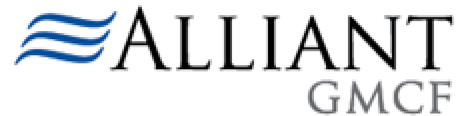

Dear Peer Consultant:

We appreciate your interest in becoming a Clinician Consultant Reviewer for Alliant Health Solutions ("AHS").

Enclosed is a brief description of AHS' clinical review activities, an application/agreement and confidentiality statement. Please submit your Application/Agreement along with copies of the following documents:

- A ***current*** copy of your Curriculum Vitae
- Completed W-9 Tax form, signed & dated (***if you report earnings under a Tax ID # please include the name in which this number is reported under***)
- HIPAA Compliance Form & Statement Regarding Conflict of Interest, signed & dated after reading enclosed HIPAA information
- AHS' Confidentiality Statement
- Consent form for the release of information
- Copies of **all** Board Certification (s)

Once accepted as a Clinician Consultant Reviewer, AHS will provide you with additional information about the Alliant Health Solutions Medical Review Program. The participation of practicing clinicians, such as you, is crucial to AHS' Clinical Review Activities.

If you have any questions, please contact AHS at 678-527-3617.

Sincerely,

Loy D. Cowart III MD FAAFP

Loy Cowart, MD
Chief Medical Officer, Medicaid

GMM: mh
Enclosure

A BRIEF DESCRIPTION OF CLINICAL REVIEW ACTIVITIES

Alliant Health Solutions

Alliant Health Solutions

Alliant Health Solutions (AHS) is the parent company of a number of subsidiaries which provide medical review activities to various entities. AHS conducts credentialing and re-credentialing for all of its subsidiaries and maintains accurate and up-to-date credentialing information for all Clinical Consultants/Peer Reviewers. AHS subsidiaries include:

- Alliant GMCF
- Alliant ASO
- Alliant Integrity
- Alliant Quality

Medicaid

In Georgia, Alliant GMCF provides "pre-certification" services, prior authorizations, and SURS provider and member review for the Medicaid Program. Under the Medicaid Program, certain services must be pre-approved by Alliant GMCF reviewers before Medicaid will agree to cover the cost of these procedures. Alliant GMCF also provides some additional consultative services for the Medicaid Program in Georgia when asked to do so by state officials. For example, Alliant GMCF is sometimes asked to provide advice to the state concerning coverage of some new or controversial procedure, medication, or service. Alliant GMCF also provides retrospective SURS reviews to determine the over or under utilization of services and identify substandard quality of care. SURS reviews guard against the inappropriate use of dollars which could otherwise be spent for needed quality care. Alliant GMCF utilizes its consultant clinicians in all of its Medicaid activities. Alliant ASO provides similar types of Medicaid services to various state Medicaid agencies in other states.

Other Activities

AHS may undertake additional medical review activities in the future. One activity that may be considered in the future is that of serving as an "Independent Review Organization" (IRO) in Georgia. An IRO independently and objectively evaluates disputes between managed care organizations and its member patients, when there is disagreement about the medical necessity or appropriateness of health care services. AHS would utilize its practicing clinician consultants in conducting this Please print or type information

Statement of Agreement to HIPAA Compliance

______ I agree to abide by HIPAA regulations and related Alliant Health Solutions ("AHS") policies and procedures.

Print Name ________________________________

Signature___________________________________Date ___________________

Statement regarding Conflict of Interest

Reviewers are asked not to review cases involving partners, other professionals with whom they compete directly, institutions where they practice, or in any other situation where the reviewer recognizes a potential conflict of interest. Being acquainted with another professional practicing in the same specialty is not necessarily a conflict – but the reviewer is asked to exercise care in making that judgement and to decline a review if in doubt.

Signature___________________________________Date ___________________

Please return to Alliant Health Solutions by mail or fax to:

Alliant Health Solutions
Attn: ***Peer Consultant Administrator***
1455 Lincoln Parkway,
East Suite 800
Atlanta, GA 30346
Fax: 678-527-3594

ALLIANT HEALTH SOLUTIONS
Clinician Consultant Reviewer Application/Agreement

LEGAL NAME ______________________________

DEGREE ______________________ **GRADUATION YEAR** ______________________

ADDRESS ______________________________

CITY ______________ STATE ______________ ZIP ________ COUNTY ______________

EMAIL ______________________________

DATE OF BIRTH ______________________

OFFICE TELEPHONE NUMBER(S) *(including area code)*

Main Number ______________________ Answering Service ______________________

Fax Number ______________________ Other ______________________

BOARD & ASSOCIATION STATUSES -PLEASE SUBMIT A COPY OF CURRENT BOARD CERTIFICATION (S)

SPECIALTY ______________________________

SPECIALTY ______________________________

SUBSPECIALTY ______________________________

SUBSPECIALTY ______________________________

BOARD ACTIONS OR SUITS

State Board Action: ☐ None ☐ Pending ☐ Action Taken (if so please comment)

____

____

Lawsuits: ☐ None ☐ Pending ☐ Final /Settled (if so please comment)

____

____

BILLING /IDENTIFYING INFORMATION

SS # ______________________ DEA # ______________________

Tax ID # ______________ Business Name ______________________

GEORGIA LICENSURE

Georgia License # ______________ Expiration Date ______________________

UPIN # ______________ Medicaid Provider # ______________________

OUT-OF-STATE LICENSURE

State ______________ License # ______________ Expiration Date ______________

State ______________ License # ______________ Expiration Date ______________

I AM INTERESTED IN DOING THE FOLLOWING TYPES OF REVIEWS:

Review requests and charts that are ***mailed*** to me — Yes _____ No______

Telephone review of cases with an RN — Yes _____ No______

Review of cases that are ***faxed*** to me — Yes _____ No______

On site review of cases at the Alliant Health Solutions Office — Yes _____ No______

(The Atlanta Alliant Office is near Perimeter Mall off interstate 285 North)

Web-based reviews (through Alliant Health Solutions secure web-site only) — Yes _____ No______

HOSPITAL PRIVILEGES

Name of Hospital	Type of Privileges
________________________________	
________________________________	______________
________________________________	______________

OTHER INFORMATION

Are you currently involved in direct patient care? — Yes _____ No ______

Dates of direct patient care? From _____________ To _______________

If no, have you been involved in direct patient care within the last 3 years? — Yes _____ No ______

Do you treat Medicaid patients? — Yes _____ No ______

Do you treat Medicare patients? — Yes _____ No ______

____

What type of area do you practice in: **Urban** ☐ **Rural** ☐

Do you admit and treat hospitalized patients? — Yes _____ No ______

Do you admit and treat Nursing Home patients? — Yes _____ No ______

Do you admit and treat Hospice patients? — Yes _____ No ______

Is your Georgia license restricted in any way? — Yes _____ No ______

Has your Georgia license ***ever*** been restricted in any way? — Yes _____ No ______

THE BEST DAYS AND TIMES TO CONTACT ME ARE:

MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

We request reviews from clinicians who have similar practices to the clinician who requested the service. If you have specialized training or interest in an area, or if you do not treat certain types of medical problems, we will make a note of this

to avoid a mismatch. Are there any services or procedures usually performed by members of your specialty that you do not do within your practice?

___

Are there any areas of specialization or procedures within your practice with which you have additional training or expertise?

___

To the best of my knowledge, all questions have been answered fully and truthfully.

By submitting this Application/Agreement, you agree that an arrangement has been established to become a Clinician Consultant Reviewer for Alliant Health Solutions ("AHS") in the specialty area(s) designated above, provided your Application/Agreement is accepted by AHS.

SIGNATURE ______________________

DATE ______________________

Alliant Health Solutions

CONFIDENTIALITY STATEMENT

As a Clinician Consultant Reviewer for Alliant Health Solutions (AHS), a variety of confidential information, either written or oral, may be received. Information relating to recipients and providers which is obtained through the performance of my duties under the Contract is considered confidential, as is internal financial and business operations information. Such information shall not be disclosed or made open to examination other than for purpose necessary to the proper administration of AHS business. Federal and State laws also protect the privacy of recipient's medical information and provider's personal information that is often disclosed in the auditing of medical records.

As a consultant of AHS, I agree to keep the described information confidential and will not disclose confidential information outside the necessary administration, as required in the performance of my duties as a consultant. I understand the Department of Community Health (DCH) or other State Medicaid agencies will have absolute authority to determine if and when any other party has properly obtained the right to have access to this confidential information. I will contact my management prior to disclosure of information to anyone.

The undersigned consultant certifies that he/she has read and understands this Confidentiality Statement, understands the unauthorized release or misuse of confidential information will subject any consultant to disciplinary action, up to including immediate termination of consultant duties, and may also constitute a criminal offense under state or federal laws. The terms of this agreement survives termination of my consultant duties with AHS.

Legislation on both the Federal and State levels has been enacted to provide immunity for civil and criminal lawsuits to Peer Review Organizations (PRO) and their members. As long as clinician consultants and PRO's act in good faith while carrying out the review process, and do not act in arbitrary, capricious, or discriminatory manners, blanket immunities prevail. Breaching confidentiality removes immunity and legal protection provided both by the government and AHS while functioning as a peer reviewer.

I understand that information involved in the review process is protected under the Social Security Act, HIPAA and the AHS Confidentiality and Information Disclosure Plan. I agree to abide by the current plans and all subsequent plans adopted to preserve confidentiality.

Print Name:______________________________ Signature: ____________________________

Consultant

Date: ______________

Para informacion en espanol, visite www.ftc.gov/credit o escribe a la FTC Consumer Response Center, Room 130-A 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.ftc.gov/credit or write to: Consumer Response Center, Room 130-A, Federal Trade Commission, 600 Pennsylvania Ave. N.W., Washington, D.C. 20580.**

C **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

C **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

C a person has taken adverse action against you because of information in your credit report;

C you are the victim of identify theft and place a fraud alert in your file;

C your file contains inaccurate information as a result of fraud;

C you are on public assistance;

C you are unemployed but expect to apply for employment within 60 days.

In addition, by September 2005 all consumers will be entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.ftc.gov/credit for additional information.

C **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

C **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.ftc.gov/credit for an explanation of dispute procedures.

C **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

Consumer reporting agencies may not report outdated negative information. In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

C **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

C **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.

C **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at
1-888-5-OPTOUT (1-888-567-8688).

C **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

C **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. Federal enforcers are:

TYPE OF BUSINESS:	**CONTACT:**
Consumer reporting agencies, creditors and others not listed below	Federal Trade Commission: Consumer Response Center - FCRA Washington, DC 20580 1-877-382-4357
National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)	Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219 800-613-6743
Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)	Federal Reserve Consumer Help (FRCH) P O Box 1200 Minneapolis, MN 55480 Telephone: 888-851-1920 Website Address: www.federalreserveconsumerhelp.gov Email Address: ConsumerHelp@FederalReserve.gov
Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)	Office of Thrift Supervision Consumer Complaints Washington, DC 20552 800-842-6929
Federal credit unions (words "Federal Credit Union" appear in institution's name)	National Credit Union Administration 1775 Duke Street Alexandria, VA 22314 703-519-4600
State-chartered banks that are not members of the Federal Reserve System	Federal Deposit Insurance Corporation Consumer Response Center, 2345 Grand Avenue, Suite 100 Kansas City, Missouri 64108-2638 1-877-275-3342
Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission	Department of Transportation , Office of Financial Management Washington, DC 20590 202-366-1306
Activities subject to the Packers and Stockyards Act, 1921	Department of Agriculture

ACKNOWLEDGMENT AND AUTHORIZATION

I acknowledge receipt of the **DISCLOSURE REGARDING BACKGROUND INVESTIGATION** and **A SUMMARY OF YOUR RIGHTS UNDER THE FAIR CREDIT REPORTING ACT** and certify that I have read and understand both of those documents. I hereby authorize the obtaining of "consumer reports" and/or "investigative consumer reports" at any time after receipt of this Acknowledgement and Authorization and, if I am selected to provide consulting services, throughout my consulting engagement. I understand that, except in California, Alliant Health Solutions and subsidiaries, its agents, and/or another outside organization my act on behalf of the Company, and/or Employer itself may rely on this authorization to order additional consumer reports, including investigative consumer reports, from time to time during my consultancy, as deemed necessary for consultancy purposes and as allowed by law. I also authorize the following agencies and entities to disclose to Alliant Health Solutions, and its agents, and/or another outside organization acting on behalf of the Company, and/or the Company itself, all information about or concerning me, including, but not limited to: my past or present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; insurance companies; testing facilities; motor vehicle records agencies; all other private and public sector repositories of information; and any other person, organization, or agency with any information about or concerning me. The information that can be disclosed includes, but is not limited to, information concerning my employment history, earnings history, education, credit history, motor vehicle history, criminal history, military service, drug testing results, and professional credentials and licenses. I agree that a facsimile ("fax") or photographic copy of this Acknowledgement and Authorization shall be as valid as the original.

APPLICANT:

Signature: ____________________ Date: ___/_____/__

Print Name: ______________________

Form **W-9**
(Rev. November 2005)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give form to the requester. Do not send to the IRS.

Print or type See Specific Instructions on page 2.

Name (as shown on your income tax return)

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ▶ ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.) | Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on Line 1 to avoid backup withholding. For individuals, this is your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Social security number

or

Employer identification number

Note. If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here Signature of U.S. person ▶ Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

In 3 above, if applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income.

Note. If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

For federal tax purposes, you are considered a person if you are:

- An individual who is a citizen or resident of the United States,
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States, or
- Any estate (other than a foreign estate) or trust. See Regulations sections 301.7701-6(a) and 7(a) for additional information.

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax on any foreign partners' share of income from such business. Further, in certain cases where a Form W-9 has not been received, a partnership is required to presume that a partner is a foreign person, and pay the withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid withholding on your share of partnership income.

The person who gives Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States is in the following cases:

- The U.S. owner of a disregarded entity and not the entity,