



Dear Peer Consultant:

We appreciate your interest in becoming a Clinician Consultant Reviewer for Alliant Health Solutions ("AHS"). AHS serves an important role in performing peer review for the Department of Community Health. Our peer reviewers uphold national standards of care through their review activities. Likewise, protecting patient safety and improving the quality of patient care is a top priority of our external review.

You shall be assigned cases to perform review of information and documentation for health care services that are being proposed or have already been provided. Case assignment will match the Clinician Consultant, as closely as possible, to the licensure, specialty, and practice setting of the physician or practitioner under review. Based on the type of case assigned, the review may result in a determination of medical necessity, appropriateness of services, and/or the quality of care (whether the quality of services is consistent with professionally recognized standards of health care). The Clinician Consultant will document the clinical rationale for all determinations. Clinician Consultants are expected to be independent and free from conflict of interest in performing reviews, therefore you are expected to report any instances of actual or perceived conflict of interest and the case will be reassigned.

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

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

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

If you have any questions, please contact AHS at 678-527-3683.

Sincerely,

A handwritten signature in dark ink, appearing to read "Dianne Bennett-Johnson MD, FACP".

Dianne Bennett-Johnson, MD FACP
Medical Director

ABRIEF DESCRIPTION OF CLINICAL REVIEW ACTIVITIES

Alliant Health Solutions

Alliant Health Solutions

Alliant Health Solutions is a division of Alliant Health Group, a family of companies that provides professional services supporting the effective administration of healthcare programs and funding to support healthcare improvement initiatives. Alliant Health Solutions provides Federal and state government entities with the services, expertise and information systems necessary to increase the effectiveness, accessibility and value of health care.

AHS conducts credentialing and re-credentialing for all of its subsidiaries and maintains accurate and up-to-date credentialing information for all clinical consultants/peer reviewers.

Medicaid

In Georgia, Alliant Health Solutions provides “pre-certification” services, prior authorizations (PA), and Surveillance and Utilization Review Services (SURS) provider and member review for the Medicaid Program. Under the Medicaid Program, certain services must be pre-approved by Alliant reviewers before Medicaid will agree to cover the cost of these procedures. Alliant also provides additional consultative services for the Medicaid Program in Georgia when asked to do so by state officials. For example, Alliant is sometimes asked to provide advice to the state concerning coverage of a new or controversial procedure, medication, or service. Alliant also provides retrospective SURS reviews to determine the over or under utilization of services and identify substandard quality of care. SURS reviews guard against the inappropriate use of resources which could otherwise be spent for needed quality care. Alliant utilizes its consultant clinicians in all of its Medicaid activities.

Other Activities

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

Statement of Agreement to HIPAA Compliance

☐ I agree to abide by HIPAA regulations and related Alliant Health Solutions (“AHS”) policies and procedures.

Print Name

Signature **Date**

Statement regarding Conflict of Interest

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

Signature **Date**

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

Peerreviewer@Allianthealth.org

**Alliant Health Solutions
Attn: Peer Consultant Administrator
1455 Lincoln Parkway East
Suite 800
Atlanta, GA 30346
Fax: 678-527-3566**

ALLIANT HEALTH SOLUTIONS
Clinician Consultant Reviewer Application/Agreement

LEGALNAME

DEGREE GRADUATION YEAR

ADDRESS

CITY STATE ZIP COUNTY

EMAIL

DATE OF BIRTH GENDER: MALE FEMALE

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

Main Number Answering Service

Fax Number Other

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

SPECIALTY

SPECIALTY

SUBSPECIALTY

SUBSPECIALTY

REVIEW PREFERENCE

Can perform reviews for the following specialty areas:

BOARD ACTIONS OR SUITS

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

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

BILLING /IDENTIFYING INFORMATION

SS # DEA #

Tax ID # Business Name

GEORGIA LICENSURE

Georgia License # Expiration Date

UPIN # Medicaid Provider #

OUT-OF-STATE LICENSURE

State	<input type="text"/>	License #	<input type="text"/>	Expiration Date	<input type="text"/>
State	<input type="text"/>	License #	<input type="text"/>	Expiration Date	<input type="text"/>

I AM INTERESTED IN DOING THE FOLLOWING TYPES OF REVIEWS:

Review requests and charts that are *mailed* to me

☐ Yes ☐ No

Telephone review of cases with an RN

☐ Yes ☐ No

Review of cases that are *faxed* to me

☐ Yes ☐ No

On site review of cases at the Alliant Health Solutions Office
(The Atlanta Alliant Office is near Perimeter Mall off interstate 285 North)

☐ Yes ☐ No

Web-based reviews (through Alliant Health Solutions secure web-site only)

☐ Yes ☐ No

HOSPITAL PRIVILEGES

Name of Hospital	Type of Privileges
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

OTHER INFORMATION (please address all questions below)

Are you currently involved in direct patient care?

☐ Yes ☐ No

Dates of direct patient care? From To

If no, have you been involved in direct patient care within the last 3 years?

☐ Yes ☐ No

Do you treat Medicaid patients?

☐ Yes ☐ No

Do you treat Medicare patients?

☐ Yes ☐ No

What type of area do you practice in:

☐ **Urban** ☐ **Rural**

Do you admit and treat hospitalized patients?

☐ Yes ☐ No

Do you admit and treat Nursing Home patients?

☐ Yes ☐ No

Do you admit and treat Hospice patients?

☐ Yes ☐ No

Is your Georgia license restricted in any way?

☐ Yes ☐ No

Has your Georgia license *ever* been restricted in any way?

☐ Yes ☐ No

THE BEST DAYS AND TIMES TO CONTACT ME ARE:

MONDAY	
TUESDAY	
WEDNESDAY	
THURSDAY	
FRIDAY	
SATURDAY	
SUNDAY	

We request reviews from clinicians who have similar practices to the clinician who requested the service. If you have specialized training or interest in an area, or if you do not treat certain types of medical problems, we will make a note of this to avoid a mismatch. Are there any services or procedures usually performed by members of your specialty that you do not do within your practice?

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

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

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

SIGNATURE		DATE	
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Alliant Health Solutions

CONFIDENTIALITY STATEMENT

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

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

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

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

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

Print Name: Signature:
Consultant

Date:

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

A Summary of Your Rights Under the Fair Credit Reporting Act

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

- **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.
- **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your “file disclosure”). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:
 - a person has taken adverse action against you because of information in your credit report;
 - you are the victim of identity theft and place a fraud alert in your file;
 - your file contains inaccurate information as a result of fraud;
 - you are on public assistance;
 - you are unemployed but expect to apply for employment within 60 days.

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

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

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

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

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

Margaret Hart

- **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need -- usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.
- **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.ftc.gov/credit.
- **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-5-OPTOUT (1-888-567-8688).
- **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.
- **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.ftc.gov/credit.

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

Federal enforcers are: TYPE OF BUSINESS:

Consumer reporting agencies, creditors and others not listed below

National banks, federal branches/agencies of foreign banks (word "National" or initials "N.A." appear in or after bank's name)

Federal Reserve System member banks (except national banks, and federal branches/agencies of foreign banks)

Savings associations and federally chartered savings banks (word "Federal" or initials "F.S.B." appear in federal institution's name)

Federal credit unions (words "Federal Credit Union" appear in institution's name)

State-chartered banks that are not members of the Federal Reserve System

Air, surface, or rail common carriers regulated by former Civil Aeronautics Board or Interstate Commerce Commission

Activities subject to the Packers and Stockyards Act, 1921

CONTACT:

Federal Trade Commission: Consumer Response Center - FCRA
Washington, DC 20580
Telephone: 1-877-382-4357

Office of the Comptroller of the Currency Compliance Management, Mail Stop 6-6 Washington, DC 20219
Telephone: 800-613-6743

Federal Reserve Consumer Help (FRCH)
P O Box 1200 Minneapolis, MN 55480
Telephone: 888-851-1920
Website Address: www.federalreserveconsumerhelp.gov
Email Address: ConsumerHelp@FederalReserve.gov

Office of Thrift Supervision Consumer Complaints Washington, DC 20552
Telephone: 800-842-6929

National Credit Union Administration
1775 Duke Street Alexandria, VA 22314
Telephone: 703-519-4600

Federal Deposit Insurance Corporation
Consumer Response Center,
2345 Grand Avenue, Suite 100
Kansas City, Missouri 64108-2638
Telephone: 1-877-275-3342

Department of Transportation,
Office of Financial Management
Washington, DC 20590
Telephone: 202-366-1306

Department of Agriculture

ACKNOWLEDGMENT AND AUTHORIZATION

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

APPLICANT:

Print Name:

Date:

Signature:

Request for Taxpayer Identification Number and Certification

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

► Go to www.irs.gov/FormW9 for instructions and the latest information.

Print or type. See Specific Instructions on page 3.	1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.	
	2 Business name/disregarded entity name, if different from above	
	3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only one of the following seven boxes. <input type="checkbox"/> Individual/sole proprietor or single-member LLC <input type="checkbox"/> Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____ Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is not disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner. <input type="checkbox"/> Other (see instructions) ►	
	4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3): Exempt payee code (if any) _____ Exemption from FATCA reporting code (if any) _____ <i>(Applies to accounts maintained outside the U.S.)</i>	
	5 Address (number, street, and apt. or suite no.) See instructions.	Requester's name and address (optional)
6 City, state, and ZIP code		
7 List account number(s) here (optional)		

Part I Taxpayer Identification Number (TIN)

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

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

or

Employer identification number

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

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

Sign Here	Signature of U.S. person ►	Date ►
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General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to www.irs.gov/FormW9.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)

- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, later.



Attestation Form

All peer consultants must maintain an active medical license and an active clinical practice. AHS allows individual practitioners to define this for themselves considering not all peer consultants belong to a traditional clinical practice and may choose to teach or volunteer their clinical services. In an effort to align review types with relevant clinical practices, AHS is asking peer consultants to attest to the fact that they remain in clinical practice and provide a brief description of that practice. If you have any questions or concerns please email Dr. Dianne Bennett-Johnson at dianne.bennett-johnson@allianthealth.org.

To ensure alignment of scope of practice to meet regulatory requirements:

I attest that I remain clinically active:

Yes No

If so, please provide a brief description of clinical activity:

Signature: _____

Date: _____

Please return to Alliant Health Solutions:
Attn: Marcia Davis, Credentialing Consultant
Fax: 678.527.3725 **or** 678-527-3566
Email: marcia.davis@allianthealth.org