Thank you for your interest in participating with Silver Summit Health Plan. We are excited that you selected our provider network as your network of choice. Once we have received all the requested information, we will begin the credentialing process.

Facility or Hospital Provider Checklist

Documents Needed	Facility or Hospital Provider
Hospital/Facility Provider Application	☐
Provider Data form or Provider Roster (If Applicable)	☐
Provider Statement to Release Information (Signed and dated within the last 180 days from submission) (ROI)	☐
Disclosure of Ownership & Controlling Interest Statement	☐
Behavioral Health Addendum (If Applicable)	☐
Copy of W9	☐
Copy of Current State Operational License	☐
Copy of Declaration Page of General Liability Insurance (document showing the amounts and dates of coverage and the amounts 1 Million per occurrence / 3 Million Aggregate)	☐
Copy of Current CLIA Waiver or Certificate (If Applicable)	☐
Copy of current Controlled Substance License – CDS (If Applicable)	☐
Copy of current Accreditation/certification (by a nationally-recognized accrediting body, e.g. TJC/JCAHO) (If Applicable)	☐
Copy of current Site Evaluation Results by a government agency If not accredited by a nationally-recognized body	☐
Copy of Medicaid/Medicare Certification (If not certified, provide proof of participation)	☐

Provider Application
(Ancillary, Clinic, Facility, Hospital)

Instructions: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each Legal Entity/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following to the completed application:

- State Operational License
- Other applicable State/Federal Licensures (e.g., CLIA, DEA, Pharmacy or Department of Health)
- Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO/CARF/COA/or AOA) Accreditation letter with dates of accreditation
- If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency
- W-9
- Ownership and Disclosure Form
- Other applicable State/Federal Licensures (See last page for list of state-required documents)

☐ **Initial Credentialing/ Assessment**

☐ **Re-Credentialing/ Re-Assessment**

☐ **Addition of new site to current contract**

Legal Entity/TIN: _____

This application applies to the following **Provider Types**: (Choose all that apply)

☐ Hospital (Critical Access) NPI:	☐ Hospital (Swing Bed); NPI:	☐ Hospital (General Acute Care; NPI:
☐ Hospital (Rehabilitation) NPI:	☐ Hospital (Psychiatric) NPI:	☐ Hospital; NPI:
☐ Hospital (Substance Abuse); NPI:	☐ Clinic –Federally Qualified Health Center (FQHC); NPI:	☐ Intensive Family Intervention; NPI:
☐ Adult Day Care Center; NPI:	☐ Clinic – Indian Health (IHC); NPI:	☐ Outpatient Clinic; NPI:
☐ Adult Living Facility/Assisted Living Facility; NPI:	☐ Clinic – Rural Health Center (RHC); NPI:	☐ Outpatient Infusion / Chemotherapy; NPI:
☐ Agency (Dept. of Health, State Health); NPI:	☐ Diagnostic Imaging Center; NPI:	☐ Orthotics and Prosthetics; NPI:
☐ Ambulance; NPI:	☐ Dialysis; NPI:	☐ Pediatric Day Health Care Facilities (PDHC) ; NPI:
☐ Assisted Long-Term Care Facility; NPI:	☐ Durable Medical Equipment; NPI:	☐ Personal Care Assistant Facilities (PCAs); NPI:
☐ Ambulatory Surgical Center ; NPI:	☐ Family Planning Clinics; NPI:	☐ Residential Treatment Center; NPI:
☐ Autism Facility ; NPI:	☐ Home & Community Based Services (HCBS); NPI:	☐ Rehabilitation Facility (Outside of Hospitals); NPI:
☐ Behavioral Health Agency/Child Placing Agency ; NPI:	☐ Home Health Agency; NPI:	☐ Skilled Nursing Facility; NPI:
☐ Board of Health ; NPI:	☐ Hospice; NPI:	☐ Sleep Diagnostic; NPI:
☐ Cardiac Surgery Program; NPI:	☐ Laboratory; NPI:	☐ Surgical Services (OP or ASC); NPI:
☐ Cardiac Catheterization Services; NPI:	☐ Mammography; NPI:	Transplant ☐ Heart/Lung ☐ Kidney ☐ Liver ☐ Lung ☐ Pancreas ☐ Heart NPI:
☐ Critical Care Services – Intensive Care Units (ICU); NPI:	☐ Occupational Therapy; NPI:	☐ Urgent Care (Attached to Hospital); NPI:
☐ Chemical Dependency /Substance Abuse; NPI:	☐ Physical Therapy; NPI:	☐ Urgent Care (Free Standing); NPI:
☐ Community Mental Health Center (CMHC); NPI:	☐ Speech Therapy; NPI:	☐ Inpatient Psychiatric Services; NPI:

Taxonomy:

Contact Information:

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

Credentialing Contact Information: ☐ Same as Contact Information

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

Legal Entity Information (Name on Income Tax Return)

Tax ID Holder Name:	Federal Tax ID Number:	☐ Profit ☐ Non-Profit
Legal/Tax Address (where you want the 1099 sent):		

Insurance Information (Both facility general and professional liability if required). Minimum coverage requirement is $1 million per occurrence and $3 million aggregate)

Carrier:	Amount of Coverage:	Coverage Dates:

Billing Information

How Does Provider Type Bill? (Please Circle One) ANCILLARY CLINIC RHC FQHC HOSPITAL

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

LTTS/HCBS/Home Health Agencies Servicing Counties: (if needed attach an additional sheet)

Servicing County 1:	Servicing County 2:	Servicing County 3:	Servicing County 4:
Servicing County 5:	Servicing County 6:	Servicing County 7:	Servicing County 8:
Servicing County 9:	Servicing County 10:	Servicing County 11:	Servicing County 12:

Complete for each Service Location that is part of this application.

Service Location 1 of ____

Group or Facility Name (to be displayed in the Directory)

Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID # (Group/Type 2):**
State License Number:	**Medicaid Provider ID #:**	**Medicare Number:**

Service Location Address:

☐**Same as Legal Entity**

Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**

Website:

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8 – 5**

ADA Compliant? (Check all that apply).
☐ **Building** ☐ **Bathroom(s)** ☐ **Parking** ☐ **Therapy Room(s)**
☐ **Equipment**

Service Location Accepting New Patients?
☐**Yes** ☐ **No**

Are you located on a Public Transportation route? ☐**Yes** ☐ **No**

Crisis Intervention/ Emergency Services Offered? ☐**Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐**Yes** ☐ **No**

Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:

Do you provide services to any of the following special needs population? (Check all that apply):
☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental Disability**
☐ **Other (Please specify: _____)**

Is your practice limited to certain ages? ☐**Yes** ☐ **No**
If Yes, specify age restrictions:
☐**None** ☐ **0-2 years** ☐ **0-6 years** ☐**0-12 years** ☐**0-17 years** ☐ **0-20 years** ☐ **6-12 years** ☐**13+ years**

☐**13-17 years** ☐**13-20 years** ☐**3+ years** ☐**17+ years** ☐**21+ years** ☐**65+ years** ☐**Other _____**

Behavioral Health Services Provided for Service Location 1 of _____: (check all that apply)

☐ Inpatient Mental Health ☐ Inpatient Substance Abuse ☐ Day Treatment – Mental Health ☐ Day Treatment – Substance Abuse ☐ Intensive Outpatient Program (IOP) – Mental Health ☐ Intensive Outpatient Program – Substance Abuse ☐ Observation ☐ Residential Treatment – Mental Health (PRTF) ☐ OP Treatment Services – Mental Health ☐ OP Treatment Services – Substance Abuse	☐ Inpatient – Eating Disorder ☐ Electroconvulsive Therapy (ECT) – Inpatient ☐ Electroconvulsive Therapy (ECT) - Outpatient ☐ Partial Hospitalization Program (PHP) – Mental Health ☐ Partial Hospitalization Program (PHP) – Substance Abuse ☐ Residential Treatment – Chemical Dependency ☐ Community Based Services ☐ Targeted Case Management ☐ Crisis Stabilization ☐ Detox; Ages Served: _____ ☐ Other (please specify): _____

LTSS/HCBS Services Provided for Service Location 1 of _____: (check all that apply)

☐ Adult Daily Living ☐ Assistive Technology ☐ Benefits Counseling ☐ Career Assessment ☐ Community Integration ☐ Community Transition Services ☐ Durable Medical Equipment ☐ Education Support ☐ Employment Skills Development ☐ Exceptional DME ☐ Family Support Services ☐ Financial Management Services ☐ Home Adaptations ☐ Home Delivered Meals ☐ Home Health Aide Services ☐ I & A: Service Coordinators/Care Managers ☐ Job Coaching ☐ Job Finding ☐ Non-Medical/Non-Emergency Transportation ☐ Nursing Facility Services ☐ Nursing Services ☐ Nutritional Counseling/SNAP	☐ Occupational Therapy ☐ Participant-Directed Community Support ☐ Participant-Directed Goods and Services ☐ Personal Assistance Services ☐ Personal Emergency Response System (PERS) ☐ Pest Eradication ☐ Physical Therapy ☐ Prevocational Services ☐ Residential Habilitation ☐ Respite ☐ Special Diet Preparation ☐ Specialized Medical Equipment and Sales ☐ Speech Therapy ☐ Structured Day Habilitation ☐ Supported Employment ☐ Telecare Services ☐ Temporary Crisis Services ☐ Therapeutic and Counseling Services ☐ Transportation ☐ Vehicle Modifications ☐ Other _____ ☐ Other _____

Billing Information for Service Location 1 of _____ :

☐ Same as indicated on Page 3 (If different, complete below)

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to):	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Insurance Information for Service Location 1 of _____:

☐ **Same as indicated on Page 3 (If different, complete below)**

Professional Carrier:	**Amount of Coverage:** **Per Occurrence:** **Per Aggregate:**	**Coverage Dates:**
Worker's Compensation Carrier:	**Coverage Dates:**	

Has the Provider Office completed Cultural Training? ☐ **Yes** ☐ **No**

If Yes, did the training include the following?

African American ☐ **Yes** ☐ **No** **Asian** ☐ **Yes** ☐ **No**
Alaskan Native ☐ **Yes** ☐ **No** **Hispanic/Latino** ☐ **Yes** ☐ **No**
American Indian ☐ **Yes** ☐ **No** **Pacific Islander** ☐ **Yes** ☐ **No**
Other_____ ☐ **Yes** ☐ **No**

Service Location 1 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 1 of _____ – Sanctions ☐ **Same as Legal Entity** *If yes, to any question below, please explain on a separate sheet of paper.*	
Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐**Yes** ☐ **No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐ **No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐**Yes** ☐ **No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐**Yes** ☐ **No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐**Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐**Yes** ☐ **No**

Complete for each Service Location that is part of this application. .

Service Location 2 of ____

Group or Facility Name (to be displayed in the Directory)

How Does Provider Bill? Please Circle One. GROUP ANCILLARY CLINIC HOSPITAL

Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID # (Group/Type 2):**
State License Number:	**Medicaid Provider ID #:**	**Medicare Number:**

Service Location Address:

☐**Same as Legal Entity**

Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**

Website:

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8 – 5**

ADA Compliant? (Check all that apply).
☐ **Building** ☐ **Bathroom(s)** ☐ **Parking** ☐ **Therapy Room(s)**
☐ **Equipment**

Service Location Accepting New Patients?
☐**Yes** ☐ **No**

Are you located on a Public Transportation route? ☐**Yes** ☐ **No**

Crisis Intervention/ Emergency Services Offered? ☐**Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐**Yes** ☐ **No**

Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:

Do you provide services to any of the following special needs population? (Check all that apply):
☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental Disability**
☐ **Other (Please specify: _____)**

Is your practice limited to certain ages? ☐**Yes** ☐ **No**
If Yes, specify age restrictions:
☐**None** ☐ **0-2 years** ☐ **0-6 years** ☐**0-12 years** ☐**0-17 years** ☐ **0-20 years** ☐ **6-12 years** ☐**13+ years**
☐**13-17 years** ☐**13-20 years** ☐**3+ years** ☐**17+ years** ☐**21+ years** ☐**65+ years** ☐**Other _____**

Behavioral Health Services Provided for Service Location 2 of _____: (check all that apply)

- ☐ Inpatient Mental Health
- ☐ Inpatient Substance Abuse
- ☐ Day Treatment – Mental Health
- ☐ Day Treatment – Substance Abuse
- ☐ Intensive Outpatient Program (IOP) – Mental Health
- ☐ Intensive Outpatient Program – Substance Abuse
- ☐ Observation
- ☐ Residential Treatment – Mental Health (PRTF)
- ☐ OP Treatment Services – Mental Health
- ☐ OP Treatment Services – Substance Abuse
- ☐ Inpatient – Eating Disorder
- ☐ Electroconvulsive Therapy (ECT) – Inpatient
- ☐ Electroconvulsive Therapy (ECT) - Outpatient
- ☐ Partial Hospitalization Program (PHP) – Mental Health
- ☐ Partial Hospitalization Program (PHP) – Substance Abuse
- ☐ Residential Treatment – Chemical Dependency
- ☐ Community Based Services
- ☐ Targeted Case Management
- ☐ Crisis Stabilization
- ☐ Detox; Ages Served: _____
- ☐ Other (please specify): _____

LTSS/HCBS Services Provided for Service Location 2 of _____: (check all that apply)

- ☐ Adult Daily Living
- ☐ Assistive Technology
- ☐ Benefits Counseling
- ☐ Career Assessment
- ☐ Community Integration
- ☐ Community Transition Services
- ☐ Durable Medical Equipment
- ☐ Education Support
- ☐ Exceptional DME
- ☐ Family Support Services
- ☐ Financial Management Services
- ☐ Home Adaptations
- ☐ Home Delivered Meals
- ☐ Home Health Aide Services
- ☐ I & A: Service Coordinators/Care Managers
- ☐ Job Coaching
- ☐ Job Finding
- ☐ Non-Medical/Non-Emergency Transportation
- ☐ Nursing Facility Services
- ☐ Nursing Services
- ☐ Nutritional Counseling/SNAP
- ☐ Occupational Therapy
- ☐ Occupational Therapy
- ☐ Participant-Directed Community Support
- ☐ Participant-Directed Goods and Services
- ☐ Personal Assistance Services
- ☐ Personal Emergency Response System (PERS)
- ☐ Pest Eradication
- ☐ Physical Therapy
- ☐ Prevocational Services
- ☐ Residential Habilitation
- ☐ Respite
- ☐ Special Diet Preparation
- ☐ Specialized Medical Equipment and Sales
- ☐ Speech Therapy
- ☐ Structured Day Habilitation
- ☐ Supported Employment
- ☐ Telecare Services
- ☐ Temporary Crisis Services
- ☐ Therapeutic and Counseling Services
- ☐ Transportation
- ☐ Vehicle Modifications
- ☐ Other _____
- ☐ Other _____

Billing Information for Service Location 2 of _____ :

☐ Same as indicated on Page 3 (If different, complete below)

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to):	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Tax ID Number:_____

Insurance Information for Service Location 2 of _____: ☐**Same as indicated on Page 3 (If different, complete below)**		
Professional Carrier:	**Amount of Coverage:** **Per Occurrence:** **Per Aggregate:**	**Coverage Dates:**
Worker's Compensation Carrier:	**Coverage Dates:**	
Has the Provider Office completed Cultural Training? ☐Yes ☐ No		
If Yes, did the training include the following? **African American ☐Yes ☐ No Asian ☐Yes ☐ No** **Alaskan Native ☐Yes ☐ No Hispanic/Latino ☐Yes ☐ No** **American Indian ☐Yes ☐ No Pacific Islander ☐Yes ☐ No** **Other_____ ☐Yes ☐ No**		

Service Location 2 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 2 of _____ – Sanctions ☐ **Same as Legal Entity** *If yes, to any question below, please explain on a separate sheet of paper.*	
Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐**Yes** ☐ **No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐ **No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐**Yes** ☐ **No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐**Yes** ☐ **No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐**Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐**Yes** ☐ **No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current **Silver Summit Health Plan** provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to **Silver Summit Health Plan** Credentials Committee for their review and approval, and, absent such affirmative approval, **Silver Summit Health Plan** members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from **Silver Summit Health Plan**. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying **Silver Summit Health Plan** in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy **Silver Summit Health Plan** credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ **Date:** _____

Print or type name

_____

Signature of Provider or Authorizing Representative **Title**

A stamp signature is not acceptable

CENTENE® Corporation

Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of *5%* or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity
Entity: DBA Name:
Address:
Federal Tax Identification Number:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the form by fax to (*insert Fax #*) or by mail in the enclosed postage paid envelope to:

(*insert Address here*)

Behavioral Health Addendum

Instructions: This Behavioral Health Addendum must be completed in its entirety for any Behavioral Health agreement.

Date Completed:	**Name:**

Do you provide services to the following populations? (Check all that apply)

☐ **Serious Mental Illness (SMI)** ☐ **Serious Emotional Disturbance (SED)**

☐ **Severe Persistent Mentally Ill (SPMI)**

Are you able to provide services to any of the following special needs populations? (Check all that apply)

☐ **Deaf/Hearing Impaired** ☐ **Blind/Vision Impaired**

☐ **Developmental Disability** ☐ **Physical Disability**

☐ **Other**

_____

Are the following areas in your office ADA Compliant? (Check all that apply)

☐ **Building** ☐ **Bathroom(s)** ☐ **Therapy Room(s)** ☐ **Parking** ☐ **Equipment**

Please select the types of services you offer. (Check all that apply)

Types of Services	
☐ Individual Therapy	☐ Intensive Outpatient
☐ Couples Therapy	☐ Psychological Testing
☐ Family Therapy	☐ Neuropsychological Testing
☐ Group Therapy	☐ Other (please specify):

Please select the types of disorders you treat and the modalities you practice. (Check all that apply)	
Treatment Modalities/Approaches	**Disorders/Issues**
☐ ABA (Applied Behavior Analysis)	☐ ADD/ADHD
☐ Biofeedback	☐ Adjustment Disorders
☐ Client Centered Therapy	☐ Anxiety Disorders
☐ Cognitive Behavioral Therapy	☐ Attachment Disorders
☐ Dialectical Behavioral Therapy	☐ Autism Spectrum
☐ EMDR	☐ Disruptive Behavior Disorders
☐ Family Systems	☐ Dissociative Disorders
☐ Gestalt	☐ Eating Disorders
☐ Hypnosis	☐ Impulse Disorders
☐ NLP	☐ Mood Disorders
☐ Outcomes Oriented Therapy	☐ Personality Disorders
☐ Play Therapy	☐ Physical Abuse
☐ Psychoanalytic	☐ PTSD
☐ Rationale Emotive Therapy	☐ Schizophrenia
☐ Solution Focused Therapy	☐ Sexual Abuse (Adults)
☐ Tobacco Cessation	☐ Sexual Abuse (Children)
☐ Trauma Focused – CBT	☐ Sexual Disorders
☐ Methadone/Suboxone Medication Services	☐ Substance Abuse/Dependence Disorders
☐ Other (please specify):	☐ Other (please specify):

Practitioner Data Form

Instructions:

- Information on this Data Form must be provided and completed in its entirety for each Practitioner seeing patients within the Group or Facility.
- Please submit a copy of the Provider's W-9 (one per tax entity).
- Please make copies and attach additional Location Information pages, if necessary.
- Please ensure to include the Medicaid ID number.
- Please attach the Ownership and Disclosure Form.
- If a Practitioner participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

Date Completed:	**Individual NPI:**	
Are you registered with CAQH? ☐ **Yes** ☐ **No**	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID (11 digits):**
Medicare #		
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
Has Provider completed Cultural Competency Training? ☐ **Yes** ☐ **No**		
If Yes, did the training include the following? **African American** ☐**Yes** ☐ **No** **Asian** ☐**Yes** ☐ **No** **Alaskan Native** ☐**Yes** ☐ **No** **Hispanic/Latino** ☐**Yes** ☐ **No** **American Indian** ☐**Yes** ☐ **No** **Pacific Islander** ☐**Yes** ☐ **No** **Other_____** ☐**Yes** ☐ **No**		

Billing Information (Complete this section if different than the W9):

How Does Provider Bill? (Please Circle One) GROUP ANCILLARY CLINIC RHC FQHC HOSPITAL

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	**City State, Zip:**	**Phone Number :**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Location Information 1 of _____

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist
☐ Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment

Location Information _____ of _____

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist
☐ Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment

Practitioner Data Form

Instructions:

- Information on this Data Form must be provided and completed in its entirety for each Practitioner seeing patients within the Group or Facility.
- Please submit a copy of the Provider's W-9 (one per tax entity).
- Please make copies and attach additional Location Information pages, if necessary.
- Please ensure to include the Medicaid ID number.
- Please attach the Ownership and Disclosure Form.
- If a Practitioner participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

Date Completed:	**Individual NPI:**	
Are you registered with CAQH? ☐ **Yes** ☐ **No**	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID (11 digits):**
Medicare #		
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
Has Provider completed Cultural Competency Training? ☐ **Yes** ☐ **No**		
If Yes, did the training include the following? **African American** ☐**Yes** ☐ **No** **Asian** ☐**Yes** ☐ **No** **Alaskan Native** ☐**Yes** ☐ **No** **Hispanic/Latino** ☐**Yes** ☐ **No** **American Indian** ☐**Yes** ☐ **No** **Pacific Islander** ☐**Yes** ☐ **No** **Other_____** ☐**Yes** ☐ **No**		

Billing Information (Complete this section if different than the W9):

How Does Provider Bill? (Please Circle One) GROUP ANCILLARY CLINIC RHC FQHC HOSPITAL

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	**City State, Zip:**	**Phone Number :**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Location Information 1 of _____

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist
☐ Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment

Location Information _____ of _____

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist
☐ Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment

Practitioner Data Form

Instructions:

- Information on this Data Form must be provided and completed in its entirety for each Practitioner seeing patients within the Group or Facility.
- Please submit a copy of the Provider's W-9 (one per tax entity).
- Please make copies and attach additional Location Information pages, if necessary.
- Please ensure to include the Medicaid ID number.
- Please attach the Ownership and Disclosure Form.
- If a Practitioner participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

Date Completed:	**Individual NPI:**	
Are you registered with CAQH? ☐ **Yes** ☐ **No**	**If yes, CAQH Provider ID:**	
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth:	**Social Security #:**	**Medicaid ID (11 digits):**
Medicare #		
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):		
Has Provider completed Cultural Competency Training? ☐ **Yes** ☐ **No**		
If Yes, did the training include the following? **African American** ☐**Yes** ☐ **No** **Asian** ☐**Yes** ☐ **No** **Alaskan Native** ☐**Yes** ☐ **No** **Hispanic/Latino** ☐**Yes** ☐ **No** **American Indian** ☐**Yes** ☐ **No** **Pacific Islander** ☐**Yes** ☐ **No** **Other_____** ☐**Yes** ☐ **No**		

Billing Information (Complete this section if different than the W9):

How Does Provider Bill? (Please Circle One) GROUP ANCILLARY CLINIC RHC FQHC HOSPITAL

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	**City State, Zip:**	**Phone Number :**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Location Information 1 of _____

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist
☐ Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment

Location Information _____ of _____

Location Name:	**Group NPI:**	**Tax ID:**
Location Street Address:	**Location City/State:**	**Location Zip Code:**
Location County:	**Primary Phone:**	**Primary Fax:**
Email Address:	**Website URL: (www.)**	

Credentialing Contact Information (Name, Address, E-mail):

Applying as: ☐ Specialist
☐ Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)

Primary Specialty:	**Taxonomy:**	**Display in Find-A-Provider?** **☐ Yes ☐ No**	**Languages Spoken (including American Sign Language):**

Office Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ 24 Hours ☐ 8 – 5 Monday - Friday

License Number:	**License State:**	**Exp. Date:**
Are you board certified? **☐ Yes ☐ No**	**If yes, board name:**	**Exp. Date:**
If PCP, are you accepting new patients? ☐ Yes ☐ No **☐ Yes, existing patients only**	**Gender or Age restrictions?** **Gender: ☐ None ☐ Female Only ☐ Male Only** **Age: ☐ None ☐ Age Limits: Lowest Age ____ Highest Age ____**	

Are the following areas in your office ADA Compliant? (Check all that apply)
☐ Building ☐ Bathroom(s) ☐ Therapy Room(s) ☐ Parking ☐ Equipment