MARYLAND INSURANCE ADMINISTRATION
MEDICAL DIRECTOR
APPLICATION FOR *RE-CERTIFICATION*

Review the Instructions *before* completing this re-certification application. Answer each question and return the completed application form and all attachments to medicaldirectorsubmissions.mia@maryland.gov.

A fee in the amount of $100 is due at the time of application. Send a check or money order payable to the ***Maryland Insurance Administration to:***

Medical Director/Private Review Agent Oversight Unit
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202-2272

Please include a letter with information telling us what the check is for (i.e. Medical Director Re-certification) and who the doctor is. Also send a copy of the check either with this re-certification application submission or separately to medicaldirectorsubissions.mia@maryland.gov.

The filing will not be processed until the fee is received.

1. Name of Applicant:

First_____

Middle_____

Last_____

Suffix(*e.g., Sr., Jr., II, etc*.,)_____

2. a. Previous Name of Applicant: *Has the applicant changed his or her name since the most recent certification?*

YES ☐ NO ☐

b. *If yes*, enter the previous name(s*). Legal documentation of a name change must accompany this* re-certification *application. Acceptable proof of a name change includes: a copy of a divorce decree, marriage certificate, or other court document.* ***Note we only need this documentation once. We do not need it with every re-certification application unless your name changes again****.*

_____

_____

3. Applicant Contact Information:

Home Address:

_____

_____

Personal (Cell/Home) Phone Number: _(_____)_____

Business Phone Number: _(_____)_____

Email Address:_____

4. Date of birth: _____/_____/_____

5. Gender: Male ☐ Female ☐

6. Applicant Employer Information:

Applicant Job Title:_____

Name of Employer:_____

Employer
Address:_____

_____

Employer Phone Number: _(_____)_____

Date of Hire as Medical Director:

a. Actual: _____/_____/_____

b. Expected, (if applicable): _____/_____/_____

7. Administrative Contact Person: Identify a contact person who will be available to respond to inquiries from the Maryland Insurance Administration regarding this re-certification application. This will also be the person to whom all future correspondence and certification documents will be mailed. Typically, the Administrative Contact Person is the HMO.

Name and Job Title:_____

Name of Employer:_____

Business Address:_____

_____

Phone Number: _(_____)_____

Email Address:_____

8. **Hours of Contact:** At what time during the normal business day is the contact person available by telephone? Use Eastern Standard Time as your reference.

_____

9. **Certification by the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA):**

Name of Specialty Board	Subspecialty	Year Certified	Year Re-Certified	Expiration Date

10. **Education (*Advanced Health Related Degree--Other Than MD/DO*):**

Was any additional education received since the applicant's most recent certification?
YES ☐ NO ☐

If yes, complete the information below. Do not attach a curriculum vitae in lieu of completing this section.

a. Name of Institution:

_____

Current mailing address (*street name, city, state, and any postal codes*):

_____

_____

Dates attended: From: (month/year)_____/_____ To: (month/year)____/_____

Degree Conferred:_____

b. Name of Institution:

_____

Current mailing address (*street name, city, state, and any postal codes*):

_____

_____

Dates attended: From: (month/year)_____/_____ To: (month/year)_____/_____

Degree Conferred:_____

11. Internship/Training:

Was any additional Internships or Training received since the applicant's most recent certification?
YES ☐ NO ☐

If "yes," complete the information below. Do not attach a curriculum vitae in lieu of completing this section.

a. ☐ **PGY I (internship)** ☐ **PGY II and III(residency)** ☐ **PGY IV & Greater(fellowship)** ☐ **Other**_____

Institution (*use the name the institution is currently known by*):

_____

Current mailing address (*street name, city, state, and any postal codes*):

_____

_____

Dates attended: From: (month/year)_____/_____ To: (month/year)_____/_____

Specialty:_____ ☐ Clinical ☐ Research

b. ☐ **PGY I (internship)** ☐ **PGY II and III(residency)** ☐ **PGY IV & Greater(fellowship)** ☐ **Other**_____

Institution (*use the name the institution is currently known by*):

_____

Current mailing address (*street name, city, state, and any postal codes*):

_____

_____

Dates attended: From: (month/year)_____/_____ To: (month/year)_____/_____

Specialty:_____ ☐ Clinical ☐ Research

12. Work Experience/Employment: List only new employment gained since previous certification.

Did you have any new work experience or employment since the applicant's most recent certification?
YES☐ NO☐

If "yes," complete the information below. Do not attach a curriculum vitae in lieu of completing this section.

a. Institution (*use the name the institution is currently known by*):

_____

Current mailing address (*street name, city, state, and any postal codes*):

_____

_____

Dates of service: From: (month/year)_____/_____ To: (month/year)_____/_____

Staff Category (*active, courtesy, administrative, etc*.,): _____

Name of Department Chair/Supervisor:_____

Type of Facility (*acute, inpatient care, outpatient, faculty/academic appointment, private office, etc*.):

_____

b. Institution (*use the name the institution is currently known by*):

_____

Current mailing address (*street name, city, state, and any postal codes*):

_____

_____

Dates of service: From: (month/year)_____/_____ To: (month/year)_____/_____

Staff Category (*active, courtesy, administrative, etc*.,):_____

Name of Department Chair/Supervisor:_____

Type of Facility (*acute, inpatient care, outpatient, faculty/academic appointment, private office, etc*.):

_____

Screening Questions: Any affirmative response requires an explanation. Place an "X" in the appropriate boxes. Submit complete details of any affirmative answer on a separate page with this re-certification application.

13. Since the applicant's most recent certification, has any of the following been, or are currently in the process of being, either on a voluntary or involuntary basis: denied, revoked, suspended, reduced, limited, placed on probation, not renewed or relinquished for disciplinary reasons or in anticipation of disciplinary action?

a. Medical/Professional license in any state jurisdiction?

YES ☐ NO ☐

b. Membership on any hospital/medical staff?

YES ☐ NO ☐

c. Participation in any training program?

YES ☐ NO ☐

d. Clinical privileges?

YES ☐ NO ☐

e. Specialty board certification?

YES ☐ NO ☐

f. Participation in the Medicare/Medicaid program?

YES ☐ NO ☐

g. Federal DEA Registration?

YES ☐ NO ☐

h. State controlled substance registration?

YES ☐ NO ☐

14. Since the applicant's most recent certification, other than traffic violations, have you been convicted of, or pleaded guilty or *nolo contendere* to any crime?

YES ☐ NO ☐

15. Are you currently suffering from, or receiving treatment for, any physical or mental disability or illness, including drug or alcohol abuse, which may impair the proper performance of your duties and responsibilities as a medical director?

YES ☐ NO ☐

16. To the best of your knowledge, has any action ever been reported to the National Practitioner Data Bank (NPDB) in which you were named as a defendant?

YES ☐ NO ☐

17. **Insurance Information:** Since your *most recent certification*, have you been the subject of a professional liability suit, including, but not limited to malpractice claim(s) that may or may not have resulted in a lawsuit?

YES ☐ NO ☐

18. **If the answer to question 17 above is "yes," complete the below information.** For each action taken, use the format provided below to explain your response. Provide the complete name and address for each carrier identified.

Malpractice Claims History:

Plaintiff(s):

_____

State In Which Suit Was Initiated: _____Month & Year Suit Initiated:_____/_____

Insurance
Carrier:_____

Street:_____

City, State, Zip:_____

Nature of the claim:

_____

_____

_____

_____

_____

Current Status of the Suit: Filed ☐ Awaiting Trial ☐ Dismissed ☐ Settled out of court ☐
Other:_____

Expected trial date if suit is unresolved: _____/_____/_____

Date of outcome if suit was resolved: _____/_____/_____

19. Licensure Information: Complete all of the requested information. Provide a copy of each license.

Licensures	Number	Expiration Date
Maryland Medical License _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____

Licensures	Number	Expiration Date
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____
Other State License (Name of State) _____	_____	_____

20. **Health Maintenance Organization Contact Information:** List the legal HMO entity's name for each health maintenance organization (HMO) licensed in Maryland for whom you have medical director responsibilities. The name, address, and telephone number of each HMO with whom you are employed or under contract must be provided. Also provide the name of the governing authority of each HMO. Governing authority is defined as the person or persons designated in the by-laws with the responsibility of operating the HMO. Attach additional sheets if necessary.

a. HMO Name: _____

HMO Governing Authority: _____

Street Address: _____

City, State, Zip: _____

Telephone Number: __(_____)_____

b. HMO Name: _____

HMO Governing Authority: _____

Street Address: _____

City, State, Zip: _____

Telephone Number: __(_____)_____

21. **Financial Information:** Disclose ALL methods of compensation received from the employer listed in question 6 and (if different) each HMO listed in question 20, including any related holding company (ies). Compensation includes, but is not limited to salary, stock options, bonuses, fees for attending Board of Directors or Appeal Panel meetings, profit sharing, etc.

_____

_____

_____

_____

22. **Medical Director Status:** Place an "X" where appropriate.

Chief Medical Director	YES ☐	NO ☐
Assistant or Associate Medical Director	YES ☐	NO ☐

Briefly describe your duties as medical director:

_____

_____

_____

CRITERIA CERTIFICATION

I hereby certify that the criteria and standards used in conducting utilization review for

_____

_____ are:

(Insert Legal HMO Entity Name of Each HMO Identified in Question 20)

(I) Objective.

(II) Clinically Valid.

(III) Compatible with established principles of health care, and

(IV) Flexible enough to allow deviations from norms when justified on a case by case basis.

Medical Director (Type in Name)

_____

Signature

_____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION MAY BE PROSECUTED UNDER APPLICABLE STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OR REVOCATION OF CERTIFICATION.

AUTHORIZATION

I hereby certify that this re-certification application has been examined by me and is true, correct, and complete to the best of my knowledge and belief. I understand that the information required herein is continuing in nature, and I agree to supplement the information provided as changes occur. I understand that any misstatements or inaccuracies in, or omissions from, this re-certification application may constitute a denial or revocation of Certification, and that such denial or revocation may result in a report to the Board of Physician Quality Assurance or other applicable licensing or regulatory entity.

I authorize the Maryland Insurance Administration and its contractor to consult with schools, licensing boards, hospitals, professional organizations, insurers and individuals to compile my complete professional history and qualifications to be a medical director, including evidence of my good character and trustworthiness. I acknowledge that this includes, but is not limited to, the Board of Physician Quality Assurance, current and past employers, medical boards, educational institutions, and professional groups with which I have been affiliated. Furthermore, I consent to the release of information, including otherwise privileged or confidential information, to the Maryland Insurance Administration and its contractors from all of the entities and individuals described herein for the purposes of compiling my complete professional history and qualifications to be a medical director, including evidence of my good character and trustworthiness.

Name of Applicant: _____

Signature of Applicant: _____

Date: _____/_____/_____