ATTESTATION/RELEASE FORM

I, _____, present the information included on the foregoing pages as part of the verification process in the expectation that its confidentiality and privacy will be preserved and that this information will be released or disclosed only as part of current and future credentialing, peer review and only when authorized by me.

In order for Apogee Health Partners, Inc. ("AHP") to prepare a complete personal credentials portfolio for me, I hereby give permission to AHP to request information regarding my professional credentials.

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedures. I understand that AHP is gathering, verifying my licensure to establish a contractual relationship as a Registered Medical Professional licensed in the State of Illinois.

I agree that photocopy or facsimile of this document with my signature may be accepted by any entity from which such information is sought, with the same authority as the original, and I specifically waive written notice form any such entities or individuals who may provide information based upon this authorization request.

I represent that information provided in or attached to this application is accurate and complete. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not is cause for automatic and immediate rejection of this application by AHP. I further understand that AHP shall immediately inform any entity to which it has provided information of the fact of such misrepresentation, misstatement or omission. I agree to use my best efforts to inform AHP in writing, of any license revocation, sanctions or conviction of a felony. I will notify AHP within 45 days for any other change in my information from the date I am aware of the change as a result of developments subsequent to my signing this application.

Signature: _____ Date: _____

Print Name: _____

HUMANA. *Guidance* when you need it most

ChoiceCare® NETWORK

CONSENT AND RELEASE FORM WITH ATTESTATION

I hereby apply/reapply for participation in those Humana offered or administered health benefit plans and products covered under the separate participation agreement executed or to be executed by and between myself and identified Humana licensed health maintenance organization(s) and/or Humana insurance companies and/or the Choice Care Network (hereafter severally and collectively as the "Plan") as requested in this application and I am willing to make myself available for interviews in regard to said applications.

I acknowledge and agree that: (a) Privileges to participate as a provider with the Plan is not a right; and (b) By applying for privileges with the Plan I am agreeing to comply with the terms and conditions of the Participation Agreement ("Agreement"), whether signed by me or not, pursuant to which I am rendering services to Plan Members either as a direct contractor, subcontractor, independent contractor, or covering physician.

Information given, in or attached to this application is accurate and complete to the best of my knowledge. As a condition to making this application, any misrepresentation or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of request for participation. In the event that participation has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of participation with the Plan.

For the purpose of obtaining and maintaining credentialing or privileges with the Plan, I agree to hold harmless and from any and all liability, the Plan, its authorized representatives and any third parties, for any acts performed in good faith and without malice relating to any communications or disclosures of any kind, involving me which are performed, otherwise privileged or confidential information. Such information may relate to, but not be limited to information sharing on my professional qualifications, credentials, clinical competence and any other matter which might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of a health care facility on an ongoing basis.

It is understood by both parties hereto that any and all information obtained by the Plan shall be confidential to the fullest extent permitted by law, regardless of whether my membership and privileges are approved or subsequently terminated, except as otherwise provided herein or in the separate participation agreement under which I will provide services to Plan members.

The term "Plan and its authorized representatives" means the corporation(s) with which I have applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating my credentials, or acting upon my application; the members of the Plan's Board and their appointed representatives, the Chief Executive Officer or his designees, other Plan employees, consultants to the Plan, delegated credentialing entities, the Plan's attorney and his/her partners, associates or designees. The term "third parties" means all individuals, including appointees to the Plan's medical staffs, hospitals, other physicians or health practitioners, nurses, government agencies, organizations, professional liability insurance carriers, associations, partnerships, and corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Plan or its authorized representatives or who have requested such information from the Plan and its authorized representatives.

As a condition of the Plan's acceptance of my application for participation privileges and in support of the Plan's commitment to continuous quality improvement and peer review, I hereby authorize the Plan and its authorized representatives to disclose and communicate with my employer, partners or affiliates, as applicable in relation to my provision of medical and related health care services to Plan members, regarding actions or information relating to the Plan credentialing, re-credentialing and/or quality management programs.

As an applicant, I agree to produce adequate information for proper evaluation of my professional qualifications. I also agree to update the Plan with current information regarding all responses and/or questions contained in this application and/or information obtained through the credentialing process as such information becomes available and any additional information as requested by the Plan or its authorized representatives. Failure to produce such information will prevent my application from being evaluated and acted upon, and may affect any existing privileges I have with the Plan.

I further acknowledge and agree that communications and/or documents which are required in writing in order to comply with applicable laws and regulations shall be considered to be in compliance with any such laws and requlations, if transmitted, acknowledged and/or executed through the use of mail (e-mail), electronic data interface, (EDI), internet or other electronic transmission.

I hereby acknowledge that this Consent and Release Form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

Applicant's Signature:_____ Date: _____