PHYSICIAN/PRACTITIONER REQUEST FOR LEAVE OF ABSENCE

Full Name of Physician/Practitioner Requesting LOA*:* _____

Primary Specialty: _____ **Number of SC Assigned Members:** _____

Dates of LOA: From ___/___/___ **To and Including:** ___/___/___
Beginning Date **Ending Date**

Reason for LOA: o **Illness** o **Maternity Leave** o **Vacation**
o **Education** o **Other (please specify)** _____

Covering Physician(s): _____ **Specialty(ies):**_____
(If the covering physician is a locum tenens, the information below must also be completed)

Address(es): _____ _____
(Include)
***Billing address*):**_____ _____

Phone #(s): _____ **NPI#** (*for Locum Tenens only*):_____

Does/do this/these physician(s) or practitioner(s) participate on the SC network panel? o **Yes** o **No**
(Note: If physician(s) or practitioner(s)/does/do not participate on the SC network panel, they cannot cover for you during your period of leave, unless they are a locum tenens)

For Locum Tenens only:
The following must be verified:

- o Current, valid Ohio State license
- o Current, valid DEA
- o Malpractice is current and is at least 1/3 MIL
- o NPDB is verified for Medicare/Medicaid Sanctions and claims history
- o Board Certification is verified, or if not board certified evidence that the physician completed an appropriate training program in the specialty he will be covering must be obtained.
- o Agreement between physician requesting LOA and locum tenens is in place

_____ _____
Signature of Individual who verified the above information *Date Verified*

_____ _____
Physician's or Practitioner's signature **Dated**

Please forward to: **SummaCare Credentialing/CVO**
1077 Gorge Blvd. Akron OH 44309-3620

For SC Internal Use Only

Date presented at the SC Credentialing and Peer Review Committee: ___/___/___

Echo updated by: _____ **(Initials) Date:** ___/___/___

Copy sent to SC Provider Configuration by: _____ **(Initials) Date:** ___/___/___

Credentialing personnel designated to monitor LOA: _____