Becoming a Health Partner

Step-by-Step Guide

CareSource®

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Becoming a CareSource Health Partner

Becoming a CareSource Participating Health Partner can be Achieved in Four Steps:

Application – the correct completion and submission of a completed Health Partner Contract Form by the provider.

Contracting - the process of the provider and Managed Care Entity (MCE) formally executing an agreement for the provider to deliver medical services that outlines reimbursement rates, scope of services, etc.

Credentialing - the process of reviewing the qualifications and appropriateness of a provider to join the health plan's network.

Enrollment - Provider enrollment is the process of loading a contracted and credentialed provider to all MCE internal systems, loading for claims payment, and loading to the provider directory (if applicable). Provider enrollment does not take place until the provider is fully approved and credentialed.

Each step is outlined below.

1. Application

To initiate an application, please visit the Health Partner Contract Form by accessing Become a Participating Provider. Use the “Select a Plan” tool to choose the market/state and product. Then select the “Join our Network” button.

You may elect to save your progress at any time during completion of this form if you have at minimum completed the Submitter information section. To do so, select the “Save Draft” button at the end of the form. An email will be sent to the submitter’s contact information listed with a link to allow access to the partially completed application form for up to 14 calendar days.

The Health Partner Contracting Form requires the following:

Section 1. Request Type

Section 2. Product Selection

Section 3. Submitter Information

Section 4. Group Information

Section 5. Office Contact

Section 6. Contract Signatory Information

Section 7. Addresses

Section 8. Add Provider/Location Section

Section 9. Disclosures

Section 10. Additional Information/Notes

Section 11. Attach Required Documentation

For more detailed instructions and requirements on completing this form please see the **Health Partner Contract Form, Completion Guide** section.

2. Contracting

Once a Health Partner Contract Form is submitted with the required documents, the submitter will receive a confirmation email. **Please save this email as it will contain an Application ID** (used as a reference number to check application status, see user guide section "Enrollment Status").

The individual listed as the office contact on the Health Partner Contract Form will receive an email from the Health Partner administrator confirming receipt of the participation request. The Health Partner administrator will inform the office contact if any supporting documentation or application clarifications are needed to create a contract. The Health Partner administrator will then send the contract (provider agreement) electronically for review and signature.

SUPPORTING DOCUMENTATION CAN BE LOCATED by following this path, Providers, Tools & Resources, Forms. Then selecting the appropriate market/state and product, https://www.caresource.com/providers/tools-resources/forms/.

PLEASE NOTE IF CONTRACTING ONE OF THE FOLLOWING FACILITY TYPES, YOUR REQUEST WILL BE FORWARDED TO A HEALTH PARTNER CONTRACTING MANAGER FOR PROCESSING:

Dialysis Hospital (Acute, Behavioral or Critical Access) Hospice Rehabilitation Skilled Nursing Substance Use Disorder
The individual listed as the office contact on the Health Partner Contract Form will receive an email from an assigned Health Partner Contract Manager confirming receipt of the participation request. The Health Partner Contract Manager will inform the office contact if any supporting documentation or application clarifications are needed to create the contract.

3. Credentialing

Providers who wish to contract with CareSource must also be credentialed. Credentialing is utilized to monitor the qualifications and performance of physicians and other health care practitioners. Providers are credentialed a minimum of every three years and are considered to be recredentialed unless otherwise notified. For more detailed information on the credentialing process, please see the Provider Manual.

Providers that require credentialing are:

- Practitioners who are licensed, certified, or registered to practice independently (without direction or supervision). These provider types may include, but are not limited to: MD, DO, NP, PA, LISW, DC, PSYD, LMFT, LPCC, etc.

- Practitioners who have an independent relationship with CareSource. An independent relationship is defined when the organization directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as primary care practitioners. These provider types may include, but are not limited to: Family Medicine, Internal Medicine, and Pediatrics.

- Practitioners who provide care to members under CareSource medical benefits, such as Dentists, Oral Maxillofacial Surgeons, Optometrists, and Ophthalmologists.

- Some Facilities and Organizational providers who contract with CareSource. These provider types may include, but are not limited to: Hospitals, Home Health Agencies, Skilled Nursing Facilities, Ambulatory Surgery Centers, Urgent Care Facilities, etc.

- Providers who practice exclusively within the inpatient hospital setting and provide care for CareSource members only as a result of being directed to the hospital/facility do not need to be credentialed by CareSource **unless** otherwise noted. These provider types may include Hospitalists, Pathologists, Radiologists, Anesthesiologists, and Emergency Room Physicians.

Credentialing requirements and processes follow NCQA guidelines. CareSource credentials providers using guidelines from the state insurance boards and the National Committee for Quality Assurance (NCQA). State boards require that you submit, to CareSource, a complete Council for Affordable Quality Healthcare (CAQH) application or CAQH number, National Provider Identifier (NPI) number and an active Medicaid ID where applicable.

CareSource will notify providers when an incomplete network participation request is received. Notification of an incomplete network participation request will be sent to providers within five business days after receipt of the initial request. An incomplete network participation request is a request that CareSource cannot fully process because there is missing documentation or information needed to write a contract, etc. An incomplete network participation request also includes an unclean credentialing application that contains at least one error and must be returned to the provider for correction, with a description of the deficiency. If the error was on the CAQH application, CareSource will specify the item on the application resulting in its status as unclean.

Common credentialing barriers:

1. CareSource is unable to access your CAQH application. To grant CareSource authorization please follow these steps:
    a) Log onto CAQH https://www.caqh.org/ using your account information.
    b) Select the Authorization tab.
    c) Make sure CareSource is listed as an authorized plan. If not, check the "Authorized" box to add.
2. Omission of the following documents within the CAQH application:
    a) Drug Enforcement Administration (DEA) certificate
    b) Malpractice insurance fact sheet
    c) Clinical Laboratory Improvement Amendment (CLIA) certificate, if applicable
    d) Collaborative practice agreement, if applicable

3. Incomplete documents,
    a) All documents must be complete and current
4. Missing or Expired Documents,
    a) If there are missing or expired documents, you will be notified via letter with instructions to correct and submit the updated information.

5. Enrollment

Once the enrollment process is complete and your provider information has been added to the CareSource system and Provider Directory, a **Welcome Letter** will be generated within five business days. Your CareSource participating provider Welcome Letter will include important information such as:

- Participation Effective Date
- Enrolled Products
- CareSource Provider ID
- Additional Instructions for Claim Submissions
- Contact Information

Enrollment Status:

Providers can check their Enrollment Status by going to the below link and clicking "Check Enrollment Status." Next, enter a valid Application ID and NPI. Check the captcha checkbox and then click "Check Status" button. (see image 1)

https://providerportal.caresource.com/GL/User/Login.aspx

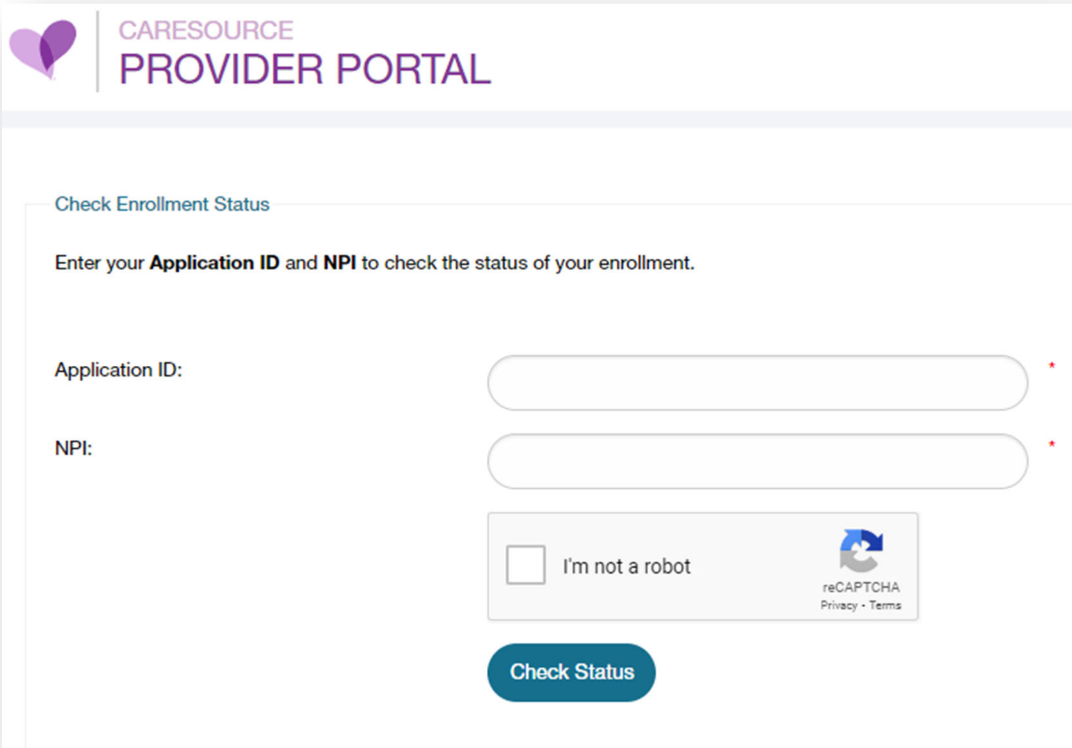


Image 1

Health Partner Contract Form

Completion Guide

Use the below guide to submit a complete and accurate Health Partner Contract Form.

Access the Health Partner Contract Form.

THIS FORM IS FOR NEW CONTRACT REQUESTS, ADDING NEW PRODUCTS, REMOVING A PRODUCT, AND TAX ID OR IRS NAME CHANGES.

ALL OTHER REQUESTS SUCH AS ADDING A PROVIDER(S) OR LOCATION NEED TO BE SUBMITTED ONLINE USING THE MAINTENANCE FORM LOCATED IN THE PROVIDER PORTAL AT:

Https://ProviderPortal.CareSource.com/GL/SelectPlan.aspx (REGISTRATION REQUIRED).

Form Maintenance

- All fields marked with an **(*)** must have a response.
- Using "**AutoFill**" on this form could cause previous information entered to be modified or erased and could create errors.

Form Sections

Request Type

This section identifies the application request type. Below the options are defined; use the boxes to select the appropriate request type.

Note: If you are requesting a new participation contract request type, then additional request types cannot be combined with the submission. Alternatively, selecting multiple items from the following add/remove a product, tax ID change or IRS name change is allowed.

- New Contract – Brand new contract request
- Add a New Product(s) – Adding an additional product(s) to a current contract/agreement
- Remove a Product(s) – Remove a product(s) from a current contract/agreement
- Tax ID Change – Current contract/agreement requires a new Tax ID
- IRS Name Change – Current contract/agreement requires a new IRS name

If selecting "Add/remove a product", change the IRS name or Tax ID. Not all of the following sections will apply to the application request.

Product

This section identifies the product(s) which will be included in the written agreement to establish participation. Please review the list and use the boxes to select the appropriate product(s) for your contract/provider agreement. At least one product must be selected to submit a request.

Submitter Information

Complete the following fields in the submitter section.

- First Name, Last Name
- Phone Number
- Email

Save Your Draft: Once the submitter information section is complete, you may save a request at any time by selecting "Save Draft" located at the bottom of the form. After selecting "Save Draft", you will receive an email with a link to access your partial application. (See image 2) (The reference ID can be used to identify the saved form in case there are problems with the link sent in the email. However, if the link does not work, please start a new application request.)

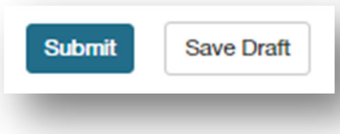


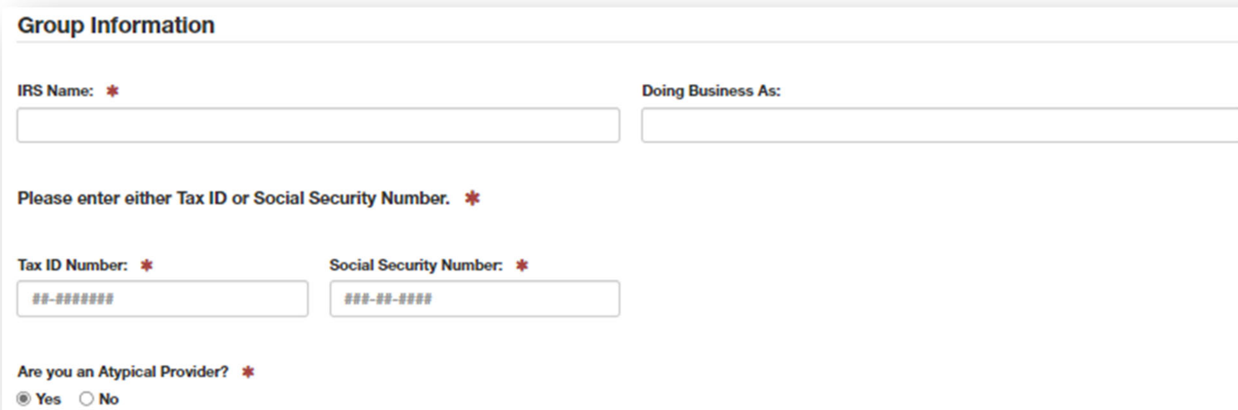
Image 2

Group Information

This section collects general information about the group and contract information. Please add all of the Group Medicaid IDs and Group NPIs to this section. For example, if there are Medicaid IDs for Supportive Living and Behavioral Health, please add both. Also, if providing services in counties with no physical office address, please “Add” those counties.

Complete the following fields in the Group Information section.

- Your IRS Name and Doing Business As (DBA) are the business name(s) listed on your W9, please use the W9 to complete accurately.
- Either a Tax ID or Social Security Number (SSN) are required. If entering a Tax ID, the SSN field is not required.
- Are you an atypical provider? An atypical provider is a provider that may bill a health plan for services as a part of medical assistance program, but the services are non-healthcare related. Atypical providers do not meet the criteria for National Provider Identification (NPI) (also known as “Rendering Provider”). Select “Yes” or “No”. If you select “Yes”, then a group NPI is not required.


Group Information

IRS Name: *

Doing Business As:

Please enter either Tax ID or Social Security Number. *

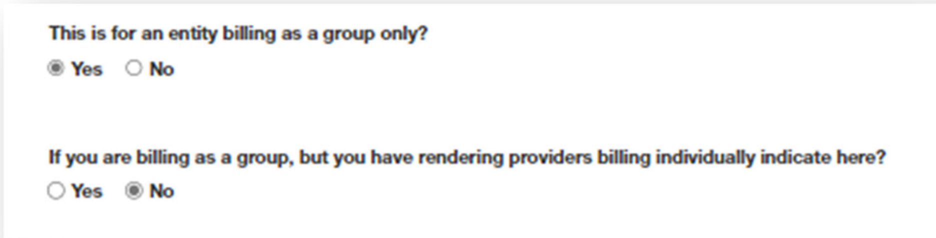
Tax ID Number: * ##-#######

Social Security Number: * ###-##-####

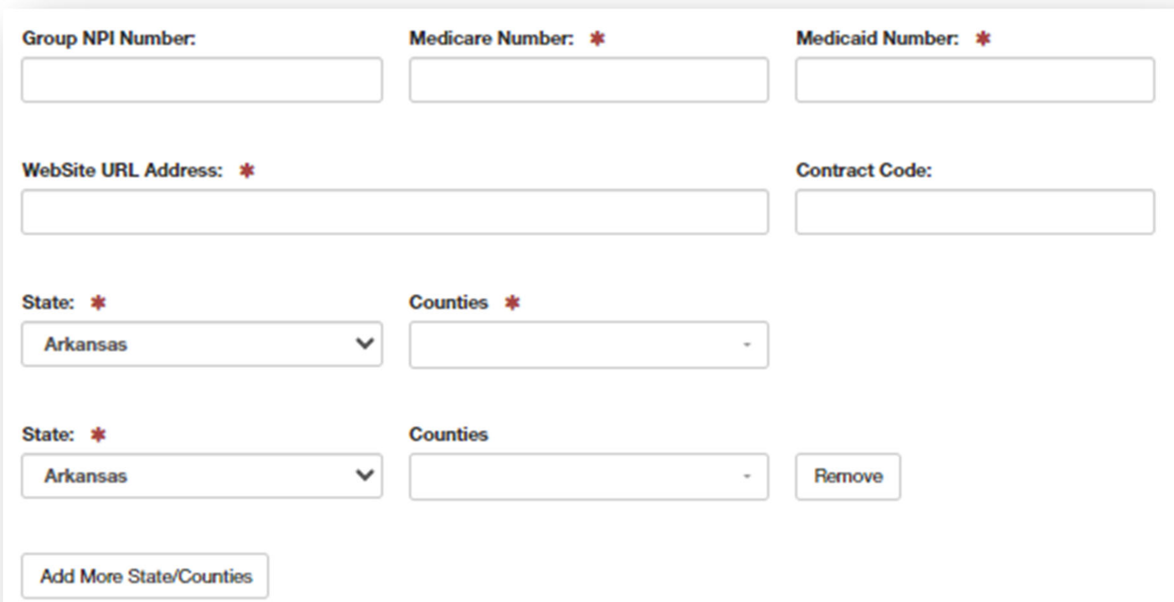
Are you an Atypical Provider? *

Yes No

- Group Billing –
  - This is for an entity billing as a group only? (Yes/No) Answer “Yes” if this application request is for an entity billing as a group only.
    (Defined: The services/items that are provided by your organization are billed via the group and the individual providing them does not bill separately, i.e. DME, Lab, Ambulance etc.)
  - If you are billing as a group, but you have rendering provider(s) billing for individually indicate here? (Yes/No)



- Group NPI – Please add all of your Group Medicaid ID(s) and Groups NPI(s) to this section. For example, if you have a Medicaid ID for Supportive Living and Behavioral Health, please add both.
- Medicare Number
- Medicaid Number
- Website URL – Enter your group's website URL.
- Contract Code – Only if provided by CareSource. For example, if you are a Waiver Provider, please enter "Waiver" in this field.
- State
- County/Counties – If providing services in counties with no physical office address, please "Add" those counties using the "Counties" drop-down menu.
- + Add more State/Counties – Use to add additional servicing states/counties

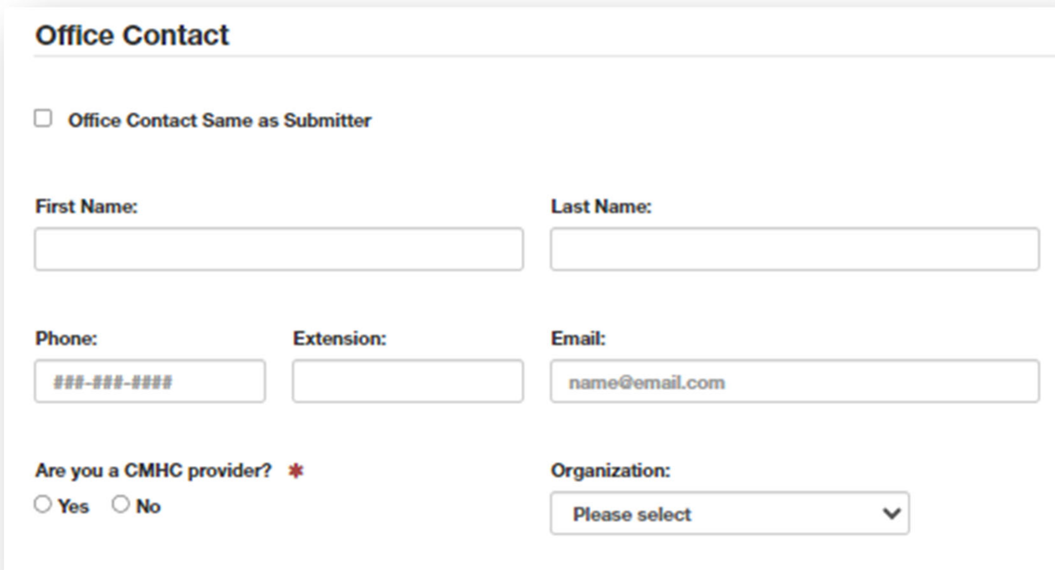


Office Contact

This section collects the required contact information for the individual that will be the main point of contact for the contract for this provider's office. **Note**: Optional selection, use "Office Contact Same as Submitter" to copy submitter contact info into the appropriate fields.

Complete the following fields in the Office Contact section.

- First and Last Name
- Phone and email
- Are you a CMHC provider? (Yes/No)
- Organization – Select an organization type from the drop-down menu, if you do not see the proper organization type you may select "Other."

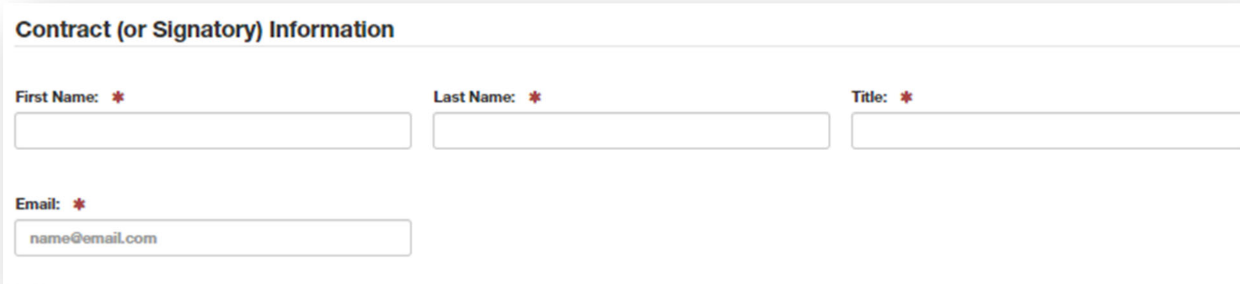


Contract Signatory

This section will identify the person in the organization who is authorized to and will sign the contract/provider agreement.

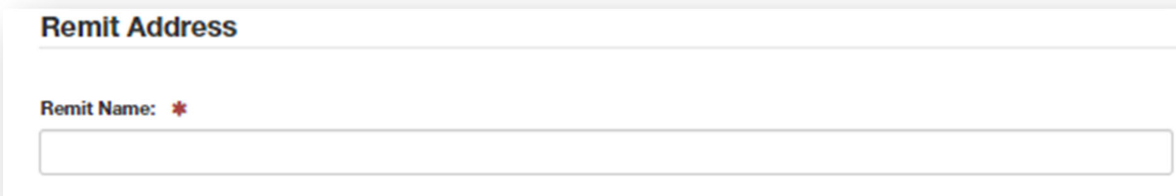
Complete the following in the Contract (or Signatory) Information Section.

- First and Last Name
- Title
- Email (the contract will be sent via email for electronic signature)

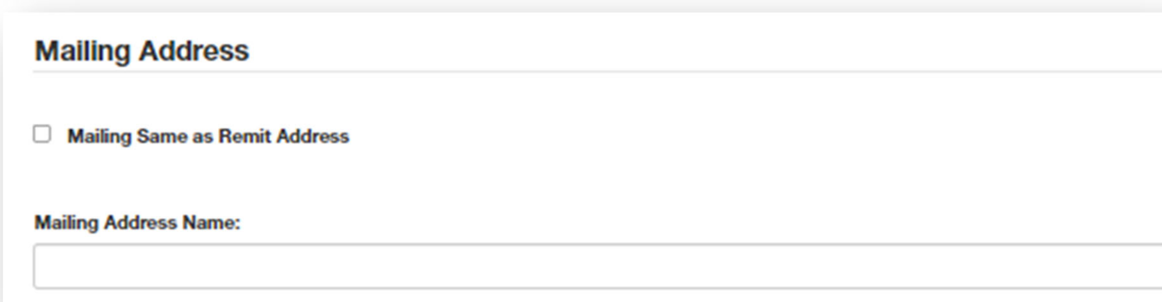


Addresses
This section will reflect the unique addresses required for the application form.

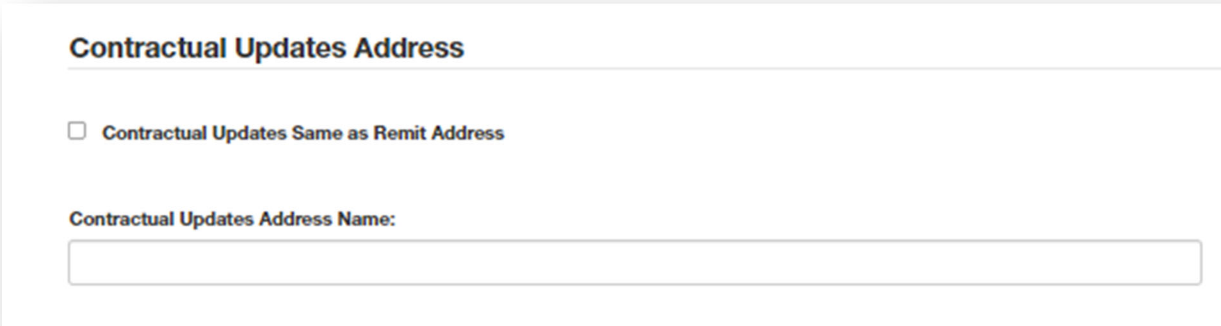
Remit Address
Used for any payments or invoices that need to be sent.



Mailing Address
Used for all mailed correspondence. Use the check box if the mailing address matches the remit address.



Contract Address
Used in the event a contract or related contract information is required to be mailed. Use the check box if the mailing address matches the remit address.

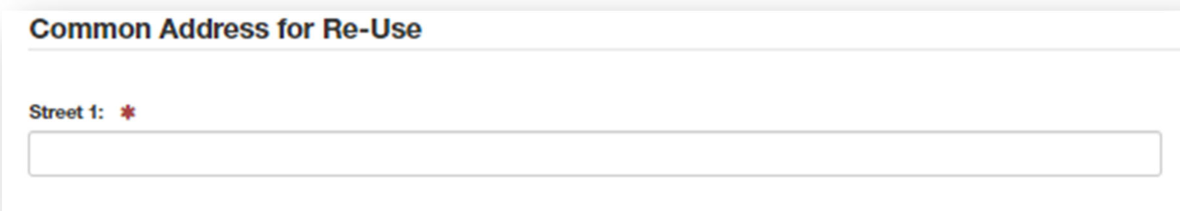


Common Address for Re-Use

This section will be used to populate the “Provider Location Details” within the “Add Provider/Locations” section of the application form. This is reviewed in the next section of this guide.

Complete the appropriate fields that reflect the main address in which the provider delivers services or care.

Additional addresses can be added if additional providers are added to the application form in the “Add Provider/Locations” section.



Add Providers/Locations

This section allows entry of any number of health partner records that will be associated with the application submission.

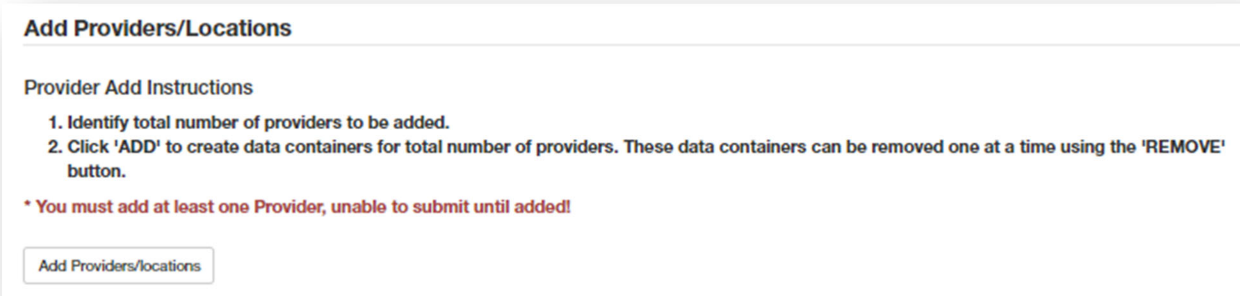
For the final submission, **at least one provider** will be required.

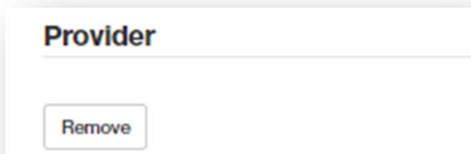
Enter as many providers as needed. A Provider Roster can also be attached within the “Attach Required Documentation” section located at the end of the application form. To access the Provider Roster template, visit roster template link.

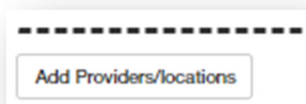
Use the “Add Provider/Location” button to access the first set of provider data to be included in the application form. You may use this button as many times as necessary until you have added all providers, however it is recommended to use the “Provider Roster” template mentioned above if you need to exceed five provider records.

Use the “Remove” button to remove provider records that are not needed (accidently added).

There is also an “Add Providers/Locations” button at the bottom of the “Provider Information” section.



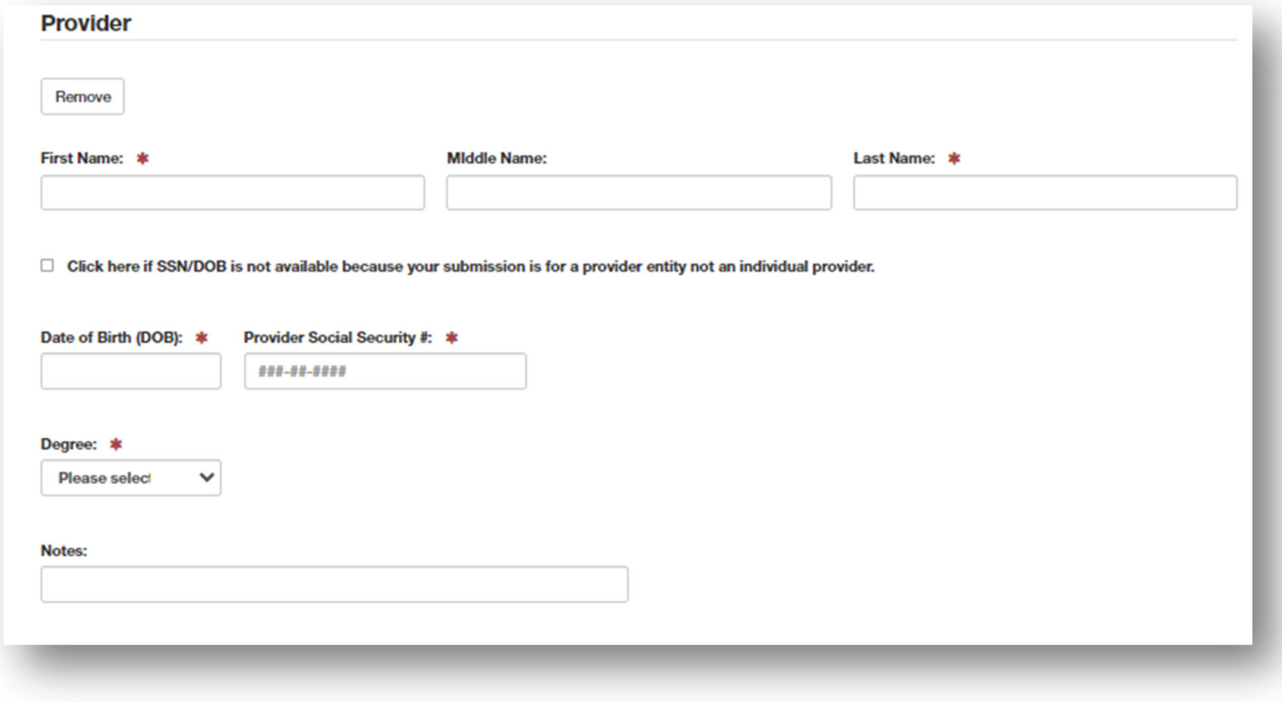




Provider

Complete the following in the Provider section.

- First and Last Name
- Date of Birth
- Social Security Number (SSN)
    - If an SSN is not available, check the box indicated.
- Degree
- Option to add notes

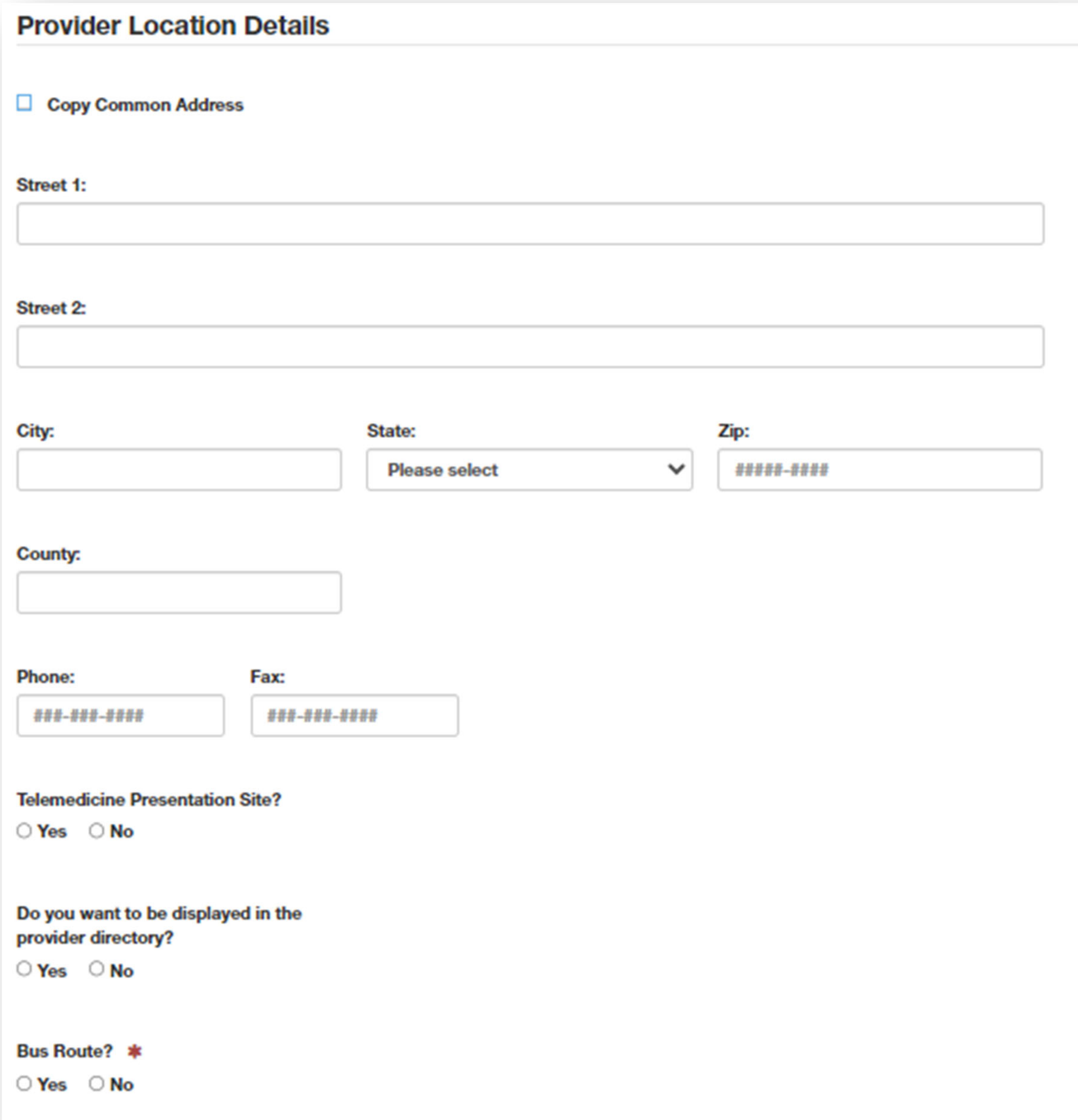


Provider Location Details

Enter the specific location details for the provider. If using the common address from the above “Common Address” section, keep the box checked. If the address is different than the “Common Address,” then uncheck the box and complete the address detail fields.

Complete the following in the “Provider Location Details” section.

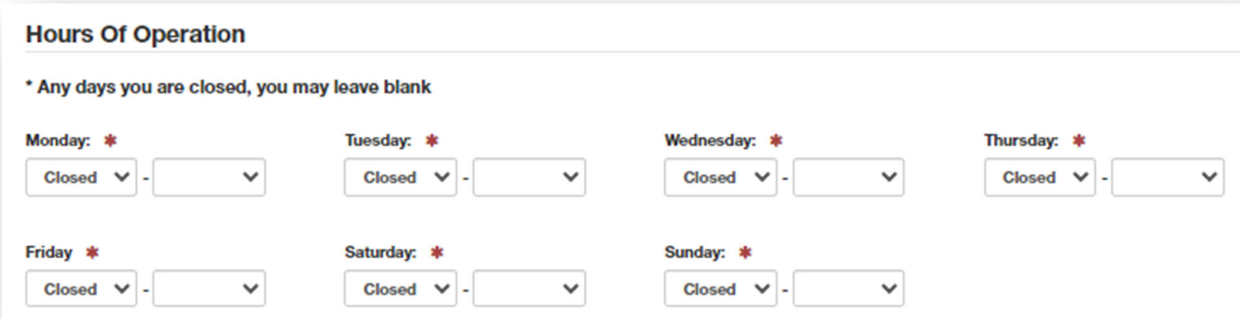
- Address fields
- County
- Phone/Fax
- Telemedicine Presentation Site
- Do you want to be displayed in the provider directory? (Yes/No)
- Bus Route? (Yes/No) – Is this location located reasonably close to a bus stop?



Hours of Operation

Complete the hours of operation for the corresponding address for this provider record.

Change “Closed” drop-down menus to indicate the opening/start time for each day, Monday through Sunday. The second field indicates the end of business date/time or closing time for each day. If the office location is closed for the entire day, then leave the “Closed” indicator on the start time and leave the end of business time blank.



Provider Details

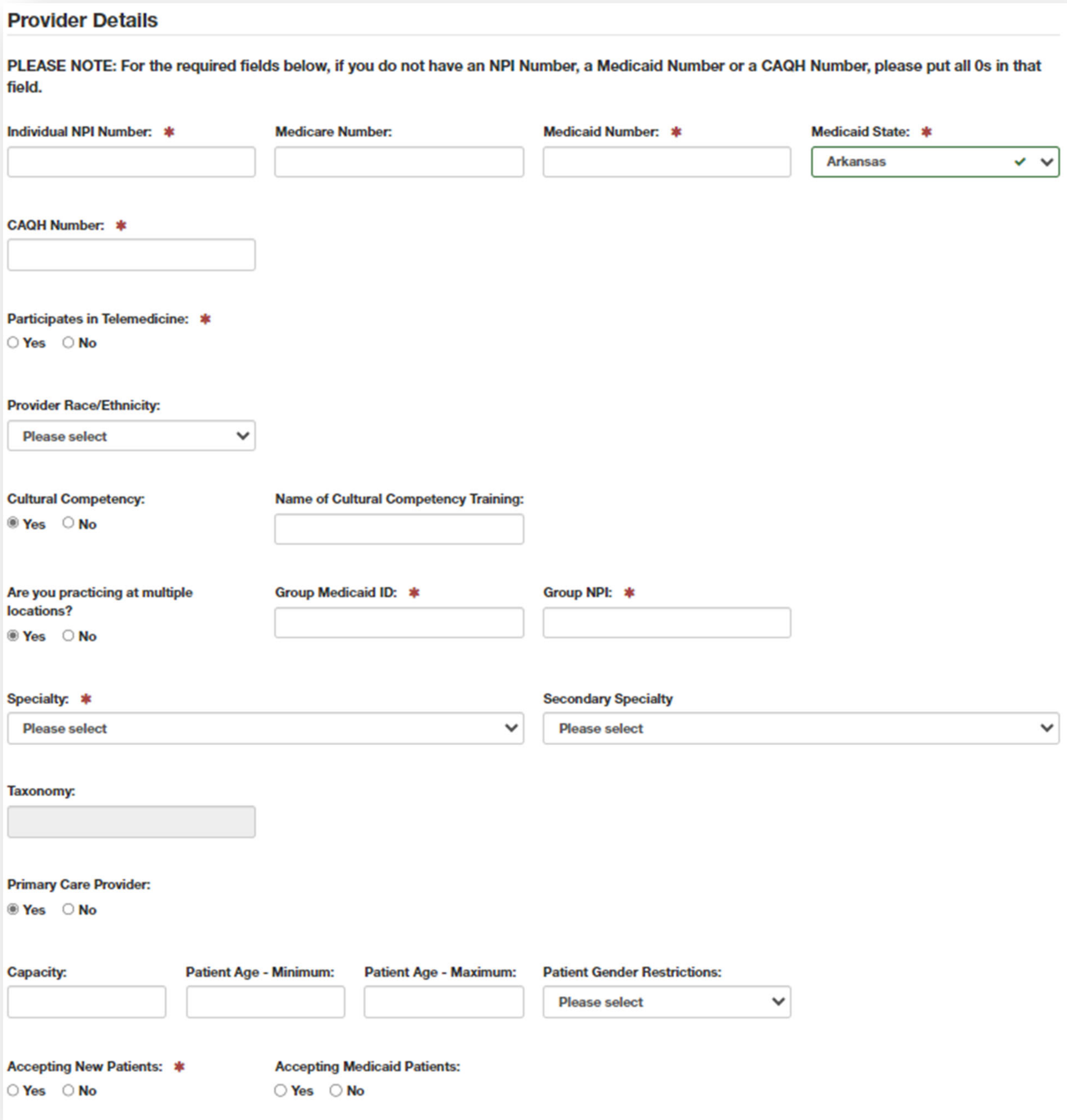
This section allows for the capture of specific provider details.

If the provider does not have an NPI, Medicaid number or CAQH number, please use zeros to fill in the field.

CAQH – In most cases a CAQH number is required to complete credentialing. A few exceptions would include atypical providers or rendering providers. Reference the "Common Credentialing Barriers" section of this document for details about obtaining a CAQH number.

Complete the provider's current information.

- Individual NPI Number
- Medicare Number
- Medicaid Number
- Medicaid State
- CAQH Number
- Participates in Telemedicine – Specific to this location
- Provider Race/Ethnicity
- Cultural Competency (Yes/No), Name of Training completed
- Are you practicing in multiple locations? (Yes/No), Group Medicaid ID, Group NPI
- Specialty, Secondary Specialty
- Taxonomy
- Primary Care Provider (Yes/No)
- Patient Details, Capacity, Patient Ages, Patient Gender Restrictions
- Accepting New Patients (Yes/No)
- Accepting Medicaid Patients (Yes/No)



Provider Details

PLEASE NOTE: For the required fields below, if you do not have an NPI Number, a Medicaid Number or a CAQH Number, please put all 0s in that field.

Individual NPI Number: *

Medicare Number:

Medicaid Number: *

Medicaid State: * Arkansas

CAQH Number: *

Participates in Telemedicine: *
Yes No

Provider Race/Ethnicity:
Please select

Cultural Competency:
Yes No

Name of Cultural Competency Training:

Are you practicing at multiple locations?
Yes No

Group Medicaid ID: *

Group NPI: *

Specialty: *
Please select

Secondary Specialty
Please select

Taxonomy:

Primary Care Provider:
Yes No

Capacity:

Patient Age - Minimum:

Patient Age - Maximum:

Patient Gender Restrictions:
Please select

Accepting New Patients: *
Yes No

Accepting Medicaid Patients:
Yes No

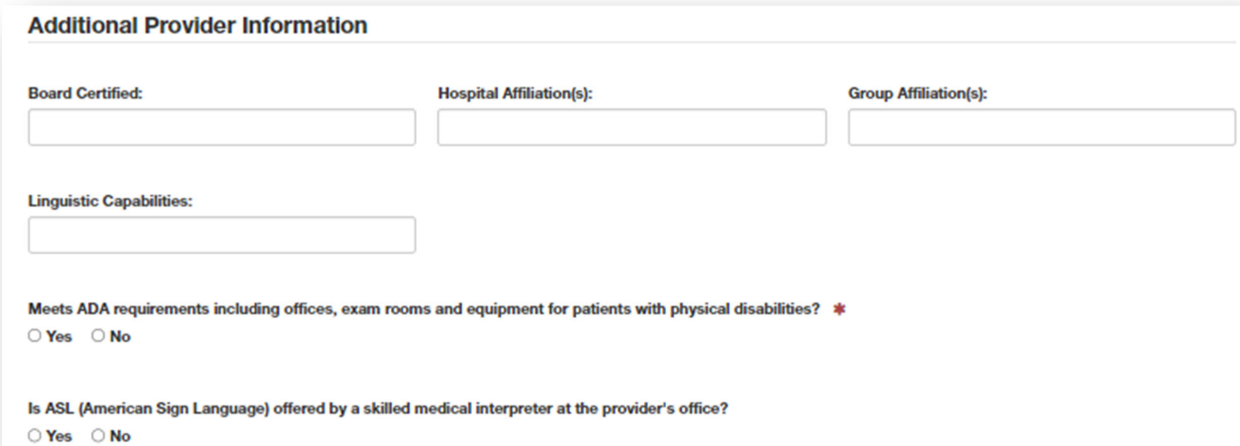
Additional Provider Information

This section allows for the capture of additional provider details.

Complete the provider’s current information.

- Board Certified
- Hospital Affiliations

- Group Affiliations
- Linguistic Capabilities/Languages Spoken
- Meets ASA requirements including offices, exam rooms, and equipment, for patients with physical disabilities?
- Is American Sign Language (ASL) offered by a skilled medical interpreter at the provider's office?



Additional Provider Information

Board Certified:

Hospital Affiliation(s):

Group Affiliation(s):

Linguistic Capabilities:

Meets ADA requirements including offices, exam rooms and equipment for patients with physical disabilities? *

○ Yes ○ No

Is ASL (American Sign Language) offered by a skilled medical interpreter at the provider's office?

○ Yes ○ No

Disclosure of Ownership, Debarment and Criminal Convictions

1. Before CareSource enters or renews an agreement with your practice or corporate entity, you must disclose any debarment, proposed for debarment, suspension or declared ineligible status related to federal programs of yourself and your managing employees and anyone with an ownership or controlling interest in your practice or corporate entity.
2. You must also notify CareSource of any federal or state government current or pending legal actions, criminal or civil, convictions, administrative actions, investigations or matters subject to arbitration.
3. In addition, if the ownership or controlling interest of your practice or corporate entity changes, you have an obligation to notify us immediately. This also includes ownership and controlling interest by a spouse, parent, child, or sibling.
4. If you have ownership of a related medical entity where there are significant financial transactions, you may be required to provide information on your business dealings upon request.
5. If you fail to provide this information, we are prohibited from doing business with you. Please refer to the Code of Federal Regulations 42 CFR 455.100-106 for more information and definitions of relevant terms.
6. To obtain a copy of the Debarment Form, please download and fill out the form here, and attach it below.

You can download the roster template here. Please attach to "Attach NOW – Roster" at the end of the submission request.

Attach Required Documentation

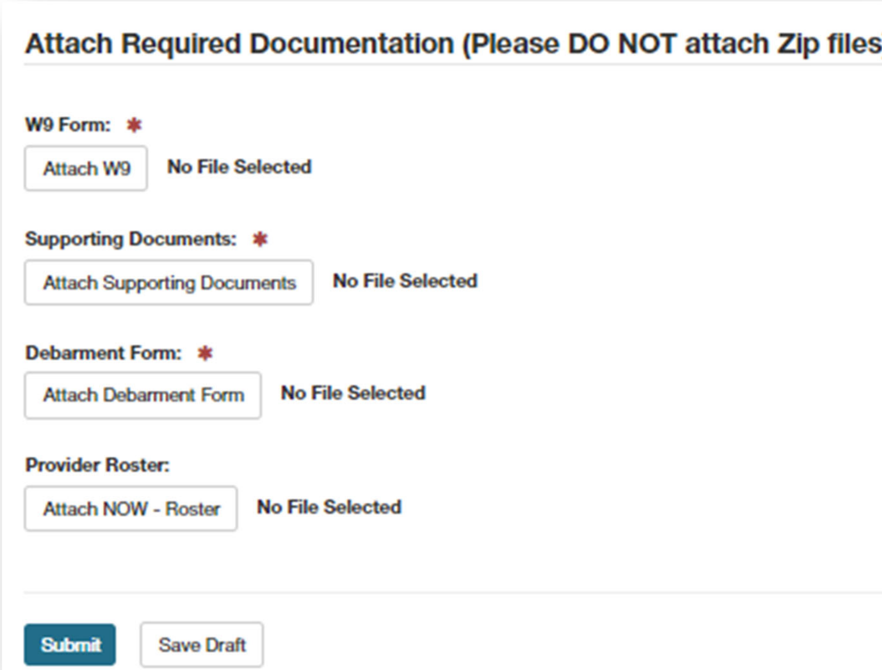
This section documents will be added. Required documents will be indicated with an **(*)**.

Links are included below to connect you to the template forms required for the application submission.

Please do not upload/attach any zip files to the submission.

- W9 – IRS form that identifies a organizations name and TIN.
- Supporting Documents
- Provider Roster – Excel document that is inclusive of all provider details and allows for easier submission of larger quantities if provider records.

State	Line of Business	Additional Forms Required	Links
Indiana	Medicaid	Roster *(For rendering providers only)*	www.caresource.com.xlsx (live.com) Only needed when required, see the following instructions, LINK
Ohio	Medicaid	Specialty Attestation Form	https://dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM10234Fillx.pdf www.caresource.com.xlsx (live.com)
Arkansas	PASSE	Attestation Form	https://www.caresource.com/documents/ar-provider-attestation-form.pdf
Arkansas	PASSE	CCVS	https://www.caresource.com/documents/ar-ccvs-provider-auth-release-form.pdf
Roster Template LINK			



Submission

Click **Submit** to fully submit the application form.

A pop-up dialogue box will be shown with the following information:

> *"Success! Your submission is on its way. You will receive an email confirmation shortly.*
>
> *Application Number: (unique to each submission)*
>
> *Click here to submit an additional application."*

Email:

Following a successful submission, the submitter will receive an email with an application number and a summary of products requested.

For information on checking the status of application request, see the "Enrollment Status" section of this guide.

Contact Us

Support and general questions can be addressed by contacting Provider Services or Market Contact(s). Please follow this link to obtain the contact information.

NV-MED-P-4304845