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 of the requested information, we will begin the credentialing process.

Individual Practitioner or Provider Group Checklist

Documents Needed	Individual Practitioner or Provider Group
Provider Data form or Provider Roster	☐
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 Business License	☐
Copy of Current DEA Controlled Substance Registration (If applicable)	☐
Copy of current Controlled Substance License – CDS (If Applicable)	☐
Board Certification Certificate (If Applicable)	☐
Education Certificate for Foreign Medical Graduates – ECFMG (If applicable)	☐
Copy of Medicaid/Medicare Certification (If not certified, provide proof of participation)	☐
CAQH	**Practitioner Profiles**
Practitioners CAQH profiles should include current attestation within the last 120 days	☐
Profiles to include Hospital Privileges or Admitting arrangements such as “refer to ER”	☐
Practitioners must be active on Centene/SilverSummit Healthplan roster and authorize Centene Corporation to access their application	☐
Need Assistance with CAQH contact the CAQH Help Desk: Providers: Log in to CAQH ProView and click the chat icon at the bottom of any page or call: **888-599-1771**	☐

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

M M D D Y Y Y Y

DATE SIGNED*

3094

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:**
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- 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**		

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