

VHP CommunityCare
7100 Commerce Way, Suite 285
Brentwood, TN 37027
615-782-7851
615-782-7876 fax



Criminal Offenses Attestation Statement

Are you currently, or have you ever been, subject to any of the following:

IMPORTANT: Provider must initial answers. Do not use “check marks” as responses.

- 1. Suspension, limitation, denial, or revocation of hospital or facility practice? Yes ____ No ____
- 2. Investigation or Sanction as a Medicare or Medicaid practitioner? Yes ____ No ____
- 3. Conviction of any criminal offense related to any Medicare, Medicaid, or Title XX program since the inception of those programs? Yes ____ No ____
- 4. Sanction as a PPO, MCO, HMO, or other third-party practitioner? Yes ____ No ____
- 5. Sanction by state or county medical society? Yes ____ No ____
- 6. Professional liability insurance restriction, limitation, denial, or cancellation? Yes ____ No ____
- 7. State license investigation, restriction, suspension, revocation, or denial? Yes ____ No ____
- 8. Arrest or conviction of a felony, moral, or ethical crime? Yes ____ No ____
- 9. DEA investigation, restriction, suspension, revocation, or denial? Yes ____ No ____
- 10. Ownership in any medical facility, or joint ownership of medical services or equipment with a facility to which you might refer patients? Yes ____ No ____
If answered “Yes” to question 10, must complete and return Disclosure of Ownership & Control Interest Statement Form.

If you answered yes to any of the above questions, please attach a thorough written explanation.

Practitioner Attestation:

I certify that the information in this attestation is true and correct. I authorize VHP to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, and authorize the copy of my signature on this attestation to be as binding as the original. I agree that VHP, their representatives, and any individuals or entities providing information to VHP in good faith shall not be liable for any act or occasion related to the evaluation or verification contained in this attestation. I agree to exhaust any and all administrative remedies available to me under any of the foregoing prior to initiating any judicial action relative to this attestation. I further agree to notify VHP in a timely manner of any change to the information requested in this attestation. Information requested in this attestation that is not publicly available will be treated as confidential by VHP.

Signature

Date

Print Name

TN Medicaid Number