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 form (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 ever used a name that is different from the above?*

YES ☐ NO ☐

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

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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*):** List only those obtained since previous certification.

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: List only training obtained since previous certification.

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.

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*.):

____

13. 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.

Have any of the following ever 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. Other than traffic violations, have you ever 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. **An affirmative response for question 17 must be explained.** 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:

____

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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) _________________________________		
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.

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____

____

22. **Medical Director Status:** Place an "X" where appropriate. **Briefly describe your duties as medical director.**

____

____

____

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

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: ______/______/______