ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION

ARKANSAS, GEORGIA, INDIANA, KENTUCKY,WEST VIRGINIA ONLY

INSTRUCTIONS

For this application to be considered complete:

1. All information must be legible (please print or type); application must be completed in its entirety, signed, and dated
2. If more space is needed, please attach additional sheets and reference the question being answered.
3. Current copies of all documents applicable to your organization MUST be submitted with the application:

- State License (current)
- Liability Insurance (current)
- Medicare Certificate (if applicable)
- CLIA Certificate/Waiver (if applicable for each location)
- Accreditation Certificate (if applicable)
- W-9
- CMS or State Site Visit/Survey (if not accredited)
- Indiana Department of Health Accreditation Certificate with Site Survey
- Drug Enforcement Agency (DEA) #

If organization is not accredited or no (Centers for Medicare and Medicaid Services (CMS) site survey, please also include a copy of the following: (does not apply to HCBS/Waiver)

- C.V. of Medical or Clinical Director
- Credentialing Plan for Clinical Staff
- QI Plan (current)
- Patient Satisfaction Survey Results (current)
- Confidentiality Plan to Include Medical Record Handling
- Copy of Medicaid Certification Letter

PROVIDER INFORMATION

LEGAL NAME: _____

DBA (if applicable): _____

PROVIDER TYPE:

☐ Ambulatory Surgical Ctr. (ASC)/Office Based Surgery*
☐ Birthing Center
☐ Community Mental Health Center (CMHC/SUD)
☐ Dialysis/End State Renal
☐ Health Departments (Local or Rural)
☐ Home Health
☐ Infusion Hospice
☐ Hospital
☐ Opioid Treatment Program (OTP)
☐ Orthotic Suppliers
☐ Pathology Laboratory
☐ Rehabilitation Facility
☐ Skilled Nursing Facility
☐ Urgent Care Center (Stand Alone) *

☐ Other_____

***If you are an ASC or Urgent Care center please complete section below:**

Medical or Clinical Director Name: _____

Medical Director National Provider Identifier (NPI):_____Medical Director CAQH number:_____

Describe scope/type of services offered (please attach additional sheet if necessary)**:**_____

CERTIFICATION/ACCREDITATION

ACCREDITATION TYPE:

☐ Accreditation Association for Ambulatory Health (AAAHC)
☐ Accreditation Commission for Health Care (ACHC)
☐ American Association for Accreditation of Ambulatory Surgery (AAAASF)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ Community Health Accreditation Program (CHAP)
☐ Health Care Finance Administration (HCFA)
☐ National Committee for Quality Assurance (NCQA)
☐ Indiana Department of Health (IDOH)
☐ Det Norske Veritas Healthcare (DNV/GL)
☐ Healthcare Facilities Accreditation Program (HFAP)
☐ Indiana Department of Mental Health Addiction (IN DMHA)
☐ Joint Commission on Accreditation of Healthcare Organization (JCAHO)
☐ National Dialysis Accreditation Commission (NDAC)
☐ Ohio Mental Health Addiction Services (OHMHAS)

☐ Other:

_____

PROVIDER PRACTICE AND BILLING INFORMATION

Primary Office/Practice Location:

Contact Person: _____

Address: _____City: _____State: _____Zip: _____

Phone Number: (___)_____ Fax Number: (___)_____E-mail address:_____

Tax ID: _____ NPI #: _____ (10 digits) Taxonomy#: _____

Medicaid #: _____ Medicare #: _____

State License #:_____ CLIA # (if applicable): _____

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

INCLUDE IN THE PROVIDER DIRECTORY YES ☐ NO ☐ *(check one)*

Secondary Office/Practice Location:

Contact Person: _____

Address: _____City: _____State: _____Zip: _____

Phone Number: (___)_____ Fax Number: (___)_____E-mail address:_____

Tax ID: _____ NPI #: _____ (10 digits) Taxonomy #: _____

Medicaid #: _____ Medicare #: _____

State License #:_____ CLIA # (if applicable): _____

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

INCLUDE IN THE PROVIDER DIRECTORY YES ☐ NO ☐ *(check one)*

Please attach separate sheet if you have additional locations. Please ensure you include the location specific information for each as well (i.e., TIN, NPI, Taxonomy,CLIA, Medicaid/Medicare #'s, Accessibility Information and State License).

Credentialing Information:

Contact Person: _____

Address: _____City: _____State: _____Zip: _____

Phone Number: (___)_____ Fax Number: (___)_____E-mail Address: _____

Provider Billing Information:

Contact Person: _____

Address: _____City: _____State: _____Zip: _____

Phone Number: (___)_____ Fax Number: (___)_____E-mail Address: _____

Provider Mailing Information:

Contact Person: _____

Address: _____City: _____State: _____Zip: _____

Phone Number: (___)_____ Fax Number: (___)_____E-mail Address: _____

GENERAL/PROFESSIONAL LIABILITY

Liability Carrier: _____ Policy Number: _____

Expiration Date: _____ Coverage Limits: _____ / _____
Occurrence *Aggregate*

DISCLOSURE QUESTIONS

1. Has your organization's license ever been restricted, conditioned, suspended, or terminated? Yes☐ No☐
2. Is your organization currently or has been in the last five years under investigation by any government entity or peer review? Yes☐ No☐
3. In the most recent 12 months has your organization lost its licensure/certification/accreditation? Yes☐ No☐
4. Does your organization have any current State or Federal actions or limits including Medicare, Medicaid, or any other medical reimbursement plan ever voluntarily or involuntarily suspended, limited, revoked, denied, not renewed, or terminated your participation for reasons related to professional competence or conduct? Yes☐ No☐
5. Have you ever been or are you currently excluded from participation with Medicare or any other federally funded health care program? Yes☐ No☐
6. Has your professional liability coverage ever been restricted, limited, denied, not renewed, or special rated (for reasons other than the carrier's termination of operations in your state)? Yes☐ No☐
7. Have you ever been disciplined for a violation of ethical standards by a professional organization? Yes☐ No☐
8. In the past five years, have there been any professional liability suits, or are there currently any pending or threatened suits against the provider, or have any judgements been made or settlements pain on its behalf? Yes☐ No☐
9. To your knowledge has information pertaining to you ever been reported to the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank? Yes☐ No☐

If you answered "Yes" to any of the above questions, please provide a written explanation and attach to application.

ACCESSIBILITY INFORMATION

1. Does the site offer accessible accommodations for the following:
   - Building Yes ☐ No ☐
   - Parking Yes ☐ No ☐
   - Restroom Yes ☐ No ☐
   - Other: _____

2. Does this site offer other services for people with disabilities?
   - Text Telephony (TTY) Yes ☐ No ☐
   - American Sign Language Yes ☐ No ☐
   - Mental/Physical Impairment Services Yes ☐ No ☐
   - Other: _____

3. Is this site accessible by public transportation?
   - Bus Yes ☐ No ☐
   - Subway Yes ☐ No ☐
   - Regional Train Yes ☐ No ☐
   - Other: _____

RENDERING PROVIDER ATTESTATION

Does your organization have rendering providers not required to enroll with IHCP? Yes ☐ No ☐

If you answered yes complete below with provider information: ***(Please attach separate sheet if you have additional providers).***

First Name	Last Name	Rendering Address	City	State	Zip	County	Taxonomy Code

Authorization, Attestation and Release

I am the authorized agent of the Applicant named below and have the authority to execute this document on behalf of the Applicant. I understand that as part of the credentialing application process to participate as a Provider (hereinafter, referred to as "Participation") with CareSource, all Applicants are required to provide sufficient and accurate information for the proper evaluation of all criteria used by CareSource for determining initial and ongoing eligibility for Participation. I acknowledge and understand that my cooperation in obtaining information in connection with this application and my consent to the release of information does not guarantee that CareSource will contract with the Applicant as a provider of services.

Authorization of Investigation Concerning Application for Participation.
The following individuals including, without limitation, CareSource, its representatives, employees, and/or designated agent(s); CareSource's affiliated entities and their representatives, employees, and/or designated agents; and CareSource's designated professional credentials verification organization (collectively referred to as "Agents"), are hereby authorized to investigate information, which includes both oral and written statements, records, and documents, concerning this application for Participation. The Applicant agrees to allow CareSource 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.
The Applicant hereby authorizes 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 CareSource and/or its Agent(s), information, including otherwise privileged or confidential information, concerning the qualifications of this Applicant, its credentials, accreditations, quality assurance and utilization data, or any other information reasonably having a bearing on the Applicant's qualifications for Participation with CareSource. This information shall also include the details of any action taken by a health care organization, Medicare or Medicaid, their administrators or their medical or other committees to revoke, deny, suspend, restrict, or condition the Applicant's Participation, impose a corrective action plan, or terminate any contract to which the Applicant was a party. The Applicant further authorizes its current and past insurance carrier(s) to release this Applicant's history of claims that have been made and/or are currently pending against it. The Applicant specifically waives written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release from Liability.
The Applicant hereby releases from all liability and holds harmless CareSource, 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 CareSource, 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. The Applicant further agrees 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 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 credentialing activities.

In this Authorization, Attestation and Release, all references to CareSource, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. CareSource and its affiliates or agents retain 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

The Applicant understands and agrees that this Authorization, Attestation and Release is irrevocable for any period during which the entity identified below is an Applicant or a Provider with CareSource. The Applicant agrees that it shall execute another form of consent if any law or regulation limits the application of this irrevocable authorization. The Applicant understands that its failure to promptly provide another form of consent may be grounds for termination or discipline by CareSource in accordance with the applicable bylaws, rules, and regulations, and requirements of CareSource, or grounds for its termination of Participation with CareSource.

The undersigned certifies that all information provided in its application is current, true, correct, accurate and complete to the best of his/her knowledge and belief and is furnished in good faith. The Applicant will notify CareSource and/or its Agent(s) within ten (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.) that has been provided in its application and /or is authorized to be released pursuant to the credentialing process. The Applicant understands 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 an authorized agent of the Applicant (may be a written or an electronic signature). The Applicant acknowledges that it is responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. The Applicant understands and agrees 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 CareSource and/or its Agent(s).

The undersigned acknowledges that he/she has read and understands the foregoing Authorization, Attestation and Release. A facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Print Name of Person Completing Application: _____

Title: _____

Signature: _____ Date: _____