Documents Required in Support of Credentialing Application

Please submit the following information with your application:

- A copy of your current accreditation certificate
- If not accredited a copy of your most recent CMS review
- A copy of your current general liability malpractice insurance face sheet, which must include current coverage dates, facility name, and limits of coverage. Minimum coverage $1 million occurrence/$3 million aggregate.

In addition, the following information is also needed:

If you are a **Hospital, Ambulatory Surgical Center, Birthing Center, Skilled Nursing Facility, Home Health, Hospice, or Private Duty Nursing** provider please also submit the following:

- A current copy of the Division of Health Service Regulation License
- A copy of the policy and procedure for coverage arrangements with a participating provider and hospital, in the event of an emergency situation (Birthing Centers Only).

If you are a **Home Infusion** provider please also submit the following:

- A current copy of the Division of Health Service Regulation License and Board of Pharmacy Permit-Infusion Services Permit.

If you are **Home Durable Medical Equipment, Durable Medical Equipment (Diabetic Supplies Only), Durable Medical Equipment (Equipment Only), Orthotics & Prosthetics, or Cardiac Event Monitoring Equipment** provider please also submit the following:

- A current copy of the Division of Health Service Regulation License or Board of Pharmacy Permit-Devise Dispensing Permit or Board of Pharmacy Permit-Devise and Medical Equipment Permit. (if applicable)

If you are a **Dialysis Facility** please also submit the following:

- A current copy of the CLIA certification or registration (Clinical Laboratory Improvement Amendments) and/or ACR (American College of Radiology).
- A copy of the current Utilization Management Program.
- A copy of the current Quality Management (Quality Assurance) Program.
- A copy of the current Infection Control Plan to include infection rates and transfers from the Dialysis Center(s) to Acute Care Centers.
- A copy of all current services provided at the facility.
- A current copy of the Division of Facility Services/ ESRD Facility Survey Report.

- A copy of the facility's one year of quarterly reporting of quality outcomes data for the following K/Dialysis Outcome Quality Initiative Indicators (K/DOQI):

  *Urea Reduction Ration (URR)
  *Urea Kinetic Modeling (Kt/V)
  *Hemoglobin
  *Hematocrit
  *Albumin

PROVIDER APPLICATION FOR PARTICIPATION

Complete a separate application for:

- Each site location
- Each organization with a unique Federal Tax ID Number

W9 Information
The following list shows which type of identification number you should provide depending on your type of organization:

TYPE OF ORGANIZATION	TYPE OF I.D. NUMBER
Corporation	Federal I.D. Number
Partnership	Federal I.D. Number
Sole Proprietorship	Social Security Number
Individual	Social Security Number

If you are an individual or sole proprietor, your own name is to be reported on the first line of the form, NOT a business or trade name. Please complete a W-9 form for each different taxpayer identification number. In addition, if your organization is a corporation or partnership, please submit a copy of your Employer Identification Number Notification (Form Letter 147C) from the IRS for each different employer identification number. If you have any questions regarding this form, you may call 1-800-829-1040.Your timely response will allow us to comply with IRS regulations and prevent your application from being delayed.

Please Note:

- ***The legal name must be the same on all supporting documents.***
- ***Printed or typed, leaving no blank spaces*.**

1. PROVIDER INFORMATION ☐ **Initial Request** ☐ **Recredentialing**

Is this application for the addition of a new site to your current contract?
☐ **Yes** ☐ **No**

Please complete the following information for the location being credentialed or contracted.

Legal Name:
____

d/b/a Name:____

Phone Number: (___) _____________ Facsimile Number (____) _______________

Street Address:

____

(No PO Box addresses) **Street Address**

____

City State Zip County

Counties Served by this address:

____

(I*f additional space is needed please add a separate page*)

Credentialing Contact Name:

____

Title:

____

Phone Number:

____

Email:

____

Remittance Address: (*if different*):

____

(Street or PO Box)

____

City State Zip County

Phone Number: (___) ____________ Facsimile Number (____) ______________

Does your organization submit claims electronically? ☐ Yes ☐ No

A. Federal Tax Identification Number: ___________________________________
(Please provide your W-9)

B. Provider Number(s)

Please list all existing Provider numbers with Carriers associated with this Tax ID number

____

____

Please list National Provider Identifier (NPI) number

____

(Required)

C. Accreditation ☐ Yes ☐ No

If yes, please indicate which Accreditation body you are affiliated:

____

____

Effective Date________________ **Expiration Date**_______________

D. Medicare Certified ☐ Yes ☐ No

If you have checked "YES", please provide your certification number.

Medicare No._______________ **Medicare No.**_______________
Part A Part B

If you have checked "No", please provide an explanation why you are not Medicare certified:

____

____

E. Medicaid Certified ☐ Yes ☐ No

If you have checked "YES", please provide your certification number.

Medicaid No._____________________

If you have checked "No", please provide an explanation why you are not Medicaid certified:

____

____

F. Change in Name/Ownership:

If your organization has changed names and/or ownership in the last 3 years, please provide the organization's previous names and addresses under which credentialing/recredentialing was processed.

____

____

____

G. Other Information

If you are not currently accredited, and you have answered "YES" to any question below, please attach an explanation, including the specific details of each incidence.

- **Number of cases less than $200,000**
- **If greater than $200,000 actual or anticipated, include the occurrence date, settlement date, and nature of case.**

A. Has your organization's license to practice ever been limited, suspended or revoked?

☐ Yes ☐ No

B. Has your organization ever been sanctioned, expelled or suspended from receiving payment under the Medicare or Medicaid programs?

☐ Yes ☐ No

C. Has your organization been named in any malpractice actions in the last 5 years?

☐ Yes ☐ No

2. PROVIDER TYPE *Please indicate services for which you are applying.*

☐ **Home Health Agency**

- ☐ Skilled Nursing Visits
- ☐ Home Health Aide
- ☐ Speech Therapy
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Medical Social Services

☐ **Home Infusion Therapy (HIT) Agency**

☐ **Home Durable Medical Equipment Company**

☐ **HDME (Cardiac Event Monitoring Equipment Only)**

☐ **HDME (Diabetic Supplies Only)**

☐ **HDME (Orthotics and Prosthetics)**

☐ **HDME (Breast Prosthesis Only)**

☐ **Dialysis Facility**

☐ **Ambulatory Surgery Center**

☐ **Hospital**

Please indicate with a "YES" or "NO" if you provide the following In Patient Services:

- ☐ **Yes** ☐ **No Licensed Hospital Beds/ Number _______**
- ☐ **Yes** ☐ **No Substance Abuse Services**
- ☐ **Yes** ☐ **No Mental Health Services**
- ☐ **Yes** ☐ **No OB/GYN Services**
- ☐ **Yes** ☐ **No Pediatrics**
- ☐ **Yes** ☐ **No Physical Rehabilitation**

☐ **Birthing Center**

☐ **Private Duty Nursing Agency**

☐ R.N.
☐ L.P.N.

☐ **Hospice Agency**
Please check type of care:

☐ Inpatient Beds, No. of Beds _____
☐ Resident/Respite Beds, No. of Beds _____

☐ **Residential Treatment Facility**

☐ **Intensive Outpatient Facility**

☐ **Skilled Nursing Facility and/or Hospital with Skilled Nursing Beds**

Are you qualified and enrolled with the National Supplier Clearinghouse (NSC) as a:

Medicare Certified DMEPOS supplier? ☐ ***Yes*** ☐ ***No***
If yes, please enclose a copy of your Supplier Letter (approval letter) received from the NSC?

☐ **Free Standing Radiology Facility**

☐ **Specialty Pharmacy**

☐ Provide **all** Medicare Part B drugs (oral & infused)
☐ Provide these drugs directly to physicians
☐ Provide these drugs directly to Members

☐ **Reference Laboratory**

☐ **Cardiac Event Monitoring**

☐ **Ambulance**

☐ **Independent Diagnostic Testing Facility**

☐ **Mobile X-ray**

☐ **Sleep Centers**

Is your entity a Physician-owned facility? ☐ **Yes** ☐ **No**

If no, please describe the ownership:

____

____

4. ATTESTATION

I certify that all the information submitted in this application is true and accurate to the best of my knowledge, and agree to promptly provide National Integrated HealthCare Group with notice of any changes in the submitted information, which occur from time to time. I also agree to promptly provide additional information as is requested by it in its review of my application. I understand that this application is not a guarantee of network participation. Further I hereby certify that I will not disclose any proprietary and/or otherwise competitively sensitive information of NIHC Group or Carriers to any person not authorized to receive it.

Signature___________________________________
(Must be an Authorized Representative of the Company)

Print Name: ________________________________

Title: ____

Date: ____

Legal Contract Notice Information:

Name: ____

Title: ____

Organization: ____

Address: ____

This application was completed by:

Name: ____

Title ____

Date: ____

Phone Number: ____

Facsimile Number: ____

Email: ____