

NAMSS PASS

TERMS OF SERVICE

This Agreement is made between _____, a Health Care Entity (HCE), and WIN/Staff, Inc., dba NAMSS PASS (WIN/Staff) as of the signature date listed below. HCE desires to utilize the NAMSS PASS service offered by WIN/Staff so in consideration of the premises and mutual promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

I. DEFINITIONS

“NAMSS PASS” means a secure, on-line database that contains hospital and other Health Care Entity affiliation history for Practitioners.

“Health Care Entity” means any health care organization that is involved in the formal credentialing of Practitioners. Health Care Entities include, but are not limited to, the following:

- Hospitals
- Surgery centers
- Health plans
- Preferred Provider Organizations (“PPOs”)
- Independent Practice Associations (“IPAs”)
- Accountable Care Organizations (“ACOs”)
- Group Medical Practices
- Credentials Verification Organizations (CVOs)
- Management Services Organizations (“MSOs”)
- Locum Tenens Provider Organizations
- Telemedicine Providers
- Professional Licensing Boards
- Medical specialty certification boards.

“Practitioner” means any health care professional who is credentialed and granted clinical privileges by a Health Care Entity to provide patient care services (e.g., physician, dentist, podiatrist, physician assistant, advanced practice nurse).

“Contributing Entity” means any Health Care Entity that submits Practitioner affiliation information to NAMSS PASS.

“Querying Entity” means any Health Care Entity who queries NAMSS PASS to obtain Practitioner affiliation information.

“My Facility” means the Health Care Entity that has agreed to these Terms of Service, as evidenced by its authorized representative submitting this form.

II. CONTRIBUTING ENTITY

- My Facility agrees to electronically submit Practitioner affiliation information to NAMSS PASS for (i) all Practitioners at the Health Care Facility and (ii) all Practitioners who meet NAMSS PASS’s definition of “good standing.”

- My Facility agrees to keep its Practitioner affiliation information current in the NAMSS PASS database by submitting periodic electronic updates.
- My Facility designates NAMSS PASS as a primary source for its Practitioner affiliation information.
- My Facility will select either the Option I or Option II, or a custom format “good standing” letter to be used by NAMSS PASS to provide all Practitioner affiliation information for my facility. Copies are attached.
- My Facility certifies that it has an appropriate signed release on file for every Practitioner, which authorizes my facility to provide the Practitioner’s affiliation information to NAMSS PASS and to any Health Care Entity that may query NAMSS PASS for this information.
- My Facility acknowledges that it directly submits Practitioner affiliation information to NAMSS PASS for inclusion in the database and that NAMSS PASS conducts no independent verification of this information. My Facility agrees to indemnify and hold harmless NAMSS PASS, NAMSS, WIN/Staff, Inc., and their respective directors, officers, employees, agents, and attorneys from any and all liability and damages, to the fullest extent permitted by law that may result from My Facility’s submission of inaccurate or incomplete Practitioner affiliation information.

III. QUERYING ENTITY

- My Facility (or its authorized CVO or other agent) acknowledges that it is querying NAMSS PASS to obtain Practitioner affiliation information solely for credentialing purposes and not for any other purpose.
- My Facility certifies that it has an appropriate signed release on file for every Practitioner, which authorizes my facility to obtain Practitioner affiliation information from primary sources such as NAMSS PASS to be used for credentialing purposes.
- My Facility acknowledges that all Practitioner affiliation information contained in NAMSS PASS’s database is submitted directly by Contributing Entities and that NAMSS PASS conducts no independent verification of this information. My Facility agrees to release and hold harmless NAMSS PASS, NAMSS, WIN/Staff, Inc., and their respective directors, officers, employees, agents, and attorneys from any and all liability and damages, to the fullest extent permitted by law that may result from a Contributing Entity’s submission of inaccurate or incomplete Practitioner affiliation information.
- My Facility understands that it is completely and independently responsible for properly evaluating the Practitioner affiliation information that it obtains from NAMSS PASS and for any and all credentialing determinations that result from that evaluation. If additional information is required regarding a Practitioner’s qualifications, My Facility can obtain it through the questions on our application forms, follow-up letters to a Health Care Entity, confidential evaluation forms sent to references, and/or phone calls to references.
- My Facility agrees to release all Contributing Entities and their authorized representatives from any and all liability and damages, to the fullest extent permitted by law, and to not sue them, for contributing Practitioner affiliation information to NAMSS PASS. Consistent with the Health Care Quality Improvement Act, the only exception to this release is if a Contributing Hospital provides knowingly false information.

IV. FEES FOR SERVICES

There is no charge to contribute data to NAMSS PASS and utilize the web feature for other entities to print your “good standing” letters. In 2015 the gap analysis data will be available free to all HCEs that upload their roster of practitioners to the database (contributing entities). Non-contributing entities will need to pay a fee for access to the gap analysis data. All entities (contributing and non-contributing) can pay a fee to print affiliation letters. NAMSS members will receive deep discounts on all fees. Please refer to the latest Fee Schedule for the most current rates.

V. CERTIFICATION AND AGREEMENT

- 1. I certify that My Facility is a Health Care Entity as defined in these Terms of Service.**
- 2. I certify that I am authorized to agree to these Terms of Service on behalf of My Facility.**
- 3. By submitting this form, My Facility agrees to these Terms of Service and intends to be legally bound by them.**

VI. TERM AND TERMINATION

There is no term requirement for this Agreement and HCE may terminate this service at any time by requesting their data to be archived from NAMSS PASS database.

ATTACHMENTS
Option Template #1

Hospital Letterhead Graphic Header

CONFIDENTIAL PEER REVIEW DOCUMENT

Date

Person Making Query
Name of Querying Entity
Address
City, State, Zip

Picture of
Practitioner

(If Available)

RE: [Practitioner Name] (License#: [License Number], State: [State], NPI: [NPI Number])

To Whom It May Concern:

This letter is to respond to your request for primary source verification regarding the status of the above-referenced practitioner at [Hospital Name]. Please note the following information:

<u>Dates of Affiliation</u>	<u>Specialty</u>	<u>Staff Category</u>	<u>Status</u>
Dates	Specialty	Staff Category	Status- Good Standing

“*Good Standing*” means that *no adverse professional review action* as defined in the Health Care Quality Improvement Act has been taken regarding this practitioner. That means that there has been no reduction, restriction, suspension, revocation, denial, or non-renewal of the practitioner’s staff membership or clinical privileges. For purposes of this letter, a “*restriction*” is defined to mean that a mandatory concurring consultation requirement has been imposed upon the practitioner (i.e., the practitioner must obtain a consult and the consultant must approve the course of treatment in advance).

If this information does not agree with your records or if you need additional information, please feel free to contact us at [Medical Staff Office Phone].

Sincerely,
Signature Graphic

[Name of MSP]
[Title of MSP]
[Hospital Name]

Information in this letter last updated by [Hospital Name]: [Valid Date]
Query Confirmation Number: [Confirmation Number]

Legend:

Green – Info submitted by person making inquiry

Red – Info submitted by your hospital

Blue – Graphics/text submitted by your hospital

Option Template #2

Hospital Letterhead Graphic Header

Date CONFIDENTIAL PEER REVIEW DOCUMENT

Person Making Query
Name of Querying Entity
Address
City, State, Zip

Picture of
Practitioner
(If Available)

RE: [Practitioner Name] (License#: [License Number], State: [State], NPI: [NPI Number])

To Whom It May Concern:

This letter is to respond to your request for primary source verification regarding the status of the above-referenced practitioner at [Hospital Name]. Please note the following information:

Table with 4 columns: Dates of Affiliation, Specialty, Staff Category, Status. Includes sub-headers and a note 'Status- Good Standing'.

“Good Standing” means as follows:

- 1. Our Hospital evaluates the six ACGME general competencies...
2. No adverse professional review action as defined in the Health Care Quality Improvement Act...
3. Our Hospital is unaware of any health issues that might affect the practitioner’s ability to practice safely and competently.

If this information does not agree with your records or if you need additional information, please feel free to contact us at [Medical Staff Office Phone].

Sincerely,
Signature Graphic

[Name of MSP]
[Title of MSP]
[Hospital Name]

Information in this letter last updated by [Hospital Name]: [Valid Date]
Query Confirmation Number: [Confirmation Number]

Legend:
Green – Info submitted by person making inquiry
Red – Info submitted by your hospital
Blue – Graphics/text submitted by your hospital

Option Template #3

Hospital Letterhead Graphic Header

CONFIDENTIAL PEER REVIEW DOCUMENT

Date

Person Making Query
Name of Querying Entity
Address
City, State, Zip

Picture of
Practitioner
(If Available)

RE: [Practitioner Name] (License#: [License Number], State: [State], NPI: [NPI Number])

To Whom It May Concern:

This letter is to respond to your request for primary source verification regarding the above-referenced practitioner at [Hospital Name]. Please note the following information:

Dates of Affiliation Facility/Location Specialty Staff Category Department
Dates Facility Name Specialty Staff Category Department

If this information does not agree with your records or if you need additional information, please feel free to contact me at [Medical Staff Office Phone].

Sincerely,
Signature Graphic

[Name of MSP]
[Title of MSP]
[Hospital Name]

Information in this letter last updated by [Hospital Name]: [Valid Date]
Query Confirmation Number: [Confirmation Number]

Legend:
Green - Info submitted by person making inquiry
Red - Info submitted by your hospital
Blue - Graphics/text submitted by your hospital