Primary Care Case Management (PCCM)
Texas Standard Credentialing Application Addendum
Submit with Initial Enrollment Application

Section I Panel Capacity Verification

Complete the requested Service Area(s) information for each region from which you are willing to accept clients.

☐ **Southeast:** Chambers, Jefferson, Hardin, Liberty, and Orange counties

Panel Capacity _____

Accepting New Patients? ☐ Yes ☐ No

☑ **PCCM Service Area:** All counties not in the Southeast Region or listed below are included in PCCM

The following counties are not included in the PCCM Service Area
Atascosa, Bexar, Brazoria, Collin, Comal, Crosby, Dallas, Denton, Ellis, El Paso, Floyd, Fort Bend, Galveston, Garza, Guadalupe, Hale, Harris, Hockley, Hunt, Johnson, Kaufman, Kendall, Lamb, Lubbock, Lynn, Medina, Montgomery, Navarro, Nueces, Rains, Rockwell, Terry, Waller, and Wilson.

Panel Capacity _____

Accepting New Patients? ☑ Yes ☐ No

Section II Provider Practice Information

Theard MD. Franz C
Provider Last Name First Name Middle Initial

Age range of patients seen. From 12 to 50

Are you a currently enrolled Texas Health Steps (THSteps) provider? ☐ Yes ☑ No

If Yes, please provide your Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Number:_____

If you are not currently enrolled as Texas Health Steps (THSteps) provider, are you interested in becoming a Texas Health Steps (THSteps) provider? ☐ Yes ☑ No

Do you provide any of the following specialized services?

☐ HIV ☐ Children with Disabilities (CIDC) ☑ High risk OB/GYN ☐ OB/GYN Care/Delivery ☐ Other _____

Practice limited to: ☐ Male only ☑ Female only ☐ No limitation

Section III Ethnicity

☐ White, Non-Hispanic ☑ Black, Non-Hispanic ☐ Hispanic
☐ Asian, Pacific Islander ☐ American Indian or Alaskan ☐ Unknown/Other

To the individual filling out this form:
Every individual has the right to make inquiries about this form and the right to review the information submitted on the form. (There are a few exceptions). If the information is wrong, submit a request to correct it. The Health and Human

Services Commission has a method for asking for corrections. The procedure is located in Title 1 *Texas Administrative Code* (TAC) §§351.17–351.23. For information about this form or to request corrections, call the PCCM Provider Helpline at 1-888-834-7226 or write to: TMHP - Provider Helpline, PO Box 204270, Austin, Texas 78727-4270

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

PCCM Credentialing MC-B05
P.O. Box 204270
Austin, TX 78720-0420
1-800-925-9126

Addendum B

Primary Care Case Management (PCCM)
Primary Care Provider Addendum

This PCCM Primary Care Provider Addendum, an addendum to the Health and Human Services Commission Medicaid Provider Agreement (Medicaid Agreement), as amended, sets forth the duties and responsibilities of a primary care provider who agrees to provide medical services to Medicaid-eligible recipients enrolled in the Texas Medicaid PCCM Program who have selected or been assigned to the primary care provider. By signing this Addendum, the primary care provider agrees to comply with the conditions, policies, and procedures set forth in the Medicaid Agreement and in the *Texas Medicaid Provider Procedures Manual (Medicaid Manual)*, the PCCM provider policies and procedures (PCCM Policies), as provided by the Health and Human Services Commission (HHSC) and ACS State Healthcare, LLC (ACS), and all updates published in the *Texas Medicaid Bulletin*, all of which are incorporated by reference into this Addendum.

1.0 PARTIES

Health and Human Services Commission (HHSC): The single state agency designated to administer the Medical Assistance Program (Medicaid) in the state of Texas.

Primary care provider: The primary care provider identified below by signature and Texas Provider Identifier number.

2.0 DEFINITIONS

The terms used in this Addendum have the same meaning as they have in the *Medicaid Manual* and the PCCM Policies, unless the context clearly indicates otherwise. If there is a conflict between the *Medicaid Manual* and the PCCM Policies, the *PCCM Policies* control.

ACS State Healthcare, LLC, means the primary contractor for the Texas Medicaid & Healthcare Partnership, under contract with HHSC to administer the PCCM program for the state of Texas (ACS/TMHP).

Medical Home means a primary care or specialty care provider who has accepted the responsibility for providing accessible, continuous, comprehensive, and coordinated care to Members participating in the Texas Medicaid managed care program.

Member means a Medicaid-eligible recipient who is currently enrolled in the PCCM program.

PCCM means the Texas Medicaid managed care delivery system that delivers care to enrolled Members through a contracted network of primary care providers and inpatient facilities.

Primary care provider means a Medicaid-enrolled physician or other provider, who has agreed with HHSC to provide a Medical Home to Medicaid recipients who are Members of the PCCM program, and who is responsible for providing initial and primary care to these Members, maintaining continuity of patient care, and initiating referrals for care.

3.0 DUTIES and RESPONSIBILITIES of Primary Care Provider

3.1 **Referral to Specialists** The primary care provider must assess the medical needs of Members and make medically necessary referrals to specialty care providers who are currently enrolled as participating providers in the Texas Medicaid Program. Members cannot access specialty care (excluding OB/GYN and behavioral health) without a primary care provider referral.

3.2 **Emergency and After Hours Access** The primary care provider must ensure that he/she will be available or accessible, or arrange to have another qualified medical professional available or accessible, twenty-four (24) hours a day, seven (7) days a week. The primary care provider must arrange to have an answering service that is answered after hours by a person or an answering machine that provides the Member with a number where live, interactive advice from a qualified medical professional can be obtained.

3.3 **Timeliness** The primary care provider must ensure that the following timeliness standards are met when providing services to Members:

- Emergency Services must be provided upon member presentation at the time the service delivery site, including at non-network and area facilities.
- Urgent care, including urgent specialty care, must be provided within twenty-four (24) hours of request.
- Routine primary care must be provided within fourteen (14) days of request.
- Initial outpatient behavioral health visits must be provided within fourteen (14) days of request.
- *Routine specialty care referrals must be provided within thirty (30) days of request.*
- Pre-natal care must be provided within fourteen (14) days of request, except for high-risk pregnancies or new Members in the third trimester for whom an appointment must be offered within five (5) days, or immediately, if an emergency exists.
- Preventative health services for children, including well-child check-ups, should be offered to Members in accordance with the THSteps Program periodicity schedule. For newly enrolled members from birth to age 20, overdue or upcoming well-child checkups, including THSteps medical check-ups, should be offered as soon as practicable, but in no case later than fourteen (14) days of enrollment for newborns, and no later than sixty (60) days of enrollment for all other eligible child members.

3.3 **Texas Health Steps (THSteps)** The primary care provider must ensure that Members under the age of 21 receive all services required by the THSteps program (formerly EPSDT). All services must be provided in compliance with all generally accepted medical standards for the community in which services are rendered.

3.4 **Licensing/Certification** The primary care provider agrees to submit a current copy of his/her malpractice insurance at the time of enrollment, recredentialing, and upon request by ACS/TMHP.

4.0 DUTIES and RESPONSIBILITIES of HHSC

4.1 **Case Management Fee** HHSC will pay the primary care provider a monthly case management fee per member per month based on the total number of Members on the primary care provider's panel. The case management fee rate is published in the *Texas Medicaid Provider Procedures* Manual, with updates in the *Texas Medicaid Bulletin*.

4.2 **Panel Reports** HHSC will provide the primary care provider with a monthly list of Members enrolled with the primary care provider.

5.0 TERM and TERMINATION

This Addendum is effective from the date executed and terminates 90 days after receipt by either party of certified written notice of the other party's intent to terminate the Addendum or on termination of the primary care provider's Medicaid Agreement. All efforts must be made to establish acceptable continuity of care for Members during and after termination.

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Primary Care Provider's TPI Number: 133825308

Primary Care Provider's Printed Name: FRANZ C. THEARD MD.

Primary Care Provider's Signature: Franz C. Theard MD

Date of Execution: 10.21.05.

MR08

Pursuant to Texas Insurance Code § 1452.052, LHL234 Rev. 01/07 is promulgated by the Texas Department of Insurance. Please send this application to the carrier with whom you wish to become credentialed.

Texas Standardized Credentialing Application

(Please type or print)

Section I-Individual Information

TYPE OF PROFESSIONAL
M D

LAST NAME: Theard | FIRST: Franz | MIDDLE: C | (JR., SR., ETC.)

MAIDEN NAME: n/a | YEARS ASSOCIATED (YYYY-YYYY) | OTHER NAME | YEARS ASSOCIATED (YYYY-YYYY)

HOME MAILING ADDRESS

CITY: El Paso | STATE/COUNTRY: TX/USA | POSTAL CODE: 79902

HOME PHONE NUMBER | SOCIAL SECURITY NUMBER | ☐ Female ☒ Male

CORRESPONDENCE ADDRESS
P O Box 9520

CITY: El Paso | STATE/COUNTRY: TX/USA | POSTAL CODE: 79995

PHONE NUMBER: 915-783-8162 | FAX NUMBER: 915-783-8187 | E-MAIL

DATE OF BIRTH (MM/DD/YYYY) | PLACE OF BIRTH | CITIZENSHIP: U.S

IF NOT AMERICAN CITIZEN, VISA NUMBER & STATUS | ARE YOU ELIGIBLE TO WORK IN THE UNITED STATES? ☒ Yes ☐ No

U.S MILITARY SERVICE/PUBLIC HEALTH ☒ Yes ☐ No | DATES OF SERVICE (MM/DD/YYYY) TO (MM/DD/YYYY): 07/01/1976 08/01/1988 | LAST LOCATION: William Beaumont-El Paso

BRANCH OF SERVICE: Army | ARE YOU CURRENTLY ON ACTIVE OR RESERVE MILITARY DUTY? ☐ Yes ☒ No

Education

PROFESSIONAL DEGREE (MEDICAL, DENTAL, CHIROPRACTIC, ETC.)
Issuing Institution: The George Washinton University

ADDRESS
2300 I Street NW

CITY: Washington | STATE/COUNTRY: DC/USA | POSTAL CODE: 20037

DEGREE: M D | ATTENDANCE DATES (MM/YYYY TO MM/YYYY): 09/1968 05/1972

☐ *Please check this box and complete and submit Attachment A if you received other professional degrees.*

POST-GRADUATE EDUCATION ☒ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment | SPECIALTY

INSTITUTION
District of Columbia General

ADDRESS
110 Irving Street, NW

CITY: Washington | STATE/COUNTRY: DC/USA | POSTAL CODE: 20010

☒ Program successfully completed | ATTENDANCE DATES (MM/YYYY TO MM/YYYY): 06/1972 06/1973

PROGRAM DIRECTOR | CURRENT PROGRAM DIRECTOR (IF KNOWN)

POST-GRADUATE EDUCATION ☐ Internship ☒ Residency ☐ Fellowship ☐ Teaching Appointment | SPECIALTY

INSTITUTION
Washington Hospital Center

ADDRESS
110 Irving Street NW

CITY: Washington | STATE/COUNTRY: DC/USA | POSTAL CODE: 20010

Education *continued*

POST-GRADUATE EDUCATION ☒ Program successfully completed	ATTENDANCE DATES (MM/YYYY TO MM/YYYY) 06/1973 06/1976
PROGRAM DIRECTOR	CURRENT PROGRAM DIRECTOR (IF KNOWN)

☐ Please check this box and complete and submit Attachment B if you received additional postgraduate training.

OTHER GRADUATE-LEVEL EDUCATION Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES (MM/YYYY TO MM/YYYY)	

Licenses and Certificates - Please include all license(s) and certifications in all States where you are currently or have previously been licensed.

LICENSE TYPE Physician Permit	LICENSE NUMBER F6332	STATE OF REGISTRATION TX
ORIGINAL DATE OF ISSUE (MM/DD/YYYY) 05/01/1974	EXPIRATION DATE (MM/DD/YYYY) 05/31/2010	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☒ Yes ☐ No
LICENSE TYPE Physician Permit	LICENSE NUMBER 79-228	STATE OF REGISTRATION NM
ORIGINAL DATE OF ISSUE (MM/DD/YYYY) 11/19/1979	EXPIRATION DATE (MM/DD/YYYY) 07/01/2010	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☒ Yes ☐ No
LICENSE TYPE	LICENSE NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No
☒ DEA Number: AT9162809	ORIGINAL DATE OF ISSUE (MM/DD/YYYY) 11/17/2008	EXPIRATION DATE (MM/DD/YYYY) 11/30/2011
☒ DPS Number: N0040059	ORIGINAL DATE OF ISSUE (MM/DD/YYYY) 10/08/2008	EXPIRATION DATE (MM/DD/YYYY) 10/31/2010
OTHER CDS (PLEASE SPECIFY) n/a	NUMBER	STATE OF REGISTRATION
ORIGINAL DATE OF ISSUE (MM/DD/YYYY)	EXPIRATION DATE (MM/DD/YYYY)	DO YOU CURRENTLY PRACTICE IN THIS STATE? ☐ Yes ☐ No

UPIN B88166	NATIONAL PROVIDER IDENTIFIER (WHEN AVAILABLE) 1770633216
ARE YOU A PARTICIPATING MEDICARE PROVIDER? ☒ Yes ☐ No Medicare Provider Number: 8L14429	ARE YOU A PARTICIPATING MEDICAID PROVIDER? ☒ Yes ☐ No Medicare Provider Number: 133825308
EDUCATIONAL COUNCIL FOR FOREIGN MEDICAL GRADUATES (ECFMG) ☒ N/A ☐ Yes ☐ No ECFMG Number:	ECFMG ISSUE DATE (MM/DD/YYYY)

Professional/Specialty Information

PRIMARY SPECIALTY OBGYN	BOARD CERTIFIED? ☒ Yes ☐ No	Name of Certifying Board: American Board of Obstetrics and Gynecology
INITIAL CERTIFICATION DATE (MM/YYYY) 11/1978	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY:

☐ I have taken exam, results pending for Board

☐ I have taken Part I and am eligible for Part II of the Exam.

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO ☒ Yes ☐ No PPO ☒ Yes ☐ No POS ☒ Yes ☐ No

SECONDARY SPECIALTY Maternal-Fetal Medicine	BOARD CERTIFIED? ☒ Yes ☐ No	Name of Certifying Board: American Board of Obstetrics and Gynecology
INITIAL CERTIFICATION DATE (MM/YYYY) 12/1983	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

Professional/Specialty Information - continued

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY

☐ I have taken exam, results pending for Board

☐ I have taken Part I and am eligible for Part II of the Exam

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO ☒ Yes ☐ No PPO ☒ Yes ☐ No POS ☒ Yes ☐ No

ADDITIONAL SPECIALTY
n/a

BOARD CERTIFIED?
☐ Yes ☐ No Name of Certifying Board

INITIAL CERTIFICATION DATE (MM/YYYY)	RECERTIFICATION DATE(S), IF APPLICABLE (MM/YYYY)	EXPIRATION DATE, IF APPLICABLE (MM/YYYY)

IF NOT BOARD CERTIFIED, INDICATE ANY OF THE FOLLOWING THAT APPLY

☐ I have taken exam, results pending for Board

☐ I have taken Part I and am eligible for Part II of the Exam

☐ I am intending to sit for the Boards on (date)

☐ I am not planning to take Boards

DO YOU WISH TO BE LISTED IN THE DIRECTORY UNDER THIS SPECIALTY?
HMO ☐ Yes ☐ No PPO ☐ Yes ☐ No POS ☐ Yes ☐ No

PLEASE LIST OTHER AREAS OF PROFESSIONAL PRACTICE INTEREST OR FOCUS (HIV/AIDS, ETC.)

Work History - *Please provide a chronological work history. You may submit a Curriculum Vitae as a supplement. Please explain all gaps in employment that lasted more than six months.*

CURRENT PRACTICE/EMPLOYER NAME
Texas Tech University Health Sciences Center

START DATE/END DATE (MM/YYYY TO MM/YYYY)
04/2009

ADDRESS
4800 Alberta Ave

CITY	STATE/COUNTRY	POSTAL CODE
El Paso	TX/USA	79905

PREVIOUS PRACTICE/EMPLOYER NAME
Franz C Theard, M D

START DATE/END DATE (MM/YYYY TO MM/YYYY)
09/1983

ADDRESS
1201 E Schuster, Ste 2B

CITY	STATE/COUNTRY	POSTAL CODE
El Paso	TX/USA	79902

REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME
Paso Del Norte OBGYN

START DATE/END DATE (MM/YYYY TO MM/YYYY)
11/1999 05/2003

ADDRESS
1900 N Mesa

CITY	STATE/COUNTRY	POSTAL CODE
El Paso	TX/USA	79902

REASON FOR DISCONTINUANCE
Second location-moved practice to 1201 E Schuster #2B (Combined practices)

PREVIOUS PRACTICE/EMPLOYER NAME
Perinatal Healthcare Center

START DATE/END DATE (MM/YYYY TO MM/YYYY)
09/1983

ADDRESS
1201 E. Schuster, Ste. 2B

CITY	STATE/COUNTRY	POSTAL CODE
El Paso	TX/USA	79902

REASON FOR DISCONTINUANCE
Still in practice-High risk pregnancies only

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS (MM/YYYY TO MM/YYYY) IN WORK HISTORY.

Gap Dates: Explanation:

Gap Dates: Explanation:

Work History – *continued*

Gap Dates | Explanation

Gap Dates | Explanation

☐ *Please check this box and complete and submit Attachment C if you have additional work history*

Hospital Affiliations-*Please include all hospitals where you currently have or have previously had privileges.*

DO YOU HAVE HOSPITAL PRIVILEGES? ☒ Yes ☐ No

IF YOU DO NOT HAVE ADMITTING PRIVILEGES, WHAT ADMITTING ARRANGEMENTS DO YOU HAVE?

PRIMARY HOSPITAL WHERE YOU HAVE ADMITTING PRIVILEGES: University Medical Center of El Paso

START DATE (MM/YYYY): 04/2009

ADDRESS: 4815 Alameda

CITY: El Paso | STATE/COUNTRY: TX/USA | POSTAL CODE: 79905

PHONE NUMBER: (915) 521-7620 | FAX: (915) 521-7842 | E-MAIL:

FULL UNRESTRICTED PRIVILEGES? ☒ Yes ☐ No

TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)

ARE PRIVILEGES TEMPORARY? ☐ Yes ☒ No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO PRIMARY HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES: Providence Memorial Hospital

START DATE (MM/YYYY): 03/1984

ADDRESS: 2001 N Oregon

CITY: El Paso | STATE/COUNTRY: TX/USA | POSTAL CODE: 79902

PHONE NUMBER: 915-577-6011 | FAX: | E-MAIL:

FULL UNRESTRICTED PRIVILEGES? ☒ Yes ☐ No

TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.): Active-OBGYN

ARE PRIVILEGES TEMPORARY? ☐ Yes ☒ No

OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

☒ *Please check this box and complete and submit Attachment D if you have additional current hospital affiliations.*

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES

AFFILIATION DATES (MM/YYYY TO MM/YYYY)

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No

TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)

WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No

REASON FOR DISCONTINUANCE

☐ *Please check this box and complete and submit Attachment E if you have additional previous hospital affiliations.*

References-*Please provide three peer references from the same field and/or specialty who are not partners in your own group practice and are not relatives. All peer references should have firsthand knowledge of your abilities*

1 NAME/TITLE: Jorge Kareh, MD | PHONE NUMBER: 915-577-9799

ADDRESS: 1501 N Mesa, Ste 1A

CITY: El Paso | STATE/COUNTRY: TX/USA | POSTAL CODE: 79902

References continued

2 NAME/TITLE
Nilda Rivera, MD

PHONE NUMBER
915-577-9799

ADDRESS
1501 N. Mesa, Ste 1A

CITY
El Paso

STATE/COUNTRY
TX/USA

POSTAL CODE
79902

3 NAME/TITLE
Juan Rolan, MD

PHONE NUMBER
915-533-2228

ADDRESS
1300 Murchison

CITY
El Paso

STATE/COUNTRY
TX/USA

POSTAL CODE
79902

Professional Liability Insurance Coverage

SELF-INSURED?
☒ Yes ☐ No

NAME OF CURRENT MALPRACTICE INSURANCE CARRIER OR SELF-INSURED ENTITY
Texas Tech Professional Self-Insurance Plan

ADDRESS
P.O. Box 42021

CITY
Lubbock

STATE/COUNTRY
Texas

POSTAL CODE
79409

PHONE NUMBER
(806) 7421216

POLICY NUMBER
n/a

EFFECTIVE DATE (MM/DD/YYYY)
06/01/2009

EXPIRATION DATE (MM/DD/YYYY)

AMOUNT OF COVERAGE PER OCCURRENCE
$400,000.00

AMOUNT OF COVERAGE AGGREGATE
$1,200,000.00

TYPE OF COVERAGE
☒ Individual ☐ Shared

LENGTH OF TIME WITH CARRIER

NAME OF PREVIOUS MALPRACTICE INSURANCE CARRIER IF WITH CURRENT CARRIER LESS THAN 5 YEARS
Texas Medical Liability Insurance

ADDRESS
505 E. Huntland Dr., Ste. 180

CITY
Austin

STATE/COUNTRY
TX/USA

POSTAL CODE
78752

PHONE NUMBER
512-452-4370

POLICY NUMBER
MP002970

EFFECTIVE DATE (MM/DD/YYYY)
10/01/2003

EXPIRATION DATE (MM/DD/YYYY)
10/01/2009

AMOUNT OF COVERAGE PER OCCURRENCE
$200,000.00

AMOUNT OF COVERAGE AGGREGATE
$600,000.00

TYPE OF COVERAGE
☒ Individual ☐ Shared

LENGTH OF TIME WITH CARRIER
5 years

Call Coverage

☐ **See attached list of hospital staff within my department I utilize for call coverage.**

PLEASE LIST NAMES OF COLLEAGUE(S) PROVIDING REGULAR COVERAGE AND HIS OR HER SPECIALTIES

Name: Specialty:

Name Specialty:

Name Specialty:

Name Specialty

Name Specialty:

PLEASE LIST FULL NAMES OF ALL PARTNERS IN YOUR PRACTICE ☐ CHECK THIS BOX AND ATTACH LIST FOR LARGE GROUP

Name Name:

Name Name:

Name Name:

Name Name:

Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.*

PRACTICE LOCATION

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☒ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY: Texas Tech Physician Associates

GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9: Texas Tech Physician Associates

PRACTICE LOCATION ADDRESS
☒ Primary 4800 Alberta Ave.

CITY: El Paso | STATE/COUNTRY: TX | POSTAL CODE: 79905

PHONE NUMBER: 915-545-7501 | FAX NUMBER: 915-545-7537 | E-MAIL:

BACK OFFICE PHONE NUMBER: n/a | SITE-SPECIFIC MEDICAID NUMBER: 133825308 | TAX ID NUMBER: 75-2674893

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER: 084598401 | GROUP NAME CORRESPONDING TO TAX ID NUMBER: Texas Tech Physician Associates

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☒ No | IF NO, EXPECTED START DATE? (MM/DD/YYYY): | DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☒ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT: Alicia Gachama | PHONE NUMBER: 915-545-6611 | FAX NUMBER: 915-545-6946

CREDENTIALING CONTACT: Terry Acosta

ADDRESS: P.O. Box 9520

CITY: El Paso | STATE/COUNTRY: TX | POSTAL CODE: 79995

PHONE NUMBER: 915-783-8100 ext. 253 | FAX NUMBER: 915-783-8187 | E-MAIL:

BILLING COMPANY'S NAME (IF APPLICABLE): MPIP | BILLING REPRESENTATIVE: Letty Alvarado

ADDRESS: P.O. Box 202211

CITY: Dallas | STATE/COUNTRY: TX 75320-2211 | POSTAL CODE:

PHONE NUMBER: 915-783-8199 | FAX NUMBER: 915-783-8187 | E-MAIL:

DEPARTMENT NAME IF HOSPITAL-BASED: n/a | CHECK PAYABLE TO: Texas Tech Pysician Associates | CAN YOU BILL ELECTRONICALLY? ☒ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning: 8:00 am-5:00 pm	Afternoon	Evening:
Tuesday	☐ No Office Hours	Morning: 8:00 am-5:00 pm	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning: 8:00 am-5:00 pm	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning: 8:00 am-5:00 pm	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning: 8:00 am-5:00 pm	Afternoon:	Evening:
Saturday	☒ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☒ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☒ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☒ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION.

PRACTICE LIMITATIONS
☐ Male only ☒ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☒ No If yes, provide the following information for each staff member:

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

Practice Location Information - continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.

NON ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS
Spanish/French

NON ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL
Spanish

ARE INTERPRETERS AVAILABLE?
☒ Yes ☐ No If yes, please specify languages. Spanish

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☒ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☒ Building ☒ Parking ☒ Restroom ☐ Other:

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other:

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☒ Bus ☐ Regional Train ☐ Other

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☒ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☒ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☒ Provider Exp	Advanced Life Support in OB	☐ Staff	☐ Provider Exp
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp.
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp.
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp	Other (please specify)	☐ Staff	☐ Provider Exp

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☒ No

☐ Laboratory Services, please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE). n/a

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☒ No

☐ X-ray: please list all certifications n/a

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration /Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other:			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)
Routine and high risk obstetrical include ultrasound and amniocentesis

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☒ Yes ☐ No Please specify the classes or categories.

WHO ADMINISTERS IT?
M D 's

☐ *Please check this box and complete and submit Attachment F if you have other practice locations.*

Section II-Disclosure Questions - Please *provide* an explanation for any question answered yes-except 16-on page 10.

Licensure

1 Has your license to practice, in your profession, ever been denied, suspended, revoked, restricted, voluntarily surrendered while under investigation, or have you ever been subject to a consent order, probation or any conditions or limitations by any state licensing board?

☐ Yes ☒ No

2 Have you ever received a reprimand or been fined by any state licensing board?

☐ Yes ☒ No

Hospital Privileges and Other Affiliations

3 Have your clinical privileges or Medical Staff membership at any hospital or healthcare institution ever been denied, suspended, revoked, restricted, denied renewal or subject to probationary or to other disciplinary conditions (for reasons other than non-completion of medical records when quality of care was not adversely affected) or have proceedings toward any of those ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?

☐ Yes ☒ No

4 Have you voluntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?

☐ Yes ☒ No

5 Have you ever been terminated for cause or not renewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?

☐ Yes ☒ No

Education, Training and Board Certification

6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign?

☐ Yes ☒ No

7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program?

☐ Yes ☒ No

8 Have any of your board certifications or eligibility ever been revoked?

☐ Yes ☒ No

9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation?

☐ Yes ☒ No

DEA or DPS

10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished?

☐ Yes ☒ No

Medicare, Medicaid or other Governmental Program Participation

11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?

☐ Yes ☒ No

Other Sanctions or Investigations

12 Are you currently or have you ever been the subject of an investigation by any hospital, licensing authority, DEA or DPS authorizing entities, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

☐ Yes ☒ No

Section II - Disclosure Questions - *continued*

Other Sanctions or Investigations

13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank?

☐ Yes ☒ No

14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)?

☐ Yes ☒ No

15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency?

☐ Yes ☒ No

Malpractice Claims History

16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated?

☒ Yes ☐ No

☒ *If yes, please check this box and complete and submit Attachment G.*

Criminal

17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional

☐ Yes ☒ No

18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?

☐ Yes ☒ No

19 Have you been court-martialed for actions related to your duties as a medical professional?

☐ Yes ☒ No

Ability to Perform Job

20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.)

☐ Yes ☒ No

21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

☐ Yes ☒ No

Ability to Perform Job

22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients?

☐ Yes ☒ No

23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation?

☐ Yes ☒ No

Please use the space on page 10 to explain yes answers to any question except #16.

Section II - Disclosure Questions-*continued*

Please use the space below to explain yes answers to any question except 16.

QUESTION NUMBER	PLEASE EXPLAIN

Section III – Standard Authorization, Attestation and Release (Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation and/or clinical privileges (hereinafter, referred to as "Participation") at or with

(PLEASE INDICATE MANAGED CARE COMPANY(S) OR HOSPITAL(S) TO WHICH YOU ARE APPLYING) (HEREINAFTER, INDIVIDUALLY REFERRED TO AS THE "ENTITY")
Primary Care Case Management (PCCM)

and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

For Hospital Credentialing. I consent to appear for an interview with the credentials committee, medical staff executive committee, or other representatives of the medical staff, hospital administration or the governing board, if required or requested. As a medical staff member, I pledge to provide continuous care for my patients. I have been informed of existing hospital bylaws, rules and regulations, and policies regarding the application process, and I agree that as a medical staff member, I will be bound by them.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning: (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third

MR08 APPLICANT'S INITIALS AND DATE (MM/DD/YYYY) 10-22-09

Section III - Standard Authorization, Attestation and Release - continued

party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities.

In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted on-line or in writing, and must be dated and signed by me (may be a written or an electronic signature). I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s).

I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

SIGNATURE

Franz C. Theard, MD MR08
NAME (PLEASE PRINT OR TYPE)

Last 4 digits of SSN or NPI (PLEASE PRINT OR TYPE)

10-22-09
DATE (MM/DD/YYYY)

Required Attachments or Supplemental Information - Please attach hard copy or scanned documents of the following:

- ☐ Copy of DEA or state DPS Controlled Substances Registration Certificate
- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable

Notice About Certain Information Laws and Practices Pertaining to State Governmental Bodies (i.e. State Hospitals)

With few exceptions, you are entitled to be informed about the information that a state governmental body collects about you (i.e. a state hospital). Under sections 552.021 and 552.023 of the Texas Government Code, you have a right to review or receive copies of information about yourself, including private information. However the state governmental body may withhold information for reasons other than to protect your right to privacy. Under section 559.004 of the Texas Government Code, you are entitled to request that the state governmental body correct information that it has about you that is incorrect. For information about the procedure and costs for obtaining information, please contact the appropriate state governmental body to which you have submitted this application.

OTHER PROFESSIONAL DEGREE
Issuing Institution:

ADDRESS

CITY STATE/COUNTRY POSTAL CODE

DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	
OTHER PROFESSIONAL DEGREE Issuing Institution:		
ADDRESS		
CITY	STATE/COUNTRY	POSTAL CODE
DEGREE	ATTENDANCE DATES(MM/YYYY TO MM/YYYY)	

Texas Standardized Credentialing Application **Attachment B – Other Post Graduate Education**

OTHER POST-GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment
SPECIALTY

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

☐ Program successfully completed
ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment
SPECIALTY

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

☐ Program successfully completed
ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment
SPECIALTY

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

☐ Program successfully completed
ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment
SPECIALTY

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

☐ Program successfully completed
ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

OTHER POST-GRADUATE EDUCATION
☐ Internship ☐ Residency ☐ Fellowship ☐ Teaching Appointment
SPECIALTY

INSTITUTION

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

☐ Program successfully completed
ATTENDANCE DATES (MM/YYYY TO MM/YYYY)

PROGRAM DIRECTOR
CURRENT PROGRAM DIRECTOR (IF KNOWN)

Texas Standardized Credentialing Application **Attachment C - Other Work History**

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

PREVIOUS PRACTICE/EMPLOYER NAME | START DATE/END DATE (MM/YYYY TO MM/YYYY)
ADDRESS
CITY | STATE/COUNTRY | POSTAL CODE
REASON FOR DISCONTINUANCE

Texas Standardized Credentialing Application **Attachment D – Other Current Hospital Affiliations**

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES
Sierra Medical Center
START DATE (MM/YYYY)
11/1983
ADDRESS
1625 Medical Center Dr.
CITY
El Paso
STATE/COUNTRY
TX/USA
POSTAL CODE
79902
PHONE NUMBER
915-747-4000
FAX
E-MAIL
FULL UNRESTRICTED PRIVILEGES?
☒ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
Active-OBGYN
ARE PRIVILEGES TEMPORARY?
☐ Yes ☒ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES
Las Palmas Medical Center
START DATE (MM/YYYY)
10/1983
ADDRESS
1801 N. Oregon
CITY
El Paso
STATE/COUNTRY
TX/USA
POSTAL CODE
79902
PHONE NUMBER
FAX
E-MAIL
FULL UNRESTRICTED PRIVILEGES?
☒ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
Active-OBGYN
ARE PRIVILEGES TEMPORARY?
☐ Yes ☒ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES
START DATE (MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
PHONE NUMBER
FAX
E-MAIL
FULL UNRESTRICTED PRIVILEGES?
☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
ARE PRIVILEGES TEMPORARY?
☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES
START DATE (MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
PHONE NUMBER
FAX
E-MAIL
FULL UNRESTRICTED PRIVILEGES?
☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
ARE PRIVILEGES TEMPORARY?
☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

OTHER HOSPITAL WHERE YOU HAVE PRIVILEGES
START DATE (MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
PHONE NUMBER
FAX
E-MAIL
FULL UNRESTRICTED PRIVILEGES?
☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
ARE PRIVILEGES TEMPORARY?
☐ Yes ☐ No
OF THE TOTAL NUMBER OF ADMISSIONS TO ALL HOSPITALS IN THE PAST YEAR, WHAT PERCENTAGE IS TO THIS SPECIFIC HOSPITAL?

Texas Standardized Credentialing Application **Attachment E – Other Previous Hospital Affiliations**

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES
AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES
AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES
AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES
AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES
AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE

PREVIOUS HOSPITAL WHERE YOU HAVE HAD PRIVILEGES
AFFILIATION DATES (MM/YYYY TO MM/YYYY)
ADDRESS
CITY
STATE/COUNTRY
POSTAL CODE
FULL UNRESTRICTED PRIVILEGES? ☐ Yes ☐ No
TYPES OF PRIVILEGES (PROVISIONAL, LIMITED, CONDITIONAL, ETC.)
WERE PRIVILEGES TEMPORARY? ☐ Yes ☐ No
REASON FOR DISCONTINUANCE

Texas Standardized Credentialing Application — **Attachment F – Other Practice Locations**

Practice Location Information - *Please answer the following questions for each practice location. Use Attachment F or make copies of pages 6-7 as necessary.* | PRACTICE LOCATION of

TYPE OF SERVICE PROVIDED
☐ Solo Primary Care ☐ Solo Specialty Care ☐ Group Primary Care ☐ Group Single Specialty ☐ Group Multi-Specialty

GROUP NAME/PRACTICE NAME TO APPEAR IN THE DIRECTORY | GROUP/CORPORATE NAME AS IT APPEARS ON IRS W-9

PRACTICE LOCATION ADDRESS
☐ Primary

CITY | STATE/COUNTRY | POSTAL CODE

PHONE NUMBER | FAX NUMBER | E-MAIL

BACK OFFICE PHONE NUMBER | SITE-SPECIFIC MEDICAID NUMBER | TAX ID NUMBER

GROUP NUMBER CORRESPONDING TO TAX ID NUMBER | GROUP NAME CORRESPONDING TO TAX ID NUMBER

ARE YOU CURRENTLY PRACTICING AT THIS LOCATION? ☐ Yes ☐ No | IF NO, EXPECTED START DATE? (MM/DD/YYYY) | DO YOU WANT THIS LOCATION LISTED IN THE DIRECTORY? ☐ Yes ☐ No

OFFICE MANAGER OR STAFF CONTACT | PHONE NUMBER | FAX NUMBER

CREDENTIALING CONTACT

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

PHONE NUMBER | FAX NUMBER | E-MAIL

BILLING COMPANY'S NAME (IF APPLICABLE) | BILLING REPRESENTATIVE

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

PHONE NUMBER | FAX NUMBER | E-MAIL

DEPARTMENT NAME IF HOSPITAL-BASED | CHECK PAYABLE TO | CAN YOU BILL ELECTRONICALLY? ☐ Yes ☐ No

HOURS PATIENTS ARE SEEN

Monday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Tuesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Wednesday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Thursday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Friday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Saturday	☐ No Office Hours	Morning:	Afternoon:	Evening:
Sunday	☐ No Office Hours	Morning:	Afternoon:	Evening:

DOES THIS LOCATION PROVIDE 24 HOUR/7 DAY A WEEK PHONE COVERAGE?
☐ Answering Service ☐ Voice mail with instructions to call answering service ☐ Voice mail with other instructions ☐ None

THIS PRACTICE LOCATION ACCEPTS
☐ all new patients ☐ existing patients with change of payor ☐ new patients with referral ☐ new Medicare patients ☐ new Medicaid patients

IF NEW PATIENT ACCEPTANCE VARIES BY HEALTH PLAN, PLEASE PROVIDE EXPLANATION

PRACTICE LIMITATIONS
☐ Male only ☐ Female only Age: ☐ Other:

DO NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, MIDWIVES, SOCIAL WORKERS OR OTHER NON-PHYSICIAN PROVIDERS CARE FOR PATIENTS AT THIS PRACTICE LOCATION?
☐ Yes ☐ No If yes, provide the following information for each staff member.

NAME | PROFESSIONAL DESIGNATION | STATE & LICENSE NO

NAME | PROFESSIONAL DESIGNATION | STATE & LICENSE NO

Attachment F (continued)

Practice Location Information continued

NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO.
NAME	PROFESSIONAL DESIGNATION	STATE & LICENSE NO

NON-ENGLISH LANGUAGES SPOKEN BY HEALTH CARE PROVIDERS

NON-ENGLISH LANGUAGES SPOKEN BY OFFICE PERSONNEL

ARE INTERPRETERS AVAILABLE?
☐ Yes ☐ No If yes, please specify languages

DOES THIS PRACTICE LOCATION MEET ADA ACCESSIBILITY STANDARDS?
☐ Yes ☐ No

WHICH OF THE FOLLOWING FACILITIES ARE HANDICAPPED ACCESSIBLE?
☐ Building ☐ Parking ☐ Restroom ☐ Other

DOES THIS LOCATION HAVE OTHER SERVICES FOR THE DISABLED?
☐ Text Telephony-TTY ☐ American Sign Language-ASL ☐ Mental/Physical Impairment Services ☐ Other

IS THIS LOCATION ACCESSIBLE BY PUBLIC TRANSPORTATION?
☐ Bus ☐ Regional Train ☐ Other

DOES THIS LOCATION PROVIDE CHILDCARE SERVICES?
☐ Yes ☐ No

DOES THIS LOCATION QUALIFY AS A MINORITY BUSINESS ENTERPRISE?
☐ Yes ☐ No

WHO AT THIS LOCATION HAVE THE FOLLOWING CURRENT CERTIFICATIONS? (PLEASE LIST ONLY THE APPLICANT'S CERTIFICATION EXPIRATION DATES.)

Basic Life Support	☐ Staff	☐ Provider Exp	Advanced Life Support in OB	☐ Staff	☐ Provider Exp
Advanced Trauma Life Support	☐ Staff	☐ Provider Exp	Cardio-Pulmonary Resuscitation	☐ Staff	☐ Provider Exp.
Advanced Cardiac Life Support	☐ Staff	☐ Provider Exp	Pediatric Advanced Life Support	☐ Staff	☐ Provider Exp.
Neonatal Advanced Life Support	☐ Staff	☐ Provider Exp	Other (please specify)	☐ Staff	☐ Provider Exp

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE)

DOES THIS LOCATION PROVIDE ANY OF THE FOLLOWING SERVICES ON SITE? ☐ Yes ☐ No
☐ X-ray; please list all certifications.

OTHER SERVICES

☐ Radiology Services	☐ EKG	☐ Care of Minor Lacerations	☐ Pulmonary Function Tests
☐ Allergy Injections	☐ Allergy Skin Tests	☐ Routine Office Gynecology	☐ Drawing Blood
☐ Age Appropriate Immunizations	☐ Flexible Sigmoidoscopy	☐ Tympanometry/Audiometry Tests	☐ Asthma Treatments
☐ Osteopathic Manipulations	☐ IV Hydration / Treatments	☐ Cardiac Stress Tests	☐ Physical Therapies
☐ Other			

PLEASE LIST ANY ADDITIONAL OFFICE PROCEDURES PROVIDED (INCLUDING SURGICAL PROCEDURES)

IS ANESTHESIA ADMINISTERED AT THIS PRACTICE LOCATION?
☐ Yes ☐ No Please specify the classes or categories

WHO ADMINISTERS IT?

☐ ***Please check this box and complete and submit Attachment F if you have other practice locations.***

Texas Standardized Credentialing Application — **Attachment G – Malpractice Claims History**

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
08/13/2003	08/12/2005	Pending

PROFESSIONAL LIABILITY CARRIER INVOLVED
(See Attached)

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID
		$ $

METHOD OF RESOLUTION

☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration

DESCRIPTION OF ALLEGATIONS
Plaintiff alleges that she presented with spontaneous rupture of membrane at 38 weeks on August 13, 2003 and on same delivered by vacuum extraction and a median 4th degree episiotomy subsequently after discharged developed a rectal vaginal fistula

WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT
Rectal vaginal fistula requiring surgical intervention

TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?
☐ Yes ☒ No

INCIDENT DATE (MM/DD/YYYY)	DATE CLAIM WAS FILED (MM/DD/YYYY)	CLAIM/CASE STATUS
		Settled

PROFESSIONAL LIABILITY CARRIER INVOLVED
(See attached)

ADDRESS

CITY | STATE/COUNTRY | POSTAL CODE

PHONE NUMBER	POLICY NUMBER	AMOUNT OF AWARD OR SETTLEMENT & AMOUNT PAID
		$$650,000.00 $150,000.00

METHOD OF RESOLUTION

☐ Dismissed	☐ Settled (with prejudice)	☐ Settled (without prejudice)
☐ Judgment for Defendant(s)	☐ Judgment for Plaintiff(s)	☐ Mediation or Arbitration

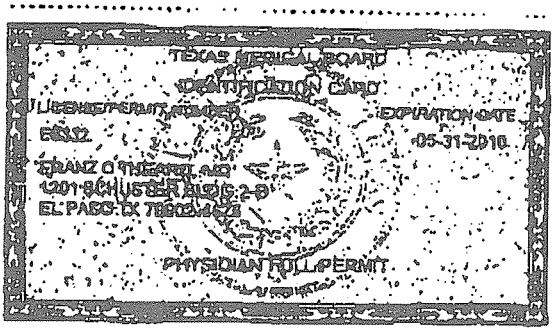
DESCRIPTION OF ALLEGATIONS
Medical negligence involving the treatment and care

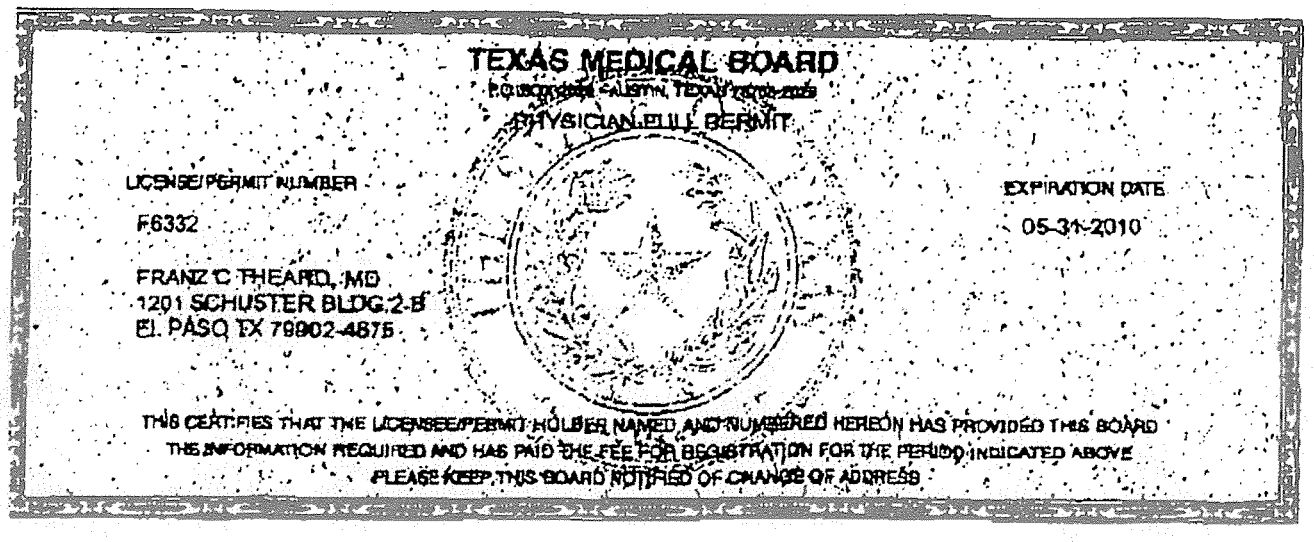
WERE YOU PRIMARY DEFENDANT OR CO-DEFENDANT?	NUMBER OF OTHER CO-DEFENDANTS	YOUR INVOLVEMENT (ATTENDING, CONSULTING, ETC.)
Co-defendant		Co-defendant

DESCRIPTION OF ALLEGED INJURY TO THE PATIENT
Medical negligence

TO THE BEST OF YOUR KNOWLEDGE, IS THIS CASE INCLUDED IN THE NATIONAL PRACTITIONER DATA BANK (NPDB)?
☐ Yes ☒ No

PLEASE NOTE OUR NEW ADDRESS AND PHONE NUMBER
P.O. BOX 2018, AUSTIN, TX 78768-2018
PHONE# 512/305-7010





APR-21-2008 MON 10:38 AM P.002

Texas Department of Public Safety
Courtesy - Service - Protection

Controlled Substances Registration

Current date/time: 10/27/2009 7:40:36 PM

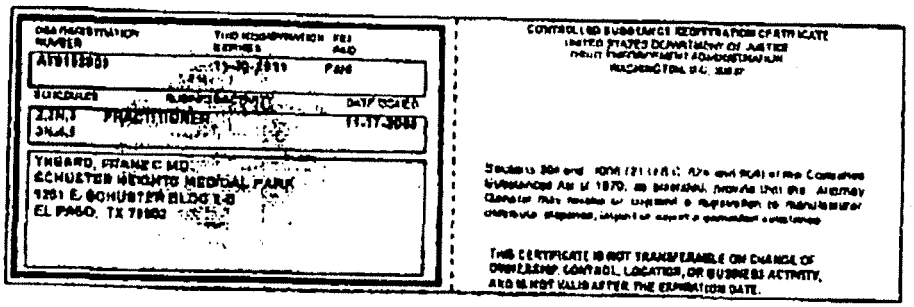
This registrant information was last updated at 10/26/2009 8:31:44 PM

Detailed View - THEARD, FRANZ CARL MD

DPS Number:	L0068566
Address:	WOMEN'S REPRODUCTIVE CENTER 500 EAST SCHUSTER BLDG B EL PASO TX 79902
Business Activity:	PRACTITIONER
Brd. Lic. #:	F6332
Schedule:	2 2N 3 3N 4 5
Exp. Date:	10-31-2010
Original Date Entered:	03-24-1988

DPS Number:	N0040059
Address:	1201 EAST SCHUSTER SUITE 2 B EL PASO TX 79902
Business Activity:	PRACTITIONER
Brd. Lic. #:	F6332
Schedule:	2 2N 3 3N 4 5
Exp. Date:	10-31-2010
Original Date Entered:	N/A

DEA Certificate



CONTROLLED SUBSTANCE REGISTRATION CERTIFICATE
UNITED STATES DEPARTMENT OF JUSTICE
DRUG ENFORCEMENT ADMINISTRATION
WASHINGTON, D.C. 20537

DEA REGISTRATION NUMBER	MO/YR REGISTRATION EXPIRES	FEE PAID
AT6162866	11-30-2011	Paid

SCHEDULES	BUSINESS ACTIVITY	DATE ISSUED
2,3N,3 3N,4,5	PRACTITIONER	11-17-2008

VNEARD, FRANZ C MD
SCHUSTER HEIGHTS MEDICAL PARK
1251 E. SCHUSTER BLDG 8-B
EL PASO, TX 79903

Sections 304 and 1008 (21 U.S.C. 824 and 958) of the Controlled Substances Act of 1970, as amended, provide that the Attorney General may revoke or suspend a registration to manufacture, distribute, dispense, import or export a controlled substance.

THIS CERTIFICATE IS NOT TRANSFERABLE ON CHANGE OF OWNERSHIP, CONTROL, LOCATION, BUSINESS ACTIVITY, OR VALID AFTER THE EXPIRATION DATE.

Form DEA-223 (Rev. 08)

FRANZ C. THEARD, MD OB GYN

TEXAS TECH UNIVERSITY SYSTEM

Office of General Counsel
(Professional Liability Division)

August 28, 2009

CERTIFICATE OF SELF-INSURANCE

COVERED: **All TTUHSC Faculty and Resident Physicians and Medical Students**

EFFECTIVE DATE: *Date of employment - Date of Termination*
Date of enrollment - Date enrollment ends

This is to advise you that the Board of Regents of Texas Tech University has approved a Plan for Professional Medical Malpractice Self-Insurance, pursuant to the authority granted by TEX. EDUC CODE ANN. § 59.02 (Vernon Supp. 1994), providing full-time medical doctors, doctors of osteopathy, oral surgeons, student health doctors, podiatrists, interns, residents, fellows and medical students of Texas Tech University Health Sciences Center with medical professional liability protection in the following amounts, ***unless lower liability limits are set by law, in which case the lower limits set by law shall apply.***

Category	Occurrence Coverage	
	Per Claim	Aggregate per Participant
Faculty Physician	$400,000.00	$1,200,000.00
Resident or Fellow	100,000.00	300,000.00
Student	25,000.00	75,000.00

The limits of liability set out above were approved by the Board of Regents of Texas Tech University Health Sciences Center on August 2, 1985, effective September 1, 1985. This schedule applies only to causes of action arising from incidents or actions occurring on or after September 1, 1985.

The Self-Insurance Plan's liability is limited to the lesser of the individual physician's(s') coverage or $1,000,000 per incident for claims filed prior to September 1, 2003, or $300,000 per incident for claims filed after September 1, 2003.

Conditions for participation are described in the text of the plan which is available to you in the handbook. Among the conditions for participation are the following:

1) Coverage as stated above shall commence on the effective date shown above and shall cease on the day when employment with, or assignment to, Texas Tech University Health Sciences Center is terminated;

3601 4th Street STOP 6237 [illegible] Texas 79430-6237 | T 806.743.9921 | F 806.743.9925

2) Coverage shall extend to all duly authorized off-campus assignments;

3) Coverage for "moonlighting" under the Plan is excluded and prohibited;

4) It is mandatory that the insured, upon becoming aware of any injury, actual or alleged, whether by direct knowledge or written notification thereof, shall advise their department chairperson, who in turn shall notify the Dean/Associate Dean for appropriate contact with Texas Tech University/Texas Tech University Health Sciences Center Office of General Counsel (refer to Professional Medical Malpractice Self-Insurance Handbook).

This Certificate is intended only for your immediate information, being only the advice that such protection has been effected subject to the particular terms, conditions and limitations of the approved Plan of Self-Insurance and the interpretation thereof by the Board of Regents or its authorized representative.

Kent R. Hance, Chancellor
Texas Tech University System

Pat Campbell
Vice Chancellor and General Counsel

Authentication

This is to certify that this, a true and correct copy which witness my hand and seal on this 28th day of September 2008, was provided to: JoAnn Cruz, TTUHSC El Paso, MPIP Business Operations, 4800 Alberta Ave., El Paso, TX 79905

SHEILA ROBINSON
Notary Public State of Texas
My Commission Expires
JAN 29 2013
Notary Without Bond

Joanna Harkey
Director, Professional Liability Division

MR08

Sheila Robinson, Notary Public in and for the State of Texas

OB/GYN Department 915-545-6730-Call Coverage
TAX ID#S: 75-2674893 / 75-2668018
Texas Tech Physician Associates / Texas Tech University Health Sciences Center
(915) 545-6730

Lizabeth J. Berkeley, CHES

Wreatha Carner, CNM

Kayla E. Castaneda, WHNP

Harvey Greenberg, MD

Heidi A. Lyn, MD

Carla Ann Martinez, M.D.

Zuber D. Mulla, PhD

Ghulam Murtaza, MD

Ha H. Nguyen, RNC

Bahij S. Nuwayhid, MD

Elizabeth Ann Portugal, CNM

Sonia Rebeles, M.D.

Jose Salvador Saldivar, MD

Antonio Santillan, MD

William H. Scragg, MD

Claudia Suarez-Martinez, MD

William R. Sullivan, MD

Franz C. Theard, MD

Robert W. Vera, MD

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

Portal Ticket #:	10390843
Date Printed:	Tuesday, February 02, 2010
NPI:	1770633216
Provider Name:	THEARD, FRANZ

Provider Enrollment : Texas Standardized Credentialing Application

If any information found on the application is incorrect, please save the application and update your information through the Online Provider Lookup (OPL). Do not continue with application until information is accurate.

Individual Information

☐ Re-Credentialing

Type of Professional: Physician (MD)

* Last Name: THEARD * First Name: FRANZ

Middle: C Jr., Sr., etc:

Maiden Name: Years Associated:(YYYY-YYYY)

Other Name: Years Associated:(YYYY-YYYY)

Home Mailing Address	Correspondence Address: ☐ Same as home address
Street:	Street:
Address Line 2:	Suite:
City:	City:
State:	State:
Zip:	Zip:

Home Phone Number: ext.

Phone Number: ext.

Fax Number: Email Address:

Social Security Number: * Gender: ◉ Male ○ Female

Date of Birth: Place of Birth:

Citizenship: United States

If not American Citizen/Visa Number: - Status: General

Are you eligible to work in the United States: ○ Yes ○ No

Military Service Public Health: ○ Yes ○ No

Dates of Service: - Last Location:

Are you currently on active or reserve Military Duty: ○ Yes ○ No

Professional Degree/Medical School

Issuing Institute: THE GEORGE WASHINGTON UNIVERSITY

Institution Address:

Street:

Suite:

City:

State:

ZIP Code: -

Degree: MD

Attendance From Dates: 9/1/1968

Attendance To Dates: 5/31/1972

Post-Graduation Education

◉ Internship ○ Residency ○ Fellowship ○ Teaching Appointment

Speciality: N/A

Institution: DISTRICT OF COLUMBIA GENERAL

Institution Address:

Street:

Suite:

City:

State:

ZIP Code:

Attendance From Dates: 6/1/1972

Attendance To Dates: 6/30/1973

Program Successfully Completed?

Program Director:

Current Program Director:

Internship Residency Fellowship Teaching Appointment

Speciality: N/A

Institution: WASHINGTON HOSPITAL CENTER

Institution Address:

Street:

Suite:

City:

State:

ZIP Code:

Attendance From Dates: 6/1/1973

Attendance To Dates: 6/30/1976

Program Successfully Completed?

Program Director:

Current Program Director:

Provider Enrollment : Texas Standardized Credentialing Application (Continued)

Licenses and Certificates

Please include all license(s) and certifications in all states where you are currently or have previously been licensed.

License Type: MD, DO
License Number: F6332
State Of Registration: TX
Original Date of Issue:
Expiration Date: 5/31/2010
Do you currently practice in the State? (•) Yes ( ) No

License Type	Number	Original Date of Issue	Expiration Date
• DEA	AT9162809		11/30/2011
• DPS	N0040059		10/31/2010

UPIN:
National Provider Identifier (when available): 1770633216

Are you a participating Medicare Provider? ( ) Yes ( ) No Medicare Number:
Are you a participating Medicaid Provider? (•) Yes ( ) No Medicaid Number: 133825308
Educational Council for foreign medical graduates (ECFMG): ( ) Yes ( ) No ECFMG Number:
ECFMG Issue Date:

Provider Enrollment : Texas Standardized Credentialing Application

Professional/ Specialty Information

Specialty: OB/GYN (MD) Board Certified: ◉ Yes ○ No

Name of Certifying Board: ABMS Initial Certification Date: 1/1/1978

Re-Certification Date: Expiration Date: 12/31/9999

If not Board Certified, indicate any of the following that apply:

○ I have taken exam, results pending for _____ board.

○ I have taken Part I and am eligible for Part II of the _____ Exam.

○ I am intending to sit for the Boards on _____

○ I am not planning to take Boards.

Do you wish to be listed in the directory under this specialty?

HMO: ○ Yes ○ No

PPO: ○ Yes ○ No

POS: ○ Yes ○ No

Please list other areas of professional practice interest or focus (HIV/AIDS, etc.)

Professional/Work History Information

* Current Practice/Employer Name: TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER

* Start Date: 4/1/2009

Street:

Suite:

City:

State:

ZIP Code:

Previous Practice/Employer Name:

FRANZ C THREARD MD

Start Date: 9/1/1983

End Date: 12/31/9999

Street:

Suite:

City:

State:

ZIP Code:

Reason for discontinuance: PROVIDER IS STILL WORKING

PLEASE PROVIDE AN EXPLANATION FOR ANY GAPS GREATER THAN SIX MONTHS IN WORK HISTORY.

Provider Enrollment : Texas Standardized Credentialing Application

Do you have hospital privileges? (•) Yes ( ) No

If you do not have admitting privileges, what admitting arrangements do you have?

Current Hospital Privileges

Primary hospital where you have admitting privileges? (•) Yes ( ) No

Hospital Name:	UNIVERSITY MEDICAL CENTER OF EL PASO	Start Date:	4/1/2009
Street:	4815 ALAMEDA		
Suite:			
City:	EL PASO		
State:	TX		
ZIP Code:	79905-		
Phone Number:			
ext.			
Fax Number:			
Email:			
Full unrestricted privileges?	(•) Yes ( ) No		
Types of Privileges:	Active		
Are privileges temporary?	( ) Yes (•) No		
Of the total number of admissions to all hospitals in the past year, what percentage is to primary hospital?			

Primary hospital where you have admitting privileges? (•) Yes ( ) No

Hospital Name:	PROVIDENCE MEMORIAL HOSPITAL	Start Date:	3/1/1984
Street:	2001 N OREGON		
Suite:			
City:	EL PASO		
State:	TX		
ZIP Code:	79901-		
Phone Number:			
ext.			
Fax Number:			
Email:			
Full unrestricted privileges?	(•) Yes ( ) No		
Types of Privileges:	ACTIVE-OB GYN		
Are privileges temporary?	( ) Yes (•) No		
Of the total number of admissions to all hospitals in the past year, what percentage is to primary hospital?			

Primary hospital where you have admitting privileges? ( ) Yes (•) No

Hospital Name:	SIERRA MEDICAL CENTER	Start Date:	11/1/1983
Street:	1625 MEDICAL CENTER DR		
Suite:			
City:	EL PASO		
State:	TX		
ZIP Code:	79902-		
Phone Number:			

ext.	
Fax Number:	
Email:	
Full unrestricted privileges?	Yes No
Types of Privileges:	ACTIVE-OB GYN
Are privileges temporary?	Yes No
Of the total number of admissions to all hospitals in the past year, what percentage is to primary hospital?	

Primary hospital where you have admitting privileges? Yes No

Hospital Name:	LAS PALMAS MEDICAL CENTER	Start Date:	10/1/1983
Street:	1801 N OREGON		
Suite:			
City:	EL PASO		
State:	TX		
ZIP Code:	79902-		
Phone Number:			
ext.			
Fax Number:			
Email:			
Full unrestricted privileges?	Yes No		
Types of Privileges:	ACTIVE-OB GYN		
Are privileges temporary?	Yes No		
Of the total number of admissions to all hospitals in the past year, what percentage is to primary hospital?			

Previous Hospital Privileges

References

Self- Insured? Yes No

* Name of current malpractice insurance carrier or self-insured entity:
TEXAS TECH UNIVERSITY SYSTEM

Address:

Street		* Policy Number:	N/A
Suite		* Effective Date:	9/1/1985
City		* Termination Date:	12/31/9999
State			
ZIP Code		* Amount of coverage per occurance:	$400,000.00
Phone Number:		* Amount of coverage aggregate:	$1,200,000.00
Fax Number:		Type of Coverage:	
E-mail:		Length of time with carrier:	(YYYY-YYYY)

* Current Insurance less than 5 years? Yes No

Name of previous malpractice insurance carrier:

Address:

Street		Policy Number:	
Suite		Effective Date:	
City		Termination Date:	
State			

ZIP Code		Amount of coverage per occurance:	
Phone Number:		Amount of coverage aggregate:	
Fax Number:		Type of Coverage:	
E-mail:		Length of time with carrier:	(YYYY-YYYY)

Provider Enrollment : Texas Standardized Credentialing Application : Call Coverage

Please list names of colleague(s) providing regular coverage and his or her specialty:

First Name:	LIZABETH	Specialty:	General surgery
Last Name:	BERKELEY		
Middle Initial:			
First Name:	WREATHA	Specialty:	General surgery
Last Name:	CARNER		
Middle Initial:			
First Name:	KAYLA	Specialty:	General surgery
Last Name:	CASTANEDA		
Middle Initial:			
First Name:	HARVEY	Specialty:	General surgery
Last Name:	GREENBERG		
Middle Initial:			
First Name:	HEIDI	Specialty:	General surgery
Last Name:	LYN		
Middle Initial:			

Please list full names of all partners in your practice:

Provider Enrollment : Texas Standardized Credentialing Application

Practice Locations

Location	Information Complete	Primary Location	Street	Suite	Update or Delete
1	Yes	Yes	4800 ALBERTA AVE		Update

Provider Enrollment : Texas Standardized Credentialing Application

Primary Practice Location

Please answer the following questions for each practice location.

Type of service provided:

○ Solo Primary Care ○ Solo Specialty Care ○ Group Primary Care ○ Group Single Specialty ○ Group Multi-Specialty

Group Practice Name:

Group/Corporate Name as it appears on IRS W-9:

Practice Location Address:

* Street: 4800 ALBERTA AVE
Suite:
* City: EL PASO
* State: Texas
* ZIP Code: 79905-2709

* Phone Number: (915)545-7501
* Fax Number: (915)545-7537
E-mail address:

Back Office Phone Number/ Private Phone Number: ext.

Site-Specific Medicaid Number:

Group number corresponding to Tax ID number (if applicable):

* Tax ID Number: 752668018

Are you currently practicing at this location? ○ Yes ○ No

If no, expected start date:

Do you want this location listed in the directory? ○ Yes ○ No

Office Manager or Staff Contact:

Phone Number: ext.

Fax Number:

Credentialing Contact Address:

Street:
Suite:
City:
State:
ZIP Code:

Phone Number: ext.
Fax Number:
E-mail:

Billing Company's Name: (If applicable)

Billing Representative:

Billing Address:

Street:
Suite:
City:
State:
ZIP Code:

Phone Number: ext.
Fax Number:
E-mail:

Department Name If Hospital-based:

Check payable to:

Can you bill electronically? ○ Yes ○ No

Provider Enrollment : Texas Standardized Credentialing Application

Primary Practice Location - Continued

Hours patients are seen

Monday:	Start Time: 08:00 AM	End Time: 05:00 PM
Tuesday:	Start Time: 08:00 AM	End Time: 05:00 PM
Wednesday:	Start Time: 08:00 AM	End Time: 05:00 PM
Thursday:	Start Time: 08:00 AM	End Time: 05:00 PM
Friday:	Start Time: 08:00 AM	End Time: 05:00 PM
Saturday:	Start Time: Closed	End Time: Closed
Sunday:	Start Time: Closed	End Time: Closed

Does this location provide 24 hour/7 day a week phone coverage?

☒ Answering service ☐ Voice mail with instructions to call answering service
☐ Voicemail with other instructions ☐ None

This practice location accepts:

☒ All new patients ☐ Existing patients with change of payor
☐ New Medicare patients ☐ New Medicaid patients
☐ New patients with referral

If new patient acceptance varies by health plan, please provide explanation:

☐ Other Practice Limitation:

Do nurse practitioners, physician assistants, midwives, dental hygenists or other non-physician providers care for patients at this practice location?
◉ Yes ◉ No
If yes, provide the following information for each staff member:

Languages spoken by health care providers:

☐ Other ☐ Vietnamese ☐ Japanese ☐ Indian ☐ Russian ☐ Norwegian ☐ Danish ☐ Hungarian ☐ Italian ☐ Dutch
☒ English ☐ Pakistani ☐ Korean ☐ Portuguese ☐ Polish ☐ Finnish ☐ German ☐ Greek ☐ Arabic ☐ Sign
☒ Spanish ☐ Chinese ☐ Thai ☒ French ☐ Swedish

Languages spoken by office personnel:

☐ Other ☐ Vietnamese ☐ Japanese ☐ Indian ☐ Russian ☐ Norwegian ☐ Danish ☐ Hungarian ☐ Italian ☐ Dutch
☐ English ☐ Pakistani ☐ Korean ☐ Portuguese ☐ Polish ☐ Finnish ☐ German ☐ Greek ☐ Arabic ☐ Sign
☒ Spanish ☐ Chinese ☐ Thai ☐ French ☐ Swedish

Language Interpreters:
Are interpreters available?
◉ Yes ◉ No

☐ Other ☐ Vietnamese ☐ Japanese ☐ Indian ☐ Russian ☐ Norwegian ☐ Danish ☐ Hungarian ☐ Italian ☐ Dutch
☐ English ☐ Pakistani ☐ Korean ☐ Portuguese ☐ Polish ☐ Finnish ☐ German ☐ Greek ☐ Arabic ☐ Sign
☒ Spanish ☐ Chinese ☐ Thai ☐ French ☐ Swedish

Does this practice location meet ADA accessibility standards? ◉ Yes ◉ No

Which of the following facilities are handicapped accessible? ☐ Building ☐ Restroom ☐ Parking ☐ Other:

Does this location have other services for the disabled? ☐ Text Telephony TTY ☐ American Sign Language ☐ Mental/Physical Impairment Services ☐ Other:

Is this location accessible by public transportation? ☐ Bus ☐ Regional Train ☐ Other:

Does this location provide childcare services? ◉ Yes ◉ No

Does this location qualify as a minority business enterprise? ◉ Yes ◉ No

Provider Enrollment : Texas Standardized Credentialing Application

Primary Practice Location - Continued

Who at this location has the following current certifications?
(Please list only the applicant's certification expiration date.)

Basic Life Support:	Staff Provider	Exp:	Advanced Life Support in OB:	Staff Provider	Exp:
Advanced Trauma Life Support:	Staff Provider	Exp:	Cardio-Pulmonary Resuscitation:	Staff Provider	Exp:
Advanced Cardiac Life Support:	Staff Provider	Exp:	Pediatric Advanced Life Support:	Staff Provider	Exp:
Neonatal Advanced Life Support:	Staff Provider	Exp:	Other:	Staff Provider	Exp:

Does this location provide any of the following services on site?

Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):

Yes No

X-Ray; please list all certifications:

Yes No

Other Services:

Radiology Services	EKG	Care of Minor Lacerations	Pulmonary Function Tests
Allergy Injections	Allergy Skin Tests	Routine Office Gynecology	Venipuncture
Age Appropriate Immunizations	Flexible Sigmoidoscopy	Tympanometry/Audiometry Tests	Asthma Treatments
Osteopathic Manipulations	IV Hydration/Treatments	Cardiac Stress Tests	Physical Therapies

Other:

Please list any special treatment maladies or additional office procedures provided (including surgical procedures):

Is Anesthesia administered at this location? Yes No

Please specify the classes or categories:

Provider Enrollment : Texas Standardized Credentialing Application

Section I: Capacity Verification

Complete the requested Service Area information for each region.

Southeast: Chambers, Jefferson, Hardin, Liberty, and Orange counties.

* Capacity: 10

* Accepting New Patients? (•) Yes ( ) No

PCCM Service Area: All counties not in the Southeast Region or listed below are included in PCCM.

The following counties are not included in the PCCM Service Area: Atascosa, Bexar, Brazoria, Collin, Comal, Crosby, Dallas, Denton, Ellis, El Paso, Floyd, Fort Bend, Galveston, Garza, Guadalupe, Hale, Harris, Hockley, Hunt, Johnson, Kaufman, Kendall, Lamb, Lubbock, Lynn, Medina, Montgomery, Navarro, Nueces, Rains, Rockwell, Terry, Waller, and Wilson.

* Capacity: 1500

* Accepting New Patients? (•) Yes ( ) No

Section II: Provider Practice Information

Provider Last Name: THEARD

First Name: FRANZ

Middle Initial: C

* Age range of patients seen: 12 to 90

* Are you a currently enrolled Texas Health Steps (THSteps) provider? (•) Yes ( ) No

If yes, please provide your Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Number:

Practice Limitations:

[ ] HIV [ ] Children w/ Disabilities [x] High Risk OB/GYN [ ] OB/GYN Care/Delivery

[ ] Other

* ( ) Male Only ( ) Female Only ( ) Both

Section III: Ethnicity

* ( ) White, Non-Hispanic ( ) Black, Non-Hispanic ( ) Hispanic

( ) American Indian or Alaskan ( ) Asian/Pacific Islander ( ) Unknown/Other

( ) Choose Not to Indicate

To the individual filling out this form:
Every individual has the right to make inquiries about this form and the right to review the information submitted on the form. (There are a few exceptions). If the information is wrong, submit a request to correct it. The Health and Human Services Commission has a method for asking for corrections. The procedure is located in Title 1 Texas Administrative Code (TAC) section 351.17 to 351.23. For information about this form or to request corrections, call the PCCM Provider Helpline at 1-888-834-7226 or write to:

TMHP - Provider Helpline
PO Box 204270
Austin, Texas 78727-4270

Provider Enrollment : Texas Standardized Credentialing Application : Section II - Disclosure Questions

Licensure and Controlled Substance Certificates

*1 Has your license or certification to practice in your profession ever been denied, suspended, revoked, restricted, voluntarily or involuntarily surrendered, or have you ever been subject to a consent order, probation, or any conditions or limitations by any state licensing board? ○ Yes ○ No

If Yes, please explain below

*2 Have you ever been reprimanded or fined by any state licensing or certification board? ○ Yes ○ No

If Yes, please explain below

Hospital Privileges and Other Affiliations

*3 Have your clinical privileges or professional staff membership at any hospital or health care institution ever been involuntarily terminated, surrendered, limited, reduced, denied, suspended, revoked, restricted, denied renewal, or subjected to probationary or to other disciplinary conditions (for reasons other than automatic action based on non-completion of medical records), or have proceedings toward any of those ends been instituted or recommended by any hospital or health care institution, medical staff or committee or governing board? ○ Yes ○ No

If Yes, please explain below

*4 Have you voluntarily surrendered or withdrawn an application, limited your privileges, or not reapplied for privileges? ○ Yes ○ No

If Yes, please explain below

*5 Have you ever been terminated for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)? ○ Yes ○ No

If Yes, please explain below

Education, Training and Board Certification

*6 Were you ever placed on probation, disciplined, formally reprimanded, suspended or asked to resign during an internship, residency, fellowship, preceptorship or other clinical education program? If you are currently in a training program, have you been placed on probation, disciplined, formally reprimanded, suspended or asked to resign? ○ Yes ○ No

If Yes, please explain below

*7 Have you ever, while under investigation, voluntarily withdrawn or prematurely terminated your status as a student or employee in any internship, residency, fellowship, preceptorship, or other clinical education program? ○ Yes ○ No

If Yes, please explain below

*8 Have any of your board certifications or eligibility ever been revoked? ○ Yes ○ No

If Yes, please explain below

*9 Have you ever chosen not to re-certify or voluntarily surrendered your board certification(s) while under investigation? ○ Yes ○ No

If Yes, please explain below

DEA or DPS

*10 Have your Federal DEA and/or DPS Controlled Substances Certificate(s) or authorization(s) ever been denied, suspended, revoked, restricted, denied renewal, or voluntarily relinquished? ○ Yes ○ No

If Yes, please explain below

Provider Enrollment : Texas Standardized Credentialing Application : Section II - Disclosure Questions Continued

Medicare, Medicaid or other Governmental Program Participation

*11 Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? ○ Yes ○ No

If Yes, please explain below

Other Sanctions or Investigations

*12 Are you currently or have you ever been the subject of an investigation by any hospital or health care institution, licensing authority, DEA or DPS authorizing entity, education or training program, Medicare or Medicaid program, or any othe rprivate, state or federal health program? ○ Yes ○ No

If Yes, please explain below

*13 To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? ○ Yes ○ No

If Yes, please explain below

*14 Have you ever received sanctions from or been the subject of investigation by any regulatory agencies (e.g., CLIA, OSHA, etc.)? ○ Yes ○ No

If Yes, please explain below

*15 Have you ever been investigated, sanctioned, reprimanded or cautioned by a military hospital, facility, or agency, or voluntarily terminated or resigned while under investigation by a hospital or healthcare facility of any military agency? ○ Yes ○ No

If Yes, please explain below

Malpractice Claims History

*16 Have you had any malpractice actions within the past 5 years (pending, settled, arbitrated, mediated or litigated? ○ Yes ○ No

If Yes,click to add malpractice details [Malpractice details]

Provider Enrollment : Texas Standardized Credentialing Application

Medical Malpractice Claims History

Incident Date: 8/13/2003 Date Claim was Filed: 8/12/2005

Date Notice of Claim Given: Claim/Case Status: PENDING

Professional Liability Carrier Involved:

Liability Carrier Address:

Street:

Suite:

City: Policy Number:

State: Award or Settlement: Award Settlement

Zip Code: - Amount of Award or Settlement Paid:

Method of Resolution:

Dismissed Settle before Filing Settled (with prejudice) Settle (without prejudice)

Judgment for Defendant(s) Judgment for Plaintiff(s) Mediation or Arbitration

Description of Allegations:

SEE ATTACHMENT

Were you Primary Defendant or Co-Defendant?

Primary Defendant Number of other Co-Defendants:

Co-Defendant

Your Involvment (Attending, Consulting, Etc.)

Description of Alleged Injury to the Patient:

To the Best of Your Knowledge, is this Case Included in the National Practitioner Data Bank (NPDB)?

Yes No

Provider Enrollment : Texas Standardized Credentialing Application : Section II - Disclosure Questions continued

Criminal

*17 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony that is reasonably related to your qualifications, competence, functions, or duties as a medical professional. ○ Yes ○ No

If Yes, please explain below

*18 Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense? ○ Yes ○ No

If Yes, please explain below

*19 Have you been court-martialed for actions related to your duties as a medical professional? ○ Yes ○ No

If Yes, please explain below

Ability to Perform Job

*20 Are you currently engaged in the illegal use of drugs? ("Currently" means sufficiently recent to justify a reasonable belief that the use of drug may have an ongoing impact on one's ability to practice medicine. It is not limited to the day of, or within a matter of days or weeks before the date of application, rather that it has occurred recently enough to indicate the individual is actively engaged in such conduct. "Illegal use of drugs" refers to drugs whose possession or distribution is unlawful under the Controlled Substances Act, 21 U.S.C. § 812.22. It "does not include the use of a drug taken under supervision by a licensed health care professional, or other uses authorized by the Controlled Substances Act or other provision of Federal law." The term does include, however, the unlawful use of prescription controlled substances.) ○ Yes ○ No

If Yes, please explain below

*21 Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety? ○ Yes ○ No

If Yes, please explain below

*22 Do you have any reason to believe that you would pose a risk to the safety or well-being of your patients? ○ Yes ○ No

If Yes, please explain below

*23 Are you unable to perform the essential functions of a practitioner in your area of practice, with or without reasonable accommodation? ○ Yes ○ No

If Yes, please explain below

Final Acknowledgement

Agreement

By submitting this application for provider enrollment or credentialing, as well as the information provided in connection with this application, I acknowledge that I intend to become enrolled or credentialed as a provider in the Texas State Programs. I also agree to adhere to all applicable laws, administrative rules, policies, and guidelines, and I understand that under these authorities I must adhere to standards of behavior that, if not met, can result in administrative, civil and/or criminal sactions.

I Decline | I Accept

Once the application is accepted and submitted, you will not be able to make modifications during TMHP processing.

Credentialing Print Screen

Application Status	PEP Ticket Number
Submitted	**10390843**

Thank you for submitting your application to TMHP.com. You can check the status of your application by logging onto TMHP.com and clicking View Existing Transactions.

Print Options

To obtain a copy of your electronic online application please allow a 24 hour processing time. To print for your personal records, log onto TMHP.com to View Existing Transactions and navigate to the Messages screen for the Portal Ticket # of the submitted application.

Adobe Acrobat 7.0 or greater is required to view and print from Provider Enrollment on the Portal.
In order to complete the application process you must print the required documentation and cover letter to submit to TMHP.

Print Required Documentation

To expedite processing, please print cover letter and send it in with the required supporting documentation.

Print Cover Letter

Print the final checklist to confirm that all applicable documentation is included for TMHP to complete processing of your application.

Final Checklist

Provider Enrollment : Texas Standardized Credentialing Application : Supplemental Information Checklist

Required for Supplement Information

Please attach hard copy or scanned documents of the following:

- ☐ Copy of other Controlled Dangerous Substances Registration Certificate(s)
- ☐ Copy of current professional liability insurance policy face sheet, showing expiration dates, limits and applicant's name
- ☐ Copies of IRS W-9s for verification of each tax identification number used
- ☐ Copy of workers compensation certificate of coverage, if applicable
- ☐ Copy of CLIA certifications, if applicable
- ☐ Copies of radiology certifications, if applicable
- ☐ Copy of DD214, record of military service, if applicable
- ☐ Call Coverage List, if applicable

Tooltips

Credentialing

Page	Field	ToolTip
Individual Information	Date of Birth	MM/DD/YYYY
License Certificates	DEA Number	Drug Enforcement Agency
License Certificates	DPS Number	Department of Public Safety
License Certificates	UPIN	Unique Physician Identification Number
Professional Specialty Info	HMO:	Health Maintenance Organization
Professional Specialty Info	PPO:	Preferred Provider Organization
Professional Specialty Info	POS:	Point of Service
Practice Locations Page 1	Group number corresponding to Tax ID number (if applicable):	Group Texas Provider Identifier
Practice Locations Page 1	Tax ID Number:	Use the Tax ID or SSN used for enrollment in Texas Medicaid: If enrolling as a group, enter the Tax ID If enrolling as an individual, enter either the Tax ID or SSN If enrolling a performing provider, enter the group Tax ID
Practice Locations Page 3	Laboratory Services; please list all Certificates of Participation (CLIA, AAFP, COLA, CAP, MLE):	Clinical Laboratory Improvement Amendments of 1988, American Academy of Family Physicians

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

3817910

12357-B Riata Trace Parkway, Ste. 150
Austin, Texas 78727

March 2, 2010

FRANZ THEARD
4800 ALBERTA AVE
EL PASO, TX 799052709

TPI: 133825308 NPI: 1770633216

Dear Provider:

The Texas Medicaid & Healthcare Partnership (TMHP) is pleased to inform you that the TMHP Credentialing Committee has approved your application for participation in Primary Care Case Management (PCCM).

Your effective date of participation is **March 1, 2010.** Participation as a primary care provider in PCCM is for three years based on your date of birth. Your re-credentialing date will be converted to your date of birth in the second year of your participation. TMHP will request all documents necessary for re-credentialing consideration in the second year.

The following publications and services are offered to PCCM providers:

Community Health Services – Community Health Services (CHS) coordinators assist PCCM clients by utilizing available resources to meet established needs, and to promote the highest available level of health and independence in living. You may refer clients to CHS by completing the "Primary Care Case Management (PCCM) Community Health Services Referral Request Form" located in the *Texas Medicaid Provider Procedures Manual*. You may fax the form to 1-512-302-0318 or call the Community Health Services Intake staff at 1-888-276-0702. Coordinators are also available to provide health education services in an office setting.

Nurse Helpline - PCCM provides a toll-free clinical Nurse Helpline at 1-800-304-5468 for its clients. The Nurse Helpline is staffed (nationally) by registered nurses who use physician-developed, symptom-based algorithms and 1,200 sets of self-care instructions to provide information, triage, and clinical assessment services for health plan clients 24 hours a day, 7 days a week. Nurse Helpline nurses do not diagnose; they assess the client's symptoms and guide the client to the most appropriate care setting.

Panel Reports – The panel report, prepared for each PCCM primary care provider, details the number of assigned PCCM clients. Panel reports are updated at the beginning of each month and are available to all providers electronically on the TMHP website. To view your secure report online, go to www.tmhp.com, and click *Activate My Account* from the "I would like to...." link on the upper right side of the TMHP.com home page. If you require assistance with the account activation process, contact the TMHP Electronic Data Interchange (EDI) Helpdesk at 1-888-863-3638 from 7 a.m. to 7 p.m. (CST). You may request to have a panel report mailed each month by calling the PCCM Provider Helpline at 1-888-834-7226.

TMHP TEXAS MEDICAID & HEALTHCARE PARTNERSHIP
A STATE MEDICAID CONTRACTOR

12357-B Riata Trace Parkway, Ste. 150
Austin, Texas 78727

Provider Relations – TMHP conducts provider seminars and workshops to present the latest information on Medicaid program policies and procedures, claims processing requirements, and federal and state regulations affecting the Medicaid program. TMHP Provider Relations representatives are also available to assist you with program issues, problem resolution, and on-site visits. Visit www.tmhp.com for workshop dates and to locate the provider representative in your area or call the PCCM Provider Helpline at 1-888-834-7226.

Provider Website – The TMHP provider website (www.tmhp.com) offers access to electronic publications, announcements, schedules for workshops and upcoming events. Providers can also check claims status, verify eligibility, web chat, update office demographic information, and find contact information for Provider Relations representatives.

Texas Medicaid Bulletins - Texas Medicaid bulletins are published bi-monthly and serve as updates to Medicaid policies and procedures published in the *Texas Medicaid Provider Procedures Manual.*

Texas Medicaid Provider Procedures Manual – Reading, understanding, and adhering to the policies outlined in this manual will greatly assist you in properly fulfilling your responsibilities as a Managed Care primary care provider. This comprehensive guide is available on the TMHP website. The manual contains information for specific provider types as well as appendices with additional reference materials, forms, and claim examples. If you are unable to access the website, a hard-copy manual, Medicaid bulletins, forms, or any other PCCM information may be requested by calling the PCCM Provider Helpline at 1-888-834-7226.

Welcome and thank you for your participation in PCCM. If you have any questions or concerns, please contact the PCCM Provider Helpline at 1-888-834-7226.

Sincerely,

Contracting/Credentialing Department