

# CHECKLIST

**ANCILLARY PROVIDER CREDENTIALING**

The ancillary provider application applies to the following organization types:

* Hospitals
* Home Health Agencies
* Skilled Nursing Facilities
* Free-Standing Surgical Centers
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please be sure that you have included the following documents to expedite the review process. Please make sure all documents are up to date and current.

* Copy of State License and Ancillary credentialing application (for each location)
* Copy of accreditation/certificate or letter with date of accreditation term
* Provide Medicare provider number
* Provide PROMISe/ Medicaid provider number with effective date (Be sure to revalidate with the State)
* Copy of face sheets for general liability Insurance (if applicable)
* Provide summary of liability judgments (if applicable)
* Copy of W-9\*\* (Must include the remittance/billing address)

\* W9 Address must match what is listed in section B of this application, if the W9 billing/remittance address is different please use the last page of this application to provide an explanation.

# HEALTH PARTNERS PLANS

**ANCILLARY PROVIDER CREDENTIALING APPLICATION**

All providers making application to become a Health Partners Plans network ancillary provider are required to furnish information which fully describes their credentials and their program of medical services. Please note that acceptance of your application and subsequent contract execution may result in your being listed as a network provider in one or more of our provider directories. This application shall apply to the following companies:

***HEALTH PARTNERS PLANS***

PLEASE NOTE: HEALTH PARTNERS PLANS RESERVES THE RIGHT TO DIRECT SERVICES TO SELECTED NETWORK PROVIDERS AND DOES NOT GUARANTEE A MINIMAL VOLUME OF SERVICES WILL BE DIRECTED TO ANY PROVIDER.

***DO NOT BIND APPLICATION OR APPLICATION MATERIALS OR REFORMAT THIS APPLICATION.***

1. Corporate Office Information

Provider Name:

Address:

(Street)

(City) (State) (Zip)

(County)

Phone Number: ( ) Area Code

Fax Number: ( ) Area Code

Facility Web Page:

Physical Location of Provider/Facility (If more than one location, please include all branch locations/ facilities. You may attach additional pages)

Provider Name:

(Street)

(City) (State) (Zip)

(County)

Phone Number: ( ) Area Code

Fax Number: ( ) Area Code

1. BILLING INFORMATION/REMITTANCE ADDRESS:

(Name)

(Street)

(City) (State) (Zip Code)

(County)

Phone Number: ( )

Fax Number: ( )

Area Code Area Code

Categorize your Provider Type: (Check only those applicable.)

Please complete general application and specific pages listed next to your provider type.

|  |  |  |
| --- | --- | --- |
| **PROVIDER TYPE** | **PEDIATRICS (0-18 Y/O) YES/NO** | **ADULT (19+) YES/NO** |
| * **Subacute Facility (complete App)** * **Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| **Home Health Agency (complete pages 7 and 8)**   * **Adult** * **Home Perinatal** * **Neonatal** |  |  |
| **Skilled Nursing/Nursing Home (complete pages 9 and 10)** |  |  |
| **Surgical Center (complete page 11)** |  |  |

Name of ancillary credentialing contact:

Contact Person/title:

Contact Phone Number: Email address:

1. CERTIFICATION/ACCREDITATION

Please respond to the following and include as ATTACHMENT 2, the following items as applicable to your organization.

* 1. Submit a copy of your state licensure from the appropriate Department of Institutions and Agencies for all jurisdictions in which you provide services (i.e., the Department of Health or the Department of Public Welfare).

Have there been any restrictions on your licensure in the past five years?

Yes No

If yes, please explain details of restrictions

* 1. Are you accredited by an independent accreditation agency such as The Joint Commission on Accreditation of Healthcare Organizations (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC), or the Community Health Accreditation Program (CHAP)?\*

Yes No

Type of Accreditation Achieved

If yes, please submit copy of the accreditation certificate or letter with the certifying date of accreditation. If any deficiencies, attach copy of the survey grid form.

Has your organization lost its accreditation, been denied accreditation, or otherwise been sanctioned by the accrediting body within the past five (5) years? (If so, please explain

circumstances and remedies.) Yes

No

NOTE: It is a requirement of Health Partners Plans and affiliates that providers be fully accredited by an accrediting body recognized by the company in order to qualify for participation in our networks.

* 1. Please advise if you are certified as a provider in Medicare and Medical Assistance Programs.

Medicare Yes Medical Assistance Yes

No No

(3) Medicare provider number (If Medicare certified for more than one service, e.g., home health and hospice, please list all Medicare numbers.)

(NOTE: Please respond to the following even if you are not currently Medicare participating.)

(5) Have there been any actions or sanctions against you by Medicare in the past

five (5) years? Yes

No

If yes, please furnish documentation concerning the dates of such sanctions and a description of any action taken against your organization and the outcome (i.e., suspension and your reinstatement under the program).

* + 1. If yes (certified) for Medical Assistance, please provide the following:
       1. PROMISe/Medicaid Provider Number
       2. Effective date of PROMISe/Medicaid participation

(NOTE: Please respond to the following even if you are not currently Medical Assistance participating.)

* + - 1. Have there been any actions or sanctions by Medical Assistance within the past five (5) years? Yes No

If yes, please furnish documentation concerning the dates of such sanctions and a description of any action taken against your organization and the outcome (i.e., suspension and your reinstatement under the program).

* + 1. Please provide the following regarding your National Provider Identification Number (NPI):
       1. NPI Number for the physical location listed on page 1:
       2. Effective date of the NPI number:
       3. Is this NPI number used for more than one site location? Yes No (if yes, please provide all physical locations that use the NPI number listed as a separate attachment)

(4) Will the providing NPI Number and the Pay to NPI Number be the same Yes or No if no, please provide the Pay to NPI Number

* 1. Submit a copy of the most current face sheets for your general liability Insurance policies.
  2. Please submit as ATTACHMENT 3, a summary of claims filed against your organization over the past five (5) years which resulted in either a settlement or court disposition adverse to you and which settlement or disposition resulted in a payment of $25,000 or more. Include claim type (professional or general liability), description, status/resolution, and amount of award.
  3. SERVICE COVERAGE AREA

Please indicate in which areas your facility/organization provides services. If you only serve portions of a county, please indicate.

What is your service area?

|  |  |  |
| --- | --- | --- |
| * **Pennsylvania State-Wide** | * **Lehigh/Capital Zone** | * **Northeast Zone** |
| * **Northwest Zone** | * **Southeast Zone** | * **Southwest Zone** |
| **If less coverage than above, please list county below:** | | |
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If additional space is needed, please list separately and attach with the ancillary provider application.

* 1. MEDICAL SERVICES INFORMATION

Please include as ATTACHMENT 4, the following information as it applies to your organization.

* + 1. If your facility is not operational 24 hours/day, 7 day/week, please explain in detail your arrangements for after-hour coverage.
  1. FINANCIAL INFORMATION
     1. Please list your Tax Identification Number and furnish a Tax Coupon, W-9 form or other Internal Revenue Service (IRS) documentation to support this number. (NOTE: This information is required to enter approved providers into our systems. Provider name and address used for payments must be the same used for IRS purposes.)
     2. Tax Identification Number:

1. Language(s) spoken by Patient-Care Staff:
2. ADDITIONAL INFORMATION

You may include any other information that you believe would assist us in reviewing your application. (Please take this opportunity to help us to understand the nature and scope of services you are offering, if need be.)

ON BEHALF OF THE PROVIDER, I hereby certify that:

* All the information included in this application and the accompanying documents are correct and complete to the best of my knowledge and belief.
* If this application contains either (i) any material omissions, or (ii) false or misleading information, participation with the Health Partners Plans network may be terminated.
* In the event that there are any changes to any of the information provided in this application, the Provider will notify Health Partners Plans immediately.

ON BEHALF OF THE PROVIDER, I hereby authorize Health Partners Plans to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation or operations to Health Partners Plans.

I hereby authorize and agree that Health Partners Plans their respective agents, employees, and representatives may provide its affiliates with any information concerning the organization’s qualifications for the purpose of credentialing, recredentialing or peer review. I release Health Partners Plans, their respective agents, employees, and representatives of any liability for furnishing any such information, which is provided in good faith and without malice.

I hereby authorize Health Partners Plans and affiliates to use the information provided in their selection, credentialing and recredentialing process, and to verify such information as appropriate. I further understand that Health Partners Plans and affiliates have its own criteria for acceptance, and that I may be accepted or rejected by each independently.

(Authorized Signature for Provider)

(Please Print Name)

(Title)

(Date)

HOME HEALTH AGENCY

* Hospital-based Agency
* Freestanding

What kinds of service are provided by the agency? Check each area and indicate any major area of expertise and please note the age ranges.

ADULT SERVICES: (Please Check) PEDIATRIC SERVICES: (Please Check)

Age ranges:

Age ranges:

* Nursing □ Nursing
* Chemotherapy □ Shift Nursing Care/Continuous Nursing Care
* AIDS Specialty □ Ventilator
* Ventilator □ Medical Social Services
* Rehabilitation Therapy (PT/OT/Speech) □ Apnea Monitoring
* Nutritional Counseling □ Phototherapy
* Medical Social Services □ Rehabilitation Therapy (PT/OT/Speech)
  + Well Mom/Well Baby-including Phototherapy\*

\*Please submit a copy of your policy describing experience requirements for nurses providing these services.

STAFFING

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **# EMPLOYED** | | **\*\*# SUBCONTRACTED** | |
| **Adult** | **Pediatric** | **Adult** | **Pediatric** |
| **RN** |  |  |  |  |
| **LPN** |  |  |  |  |
| **Home Health Aide** |  |  |  |  |
| **Speech Therapist** |  |  |  |  |
| **Physical Therapist** |  |  |  |  |
| **Occupational Therapist** |  |  |  |  |
| **Registered Dietitian** |  |  |  |  |
| **Social Worker** |  |  |  |  |
| **Certified Diabetes Educator** |  |  |  |  |
| **Other (Please list)** |  |  |  |  |

\*\*Please list any agencies with which you currently subcontract to provide patient care services and the types of services provided to you by this subcontractor. Submit current copy of license for each.

|  |  |
| --- | --- |
| **Name** | **Name** |
| **Address** | **Address** |
| **City/State/Zip** | **City/State/Zip** |
| **Contact Person/Phone** | **Contact Person/Phone** |

HOME HEALTH AGENCY (Continued)

ADDITIONAL INFORMATION

If agency is located in New Jersey, please indicate county or counties in which you have a Certificate of Need/Medicare Certification:

Pennsylvania Counties:

SKILLED NURSING/SUBACUTE/NURSING HOME FACILITY

# Licensed Beds

# Operational Beds

SERVICES:\* (Please Check)

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | **# BEDS** | | **% OCCUPANCY** | |
|  | **% of Revenue** | **Adult** | **Peds (0-18)** | **Adult** | **Peds (0-18)** |
| **Custodial** |  |  |  |  |  |
| **Skilled** |  |  |  |  |  |
| **Subacute Medical\*** |  |  |  |  |  |
| **Subacute Rehab\*** |  |  |  |  |  |
| **Ventilator** |  |  |  |  |  |

* If you provide subacute services, please advise if the Subacute beds are in a dedicated unit or if the beds are scattered in the facility.

STAFFING

|  |  |  |
| --- | --- | --- |
|  | **# EMPLOYED** | **\*\*# SUBCONTRACTED** |
| **RN** |  |  |
| **LPN** |  |  |
| **Nurse Assistant/Aide** |  |  |
| **Speech Therapist** |  |  |
| **Physical Therapist** |  |  |
| **Occupational Therapist** |  |  |
| **Respiratory Therapist** |  |  |
| **Pharmacist** |  |  |
| **Other** |  |  |

\*\* Please list any providers with which you currently subcontract to provide patient care services and the type of services provided to you by this subcontractor. Submit current copy of license for each.

|  |  |
| --- | --- |
| **Name** | **Name** |
| **Address** | **Address** |
| **City/State/Zip** | **City/State/Zip** |
| **Contact Person/Phone Number** | **Contact Person/Phone Number** |
| **Types of services provided by this subcontractor** | **Types of services provided by this subcontractor** |

TRANSFER AGREEMENT:

1. Does your facility have a transfer agreement with an acute care hospital?
   * Yes □ No

If yes, provide name(s) of hospital(s)

1. Does your facility have an agreement with an emergency medical transport/ambulance provider?
   * Yes □ No

If yes, provide name(s) of provider(s)

AMBULATORY SURGI-CENTER

# Operating Rooms

TYPES OF SERVICES/PROCEDURES:

TRANSFER AGREEMENT:

1. Does your facility have a transfer agreement with an acute care hospital?
   * Yes □ No

If yes, provide name(s) of hospital(s)

|  |  |  |
| --- | --- | --- |
| **ACCREDITATION:** | * **TJC** | * **CABC** |
|  | * **AAAHC** | * **CCAC** |
|  | * **ACHC** | * **CHAP** |
|  | * **NCQA** | * **CARF** |
|  | * **HFAP** | * **HQAA** |
|  | * **DNV** | * **ACR** |
|  | * **TCT** | * **ABCOP** |
|  | * **DOH** | * **AAHHS** |

Other:

EXPLANATION PAGE (IF APPLICABLE)