CareMore
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HEALTH CARE DELIVERY ORGANIZATION/ANCILLARY/LONG TERM CARE PROVIDER APPLICATION

****Please note: Submission of a completed application does not guarantee approval as a participating provider as additional criteria may be required as communicated by the Plan****

Submit *<u>all applicable documents</u>* from the list below with your completed and signed application. *Failure to submit a complete application with <u>all applicable documents</u> will result in the application being returned and will prohibit the Company from completing your credentialing and/or contracting process.*

- Copy of all federal, state and/or local licenses required to operate as a health care facility (by location)
- Copy of Accreditation Certificate or letter
- Copy of most recent CMS or state survey (with deficiencies) including your corrective action plan if deficiencies were cited AND cover letter from CMS/state agency stating facility is in substantial compliance
- Copy of Medicare Certification(s)
- W-9
- Current copy of Professional Liability Insurance and General Liability Insurance (must indicate coverage limits/policy number/effective date/expiration date)
- Proof of established Quality Improvement Program
- Ambulance – Include copy of current Automobile Liability Insurance
- Air Ambulance – Include copy of Federal Aviation License
- Ambulance Application Addendum
- Cardiac Event Monitoring – Include certification as an Independent Diagnostic Testing Facility (IDTF)
- Hearing Aid Providers – Include current copy of Hearing Aid Dispensing License
- Ambulatory/Home Infusion Therapy Providers – Include current copy of Pharmacy License in state where contracting
- Immunization Clinics – Include affirmation/proof of participation in VFC (vaccines for children if participating in Medicaid or Medicaid/Medicare Duals Demonstration networks)
- Laboratory Providers – Include a copy of CLIA (Clinical Laboratory Improvement Act) Certificate(s) for each location(s); Pathology Laboratories please provide College of American Pathologists (CAP) Accreditation

**** Please note that there may be additional paperwork or Addendums that will need to be completed as requested by our Network Provider Solutions Department****

CHECK YOUR PROVIDER TYPE AND COMPLETE ALL FOLLOWING PAGES					
☐	Acupuncture	☐	Durable Medical Equipment	☐	Occupational Therapy Services
☐	Ambulance, Air	☐	Federally Qualified Health Ctr.	☐	Organ Transplant Facility
☐	Ambulance, Ground	☐	Hearing Aid Supplier	☐	Orthotics & Prosthetics
☐	Ambulatory Infusion Suite	☐	Hemophilia Center	☐	Outpatient Rehab
☐	Ambulatory Surgery Center	☐	Home Health Agency	☐	Personal Assistance Services
☐	Audiology Services	☐	Home Infusion Therapy	☐	Physical Therapy Services
☐	Birthing Center	☐	Hospice Care – Outpatient	☐	Private Duty Nursing
☐	Clinic, Immunization	☐	Hospice Facility	☐	Radiology Facility
☐	Clinic, Retail Health	☐	Hospital	☐	Radiology – Mobile Unit
☐	Clinic, Rural Health	☐	Imaging Facility	☐	Skilled Nursing Facility
☐	Clinic, Urgent Care	☐	Inpatient Rehab Hospital	☐	Speech Therapy Services
☐	Clinic, Walk-In	☐	Intensive Family Interventions	☐	Sub-Acute/Intermediary Care
☐	Dialysis Center	☐	Laboratory	☐	Trauma Center
☐	Dietitian/Nutritional Services				
BEHAVIORAL HEALTH					
☐	Ambulatory Detox	☐	Intensive Outpatient Services – Substance Abuse	☐	Residential Tx Center – Psychiatric
☐	Case Management, Adult	☐	Mental Health Clinic – Outpatient Services	☐	Residential Tx Center – Substance Abuse
☐	Case Management, Child	☐	Methadone Maintenance Clinic	☐	Substance Abuse Facility – Adult
☐	Crisis, Respite	☐	Partial Hospitalization – Psychiatric	☐	Substance Abuse Facility – Child/Adolescent
☐	Crisis, Stabilization	☐	Partial Hospitalization – Substance Abuse	☐	Substance Abuse Clinic – Outpatient Services
☐	Hospital, Psychiatric	☐	Peer Support Services	☐	Supported Employment
☐	Illness Management/Recovery	☐	Psychosocial Rehab	☐	Supported Housing
☐	Intensive Outpatient Services – Psychiatric				
LONG-TERM CARE (LTSS)/HOME BASED COMMUNITY SERVICES/OTHER					
☐	Adult Companion Services	☐	Fetal Monitoring Services	☐	Nurse Registry
☐	Adult Day Activity/Health Services	☐	Financial Assessment/Risk Services	☐	Nursing Home
☐	Chore Services	☐	Genetic Services	☐	Personal Assistance Services
☐	Core Services	☐	Habilitation	☐	Pest Control
☐	Early Childhood Intervention	☐	Homemaker	☐	Residential Service Agency
☐	Emergency Response Systems	☐	Home Modification/Repair	☐	Respite Care
☐	Escort Attendant	☐	Interpreter Services	☐	Respite Care – In Home
☐	Family Planning Services	☐	Music Therapy	☐	Respite Care - Inpatient

PROVIDER IDENTIFICATION	
Legal business name:	
Doing business as: (if applicable)	
Primary Contract Person: Title:	Email:
Primary Contact Person Address:	City:
State:	Zip:
Phone:	Fax:

CREDENTIALING INFORMATION	
Credentialing Contact Name: Title:	Email:
Credentialing Address:	City:
State:	Zip:
Phone:	Fax:

PRIMARY OFFICE /SERVICE ADDRESS (Check box ☐ and attach separate sheet for addt'l locations)			
Practice location name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Primary contact:	
Primary Contact Email:	Phone:	Website URL:	
Administrator (full name):			
Medicaid #	Medicare #		
Long Term Care Vendor #:	Tax ID/EIN:		
Taxonomy Code(s)	NPI#		
Does provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			

Check all that apply:

Handicap accessible:	☐ Building	☐ Parking	☐ Restroom Services
for disabled:	☐ Tex telephone	☐ American Sign Language	☐ Mental/physical impairment
Accessible by public transportation:	☐ Bus	☐ Subway	☐ Regional train

PRIMARY OFFICE BILLING INFORMATION (CHECK/EOB ADDRESS)			
Contact Name (billing contact): Title:			
Address Line 1:			
Address Line 2:			
City:	State:	ZIP:	Phone:
Email Address:	Website URL:		Fax:

LICENSURE/OPERATING CERTIFICATE (Attach a copy of current licensure and CLIA certification, if applicable)			
State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:
CLIA certificate #:			

ACCREDITATION/CERTIFICATION (Attach a copy of current Accreditation certificate or survey)

A.

☐ AAAASF ☐ AAPSF ☐ CARF ☐ CIQH ☐ COA ☐ CTEAM ☐ HQAA ☐ TJC ☐ DNV/NIAHO NUCCA
☐ AAAHC ☐ ACHC ☐ CHAP ☐ CLIA ☐ COLA ☐ HFAP ☐ IMQ ☐ UCAOA ☐ FDA CERT
☐ BOC INTL ☐ CABC ☐ CAP ☐ **NOT ACCREDITED (complete section B below)**

Date of initial accreditation:_/______/_________ Date of next survey___________________/_____/________

Date of last survey:________/______/_________

B.

Has provider had an onsite survey by CMS or state agency? ☐ Yes ☐ No Date of last recertification/annual state survey/program review report:_______/_____/_________

If no, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the health plan to schedule the visit.

Non-accredited providers must provide a copy of their most recent government agency survey (<u>may not be older than 36 months</u>) along with your Corrective Action Plan (if deficiencies were cited), AND <u>attach</u> the letter from the government agency stating facility is in substantial compliance with most recent survey standards. Failure to provide documentation may delay your ability to become a participating provider.

GENERAL AND PROFESSIONAL LIABILITY INSURANCE

General liability coverage (Attach copy of CURRENT Insurance facesheet)	
Current carrier name:	
Policy number:	Coverage type: ☐ Occurrence based ☐ Claims based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Professional liability coverage (Attach copy of CURRENT Insurance facesheet)	
Current carrier name:	
Policy number:	Coverage Type: ☐ Occurrence based ☐ Claims based
Effective Date:	Expiration date:
Per incident: $	Aggregate: $

****Note – if Self-Insured complete all questions and sign on page X and attach proof of Self-Insurance**

Provider Directory

The following information may be utilized in our provider directory. Please answer the following questions as accurately as possible.

Question			
What are your office hours?	________ to________		N/A
Do you have experience and skills in treating persons with physical disabilities?	Yes	No	N/A
Do you have experience and skills in treating persons with chronic illness?	Yes	No	N/A
Do you have experience and skills in treating persons with HIV/AIDS?	Yes	No	N/A
Do you have experience and skills in treating persons with serious mental illness?	Yes	No	N/A
Do you have experience and skills in treating individuals who are homeless?	Yes	No	N/A
Do you have experience and skills in treating individuals who are deaf or hard of hearing?	Yes	No	N/A
Do you have experience and skills in treating individuals who are blind or visually impaired?	Yes	No	N/A
Network providers: What languages, other than English, are spoken by you, including American Sign Language?			N/A
What languages other than English, are spoken by your medical staff and/or skilled medical interpreter, including American Sign Language?			N/A
Do you have translation services available?	Yes	No	N/A
Behavioral Health Providers: What special experience, skills and/or training (e.g., trauma, child welfare, substance abuse) do you have?			

CREDENTIALINGQUESTIONS

Does the health care delivery organization/ancillary/long term care/provider have:

1. Evidence of all subcontractors' professional liability claims history? Yes ☐ No ☐
2. Any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state? Yes ☐ No ☐
3. Any history of loss or limitation of privileges or disciplinary activity? Yes ☐ No ☐

Please include an explanation on a separate sheet for any questions(s) answered YES.

ATTESTATION QUESTIONS

Please answer the following questions "yes" or "no." If you answer "yes," please provide full details on a separate sheet.

A. Has your malpractice insurance ever been terminated or revoked except with your consent or request?
Yes ☐ No ☐

B. Are you currently under investigation by any government agency?
Yes ☐ No ☐

C. Have you been expelled or suspended from receiving payment under Medicare or Medicaid?
Yes ☐ No ☐

D. Has your accreditation status ever been reduced, terminated, suspended or revoked?
Yes ☐ No ☐

E. Is your malpractice insurance provided through a self-insurance trust or program? Yes ☐ No ☐

If yes, an officer of the company (i.e. President, Vice-President, Chief Financial Officer or Chief Operating Officer) must sign the following attestation. On behalf of the applicant I represent and warrant the following with respect to the self-insurance program maintained by the applicant, or which provides professional liability insurance for the applicant:

1. The self insurance program is adequately funded to provide the minimum required limits of liability as required by Plan, and;
2. The self-insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims, and future claims based on past experience, and;
3. The self insurance program has a designated third party administrator or other appropriately licensed claims professional or attorney serving the program, and;
4. The self insurance program has a designated medical malpractice defense firm, or more than one designated medical malpractice defense firm, and;
5. The self insurance maintains excess insurance/reinsurance above the self funded level, if the self-insured level alone is insufficient to meet Plan's required limits, and;
6. The self insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit, or a captive, self management of a large retention through a trust, and;
7. The self insurance maintains a total value of the program that at a minimum meets the required limit of liability as set forth by Plan?
8. I have confirmed the foregoing with my auditor or the actuary for the self-insurance fund.

Attest: ___________________________________

Name: ___________________________________

Title: ___________________________________

NOTE: The Plan reserves the right to request documentation from the applicant to confirm the information maintained in this attestation

ATTESTATION

I hereby affirm that the information submitted in this application is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment or participating practitioner agreement.

A photocopy of this document shall be as effective as the original.

______________________________ ______________________________

Preparer's Name Here Title

______________________________ ______________________________

Signature Date

(Stamped Signature Is Not Acceptable)