enrollment processes used by commercial health plans

The need for standardization of enrollment forms is just as great, if not greater, in the commercial market as it is in the context of public health programs such as Medicare. These problems are only compounded because the commercial market has a dizzying array of players, which include fully-insured health plans, self-insured health plans, and a myriad of third-party contractors that sign physicians up for a host of "rental provider networks." Physicians report all the following concerns with the enrollment processes used in the commercial health plan marketplace:

1. Massive number of credentialing requests from hospitals, health plans, governmental bodies and others
2. Inappropriateness of data requested in credentialing process
3. Misinterpretation of the exact data requested
4. No uniformity of the data requested, or the order it is requested on the paper credentialing form
5. Burdensome requirements for notarization of enrollment forms
6. Frequency of recredentialing
7. Recredentialing is not done per a uniform scheduled timeframe
8. Time lag between credentials submission and approval is too long– results in slow/no payment by private and public payers

9. Slow response for data from primary source entities
10. Lack of guidelines for credentialing data maintenance and verification
11. Lack of security of credentialing data, especially when an entity holding credentialing data goes bankrupt or otherwise closes
12. Inclusion of bad, irrelevant or misleading data in credentialing records
13. Cost of credentialing and data acquisition is too high
    Even when a payer has initially enrolled a physician accurately within their database, numerous physician practices reports subsequent changes to that database that are erroneous. As such, there must be some process for reporting changes to initial data entered back to the physician practice. Indeed, because this enrollment data is the foundation for every other administrative transaction, it is critical that the provider enrollment transaction be structured to maximize the accuracy of the data. One study of the reasons for inaccurate claim payments attributed over 10 percent of all errors to mistakes in provider enrollment information.
14. As an indication of the enormity of the administrative burden credentialing imposes, the AMA's House of Delegates has been calling for a uniform credentialing format since 1987!

Standardization efforts to date

Several steps have been taken to standardize the credentialing information required for enrollment in a health plan. First, a number of states have enacted laws mandating the use of a single standard credentialing form in the state. For example, §31-3252 of the Official Code of the District of Columbia provides in pertinent part:

> A health insurer or its credentialing intermediary shall accept the uniform credentialing form as the sole application for a health care provider to become credentialed or recredentialed for a provider panel of the health insurer.

See Attachment 1 for the complete text of the laws governing this area.

Second, the National Committee for Quality Assurance (NCQA) has adopted credentialing standards for health plans and credentials verification organizations that seek NCQA accreditation. While NCQA accreditation standards are technically floors, and health plans are free to exceed them, as a practical matter this is rarely done, particularly with respect to credentialing requirements.

Third, the Council for Affordable Quality Healthcare (CAQH) has created the Universal Provider Datasource (UPD), a database which registered physicians and other health professionals in all 50 states and the District of Columbia may use to enter and maintain their credentialing information free of charge. At the direction of the physician or other health professional, the UPD uses the data in the database to respond to initial and ongoing credentialing requests from the numerous health plans and other entities that have agreed to accept the UPD's uniform online application. The AMA supports the use of the UPD as one method for reporting physician credentialing data. There are also states, like Ohio, that have mandated that health plans use the UPD in either its electronic or paper format. See Ohio Revised Code Annotated §3963.05.

Finally , the HIPAA mandated National Provider Identifier (NPI) has been adopted, including the associated National Plan & Provider Enumeration System (NPPES) registry, which contains much of the information included on health plan credentialing and enrollment forms.

Recommendation

We believe that the groundwork has now been laid for the development of a HIPAA standard provider enrollment transaction which would be used by all payers. By comparing the fields included in the NPPES registry, the CAQH UPD, the NCQA credentialing standards and the various state mandated forms, it should be possible to come up with a comprehensive set of data elements that would meet the credentialing needs of all payers. We suggest the following guidelines be followed in the development of the standard provider enrollment transaction:

- The UPD and some of the standard forms mentioned above include hospital and other credentialing data elements. To the extent that hospitals or other entities have more stringent requirements than those required by NCQA for health plans, we recommend that those fields not be included in the mandatory portion of the provider enrollment transaction. Rather, those additional data elements should be addressed in an optional portion of the transaction so that those who want to use the transaction for hospital credentialing purposes can do so, but that everyone is not burdened by additional informational requests which are not relevant to health plan enrollment.

- The standard should not prohibit those providers that prefer to take advantage of the convenience of the UPD to continue to have that option.

- As noted above in the discussion of the PECOS system, we recommend that the provider enrollment transaction also include fields specific to the Medicare enrollment process that exceed those required by commercial health plans, and that that portion of the transaction be situationally required only to the extent the provider is enrolling in the Medicare program.

- We recommend that the transaction include an updating function designed to minimize the burden on providers to keep their enrollment information updated. We additionally recommend that the transaction be structured such that the health plan or its enrollment agent is required to report back what was actually entered into the database and any and all subsequent changes to the provider's records.

- We also strongly recommend that the enrollment standard transaction incorporate the NPPES data, such that all updates physicians make to the NPPES are also automatically forwarded to each of the health plans with which they contract. It is confusing and burdensome for physicians to maintain disparate databases with the same data elements.

- We recommend that the needs of health plan provider directories be considered, such that the content of those directories can also be driven by the provider enrollment and enrollment update transaction.

- We recommend that EDI transaction enrollment also be considered, and that a separate, standard provider practice EDI enrollment transaction be adopted. There are various methods for enrollment in each of the different HIPAA electronic transactions — physician practices that contract with 20 or more payers may also encounter 20 or more EDI enrollment methods for each transaction. This variation alone may be enough to keep an overwhelmed physician practice from moving from paper to electronic transactions.. For example, with respect to electronic funds transfer (EFT), the EDI enrollment

transaction should provide an easy way for physician practices to transmit the standardized enrollment information relevant to EFT: (1) practice name; (2) tax identification number; (3) group or individual National Provider Identifiers (NPIs), as determined by the practice; and (4) bank routing and account numbers. Moreover, the transaction must give providers the right to control how they enroll (by practice or by individual physician), which format (CCD+ or CDX) they will use (to the extent the EFT standard provides a choice), and must not be conditioned on the use of a particular bank nor on the waiver of any rights with respect to denials or overpayment recoveries which may otherwise be available. Simple, quick online EDI enrollment will eliminate one significant barrier to adoption.

- Finally, we strongly recommend that these provider health plan and EDI enrollment transactions be accompanied by acknowledgement transactions, so that the physician or physician practice that has submitted an enrollment transaction or update gets confirmation both that the transaction has been received and, with respect to updates, the specific updates that will be made. As discussed above, it is critical that physicians and other health care providers are notified whenever their enrollment information is changed, and how it is changed, both so they can make sure that this threshold data remains accurate, but also to make sure that no unauthorized person has "hacked" their account and potentially stolen their identity.

Attachment 1: State laws requiring uniform credentialing application

Colorado Revised Statutes Annotated § 2o5-1-108.7. Health care credentials uniform application act--legislative declaration--definitions--state board of health rules

There is hereby established the health care credentials application review committee to recommend to the state board of health, and to periodically review, a single application form for the collection of core credentials data in this state. The form shall be known as the "Colorado health care professional credentials application."

District of Columbia Code § 31-3252. Application for becoming credentialed.

A health insurer or its credentialing intermediary shall accept the uniform credentialing form as the sole application for a health care provider to become credentialed or recredentialed for a provider panel of the health insurer.

Illinois Statutes Annotated 410 § 517/15 Development and use of uniform health care and hospital credentials forms

The Department, in consultation with the council, shall by rule establish a uniform health care credentials form that shall include the credentials data commonly requested by health care entities and health care plans for purposes of credentialing and shall minimize the need for the collection of additional credentials data.

Indiana Code Annotated 27-13-43-2 Credentialing application; notice

The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format. The form must be used by: (1) a provider who applies for credentialing by a health maintenance organization; and (2) a health maintenance organization that performs credentialing activities.

Indiana Code Annotated 27-8-11-7 Credentialing application; notice

This section applies to an insurer that issues or administers a policy that provides coverage for basic health care services (as defined in IC 27-13-1-4). The department of insurance shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH) in electronic or paper format, which must be used by: (1) a provider who applies for credentialing by an insurer; and (2) an insurer that performs credentialing activities.

Kentucky Revised Statutes Annotated 304.17A-545 Medical director for managed

care plan; duties; quality assurance or improvement standards; process to select health care providers; uniform application form and guidelines for health care provider evaluations

The commissioner shall promulgate administrative regulations to establish a uniform application form and guidelines for the evaluation and reevaluation of health care providers, including psychologists, who will be on the plan's list of participating providers. In developing a uniform application and guidelines, the department shall consider industry standards and guidelines adopted by the Council for Affordable Quality Healthcare. The uniform application form and guidelines shall be used by all insurers.

Louisiana Statutes Annotated 22 § 1009. Health care provider credentialing

In order to establish uniformity in the submission of an applicant's standardized information to each issuer for which he may seek to provide health care services…an applicant shall utilize and a health insurance issuer shall accept either of the following at the sole discretion of the health insurance issuer:

(a) The current version of the Louisiana Standardized Credentialing Application Form, or its successor; or

(b) The current format used by the Council for Affordable Quality Healthcare (CAQH), or its successor.

Maine Revised Statutes Annotated 24-A § 4303. Plan requirements

An application is completed if the application includes all of the information required by the uniform credentialling application used by carriers and providers in this State….

Code of Maryland Regulations 31.10.26.03 Uniform Credentialing Form -Carrier and Credentialing Intermediary Requirements.

A carrier or its credentialing intermediary shall accept the uniform credentialing form as the sole application for a health care provider to become credentialed or recredentialed for a provider panel of the carrier….

Massachusetts General Laws Annotated 1760 § 2 Bureau of managed care

In order to reduce health care costs and improve access to health care services, the bureau shall establish by regulation as a condition of accreditation that carriers use uniform standards and methodologies for credentialing of providers, including any health care provider type licensed under chapter 112 that provide identical services.

Mississippi Administrative Code 19-1-98-1:7. Uniform Application for Physician Credentialing and Recredentialing

In order to simplify the application process for physicians who are applying to multiple managed care entities, the Commissioner hereby adopts a basic uniform credentialing application which shall be used by all managed care entities performing physician credentialing and recredentialing activities in Mississippi. The uniform application is attached hereto as Exhibit "A" and hereby made a part of this Regulation.

Missouri Statutes Annotated 354.442. Written disclosure statement, when, contents--effect of inconsistencies--standard credentialing form--information provided upon request

The director of the department of insurance, financial institutions and professional registration shall develop a standard credentialing form which shall be used by all health carriers when credentialing health care professionals in a managed care plan.

North Carolina General Statutes Annotated § 58-3-230. Uniform provider credentialing

(b) The Commissioner shall by rule adopt a uniform provider credentialing application form that will provide health benefit plans with the information necessary to adequately assess and verify the qualifications of an applicant. No insurer that provides a health benefit plan may require an applicant to submit information that is not required by the uniform provider credentialing application form.

Code of New Mexico Rules § 13.10.21.9. UNIFORM PROVIDER CREDENTIALING FOR HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

Use of uniform credentialing forms required: Beginning September 1, 2009, an HMO shall not use any health professional credentialing application form other than uniform HSC or CAQH credentialing or re-credentialing forms.

Ohio Revised Code Annotated 3963.05 Credentialing application forms; prohibitions; exceptions

(A) The department of insurance shall prescribe the credentialing application form used by the council for affordable quality healthcare (CAQH) in electronic or paper format for physicians. The department of insurance also shall prepare the standard credentialing form for all other providers and shall make the standard credentialing form as simple, straightforward, and easy to use as possible, having due regard for those credentialing forms that are widely in use in the state by contracting entities and that best serve these goals.

(B) No contracting entity shall fail to use the applicable standard credentialing form described in division (A) of this section when initially credentialing or recredentialing providers in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care

services.

(C) No contracting entity shall require a provider to provide any information in addition to the information required by the applicable standard credentialing form described in division (A) of this section in connection with policies, health care contracts, and agreements providing basic health care services, specialty health care services, or supplemental health care services.

Oklahoma Statutes Annotated 36 § 4405.1. Health benefit plans--Credentialing or recredentialing of physicians and other health care providers

Any health benefit plan that is offered, issued or renewed in this state shall provide for credentialing and recredentialing of physicians and other health care providers based on criteria provided in the uniform credentialing application….

Oregon Revised Statutes Annotated § 442.805. Recommendations; meetings; staff

(1) The Advisory Committee on Physician Credentialing Information shall develop and submit recommendations to the Administrator of the Office for Oregon Health Policy and Research for the collection of uniform information necessary for hospitals and health plans to credential physicians seeking membership on a hospital medical staff or designation as a participating provider for a health plan. The recommendations must specify: (a) the content and format of a credentialing application form; and (b) the content and format of a recredentialing application form.

General Laws of Rhode Island Annotated 42-14.5-3. Powers and duties

The health insurance commissioner shall have the following powers and duties:

(d) To establish and provide guidance and assistance to a subcommittee ("The Professional Provider-Health Plan Work Group")…. This subcommittee shall include in its annual report and presentation before the house and senate finance committees the following information…(ii) a standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

Tennessee Code Annotated § 56-7-1009. Uniform health care provider credentialing application form

A health insurance entity, as defined in § 56-7-109, that credentials or recredentials the providers in its networks shall accept, in addition to its own credentialing and recredentialing applications, the credentialing and recredentialing applications from the Council on Affordable Quality Healthcare (CAQH).

Texas Statutes Annotated § 1452.052. Standardized Form for Verification of Credentials

(a) The commissioner by rule shall: (1) prescribe a standardized form for the verification of the credentials of a physician, advanced practice nurse, or physician assistant; and (2) require a public or private hospital, a health maintenance organization operating under Chapter 843, or the issuer of a preferred provider benefit plan under Chapter 1301 to use the form for verification of credentials.

Vermont Statutes Annotated § 9408a. Uniform provider credentialing

The department shall prescribe the credentialing application form used by the Council for Affordable Quality Healthcare (CAQH), or a similar, nationally recognized form prescribed by the commissioner, in electronic or paper format, which must be used beginning January 1, 2007 by an insurer or a hospital that performs credentialing.

West Virginia Code of State Rules § 64-89-4. Mandatory Use of Uniform Credentialing Form and Uniform Recredentialing Form.

Beginning July 1, 2003, all health care entities shall use the uniform credentialing form developed by the committee for credentialing health care practitioners and the uniform recredentialing form developed by the committee for recredentialing health care practitioners.