Attestation

CARESOURCE ARKANSAS PROVIDERS

Instructions:

Please answer the following questions and attach an explanation for any "Yes" responses.

1. Are there any reasons why you would be unable to perform the essential functions of the position, with or without accommodation?	☐ YES ☐ NO
2. Do you use any chemical substance(s) that would in any way impair or limit your ability to practice medicine safely and professionally?	☐ YES ☐ NO
3. Do you have a history of any physical or mental health problems that may affect your ability to provide health care?	☐ YES ☐ NO
4. Have you ever had a history of conviction or a criminal offense other than minor traffic violations?	☐ YES ☐ NO
5. Have you ever been convicted of or pled no contest to a felony or other criminal offense, including, but not limited to, a criminal offense related to Medicare, Medicaid, or any other federal program?	☐ YES ☐ NO
6. Has your license ever been revoked, suspended, relinquished, placed on probation, or other licensure condition or limitation?	☐ YES ☐ NO
7. Do you have a history of complaints or adverse action reports filed with a local, state, or national professional society or licensing board?	☐ YES ☐ NO
8. Do you have any history of suspension or revocations of a DEA certificate or State CSR/CDS?	☐ YES ☐ NO
9. Have you ever had a history of loss, limitation, privileges or disciplinary activity, to include: denial, suspension, termination or renewal of professional privileges?	☐ YES ☐ NO
10. Have you ever been sanctioned by Medicare/Medicaid?	☐ YES ☐ NO
11. Have you had any professional liability actions (pending, settled, arbitrated, mediated, or litigates) within the past 10 years?	☐ YES ☐ NO
12. Has your professional liability insurance ever been refused or cancelled?	☐ YES ☐ NO

I affirm and attest that all information provided is true, correct, current, and complete in all aspects to the best of my ability. I accept the responsibility to provide CareSource documentation if any of the above information, including any attached explanations, changes.

_____ _____

Provider Signature (Required) Date

(Stamps cannot be used, Electronic is acceptable)

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Provider Printed/Typed Name (Required)

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