Credentialing Application Packet Instructions

In support of Washington State Senate Bill 5346 (An act relating to establishing streamlined and uniform administrative services for payors and providers) Coordinated Care/WellCare requires communication of provider data materials using Council for Affordable Quality Healthcare (CAQH). This service is free to Practitioners entering their data. When completing your application with CAQH, please ensure that you have authorized Coordinated Care/WellCare to access your data. This can be done by logging into your account and adding Coordinated Care/WellCare to your list of authorized plans. Make sure that all required supporting documents are uploaded for Practitioner/Groups listed below. All other types (Ancillary/Clinic/Hospital/Facility) must email documents with the return of the appropriate application. Please submit all documents via email to JoinOurNetwork@coordinatedcarehealth.com.

NOTE: If requested by a specific person, the documents should be emailed directly back to the requestor to not delay processing.

☐ **Practitioner/Group**	☐ **Ancillary/Clinic/Facility/ Hospital**
☐ Council for Affordable Quality Healthcare (CAQH) *Completed or updated/re-attested within the last 60 days with supporting documents uploaded.* ☐ W-9 for each unique Tax ID ☐ Provider Data Form (*single practitioner*) or Completed Roster (*multiple practitioners*) *Complete both the location and practitioner tabs fully.* ☐ Disclosure of Ownership and Control Interest *ONE per TIN* *Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individuals practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls* ☐ NPI matches NPPES and NPIs used on the app are consistent throughout. *Please note that your primary taxonomy must exactly match in NPPES and CAQH.* **Documents to upload to CAQH:** *No document can expire within 30 days of the application.* ☐ Copy of COI/Professional Malpractice *Certificate detailing amounts & dates of coverage. Minimum Requirement: $1M per occurrence and $3M per aggregate* ☐ Copy License and DEA Controlled Substance Registration ☐ Board Certification Certificate (*If applicable*) ☐ Education Certificate for Foreign Medical Graduates – ECFMG (*If applicable*)	☐ Hospital/Facility Provider Credentialing Application *ONE per TIN* ☐ W-9 for each unique Tax ID ☐ Disclosure of Ownership and Control Interest *ONE per TIN* *Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individuals practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.* ☐ Copy of State Operational and/or Business License ☐ Other applicable State/Federal/Licensures ***CLIA**, DEA, Pharmacy, or Department of Health* ☐ Copy of Accreditation/certification *by a nationally-recognized accrediting body, i.e. TJC/JCAHO* **OR** Site Evaluation Results by a government agency, if not accredited by a nationally recognized body. ☐ Copy of General Liability coverage *Certificate detailing amounts & dates of coverage. Minimum Requirement: $1M per occurrence and $3M per aggregate* ☐ Copy of Medicaid/Medicare Certification ☐ NPI matches NPPES and NPIs used on the app are consistent throughout. ☐ Completed Practitioner/Location Roster *Complete both the location and practitioner tabs fully.*

Note: Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Coordinated Care/Ambetter from Coordinated Care/ WellCare.

Hospital/Facility Application

Please complete this application in its entirety. Incomplete or illegible applications can result in delay in contract implementation, service delivery and claims payment. If you have questions or need assistance with completion of this application, please contact our credentialing department at: JoinOurNetwork@Coordinatedcarehealth.com

- **A separate application must be completed for each Legal Entity/Tax ID**
- **Attach/include the following with your completed application**

☐ Disclosure of Ownership and Controls Interest Statement

☐ W9 (Signed and Dated)

☐ Copy of Medicaid/Medicare Certification (if not certified, provide proof of participation)

☐ Accreditation/Certification (by a nationally recognized accrediting body e.g., TJC/JCAHO). *If not accredited by a nationally recognized accrediting body, attach the **Site Evaluation** results from a governmental agency.*

☐ Copy of State Operational/Business License and other applicable State/Federal/Licensures (i.e. CLIA, DEA, Pharmacy, or Department Health)

☐ Copy of General Liability coverage
Minimum Requirement: $1M per occurrence and $3M per aggregate

☐ **Initial Credentialing/Assessment** ☐ **Addition of New Service Location**

This application applies to the following **Provider Types**: (Choose all that apply, and supply the associated NPI)

☐	Adult Day Care Center:	☐	Diagnostic Imaging Center:	☐	Hospice:
☐	Adult Living Facility:	☐	Dialysis Center:	☐	Indian Health Center (IHC):
☐	Ambulance:	☐	Durable Medical Equipment (DME):	☐	Rehabilitation Facility:
☐	Assisted Long Term Care Facility (LTAC):	☐	Federally Qualified Health Center (FQHC):	☐	Skilled Nursing Facility (SNF):
☐	Board of Health:	☐	Home Health Agency:	☐	Surgical Center (ASC):
☐	Community Mental Health Agency (CMHA):	☐	Home & Community Based Services (HCBS):	☐	Substance Use Disorder Facility:
☐	Clinic/Center (Other):	☐	Hospital:	☐	Urgent Care:

Contact Information (If there are questions about this application):

Contact Name				Contact Title	
Phone		Fax		Email	

Legal Entity Information (Name, Address on Income Tax return) for **Tax ID**: _____

Tax ID Holder Name		
Legal/Tax Address (where the 1099 should be sent)	Street Address/PO BOX:	City, State, ZIP

Insurance Information

Name of Carrier			
Amount of Coverage		Coverage Dates	

Billing Information (Note: Pay to Name may be different than the Name on the 1099**)**

Pay To Name/Issue Check To		
Pay To Address/Send Remittance To	Street Address/PO BOX:	City, State, ZIP:
Billing Contact Name:	Billing Contact Email:	Billing Contact Phone: Billing Contact Fax:

Note: Each Provider Type/NPI listed in the Provider Type Grid above, must have one service location.

Complete for each Service Location that is part of this application.

Service Location 1 of ____			
Group or Facility Name (to be displayed in the Directory)			
Tax ID Number:		**Provider Type:**	**National Provider ID # (NPI):**
State License Number:	**ProviderOne ID:**	**Medicaid Number:**	**Medicare Number:**
Service Location Address:			
Physical Street Address:		**City, State, Zip:**	**County**
Main Switchboard Phone Number: ( )		**Service Location Fax Number:** ( )	**Email:**

Service Location Office Hours: Please indicate 00:00 AM – 00:00 PM or 24hrs as appropriate

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Service Location Handicap Access? ☐ **Yes** ☐ **No**	**Service Location Accepting New Patients?** ☐**Yes** ☐ **No**	**ADA Compliant?** ☐ **Yes** ☐ **No**
Please list any Foreign Languages spoken at this location:		
Is your practice limited to certain ages? ☐ **Yes** ☐ **No** **If Yes, specify age restrictions: From _____(**Years**) To: _____(**Years**)**		
Billing Information for Service Location 1 of _____ : ☐ Same as indicated on Page 2 (If different, complete below)		
Pay To Name (Issue check to): Note: May be different than name on the 1099**.**		
Pay To Address (Send remit to):	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**
Insurance Information for Service Location 1 of _____: ☐ Same as indicated on Page 2 (If different, complete below)		
Carrier:	**Amount of Coverage:**	**Dates:**

CMHA (Community Mental Health Agency					
☐	PACT (Program of Assertive Community Treatment	☐	WISe Services (number of teams____)	☐	Peer Counseling Services

Substance Use Disorder Facility					
☐	Opiate Substitution Treatment	☐	Adult Outpatient	☐	Adult Intensive Outpatient
☐	Adult Intensive Inpatient (IIP)	☐	Adult Long Term (LT)	☐	Adult ITA (Involuntary Treatment Act)
☐	PPW (Pregnant Parenting Women)	☐	Adult Recovery House	☐	Youth Outpatient
☐	Youth Residential	☐	Youth Recovery House	☐	Youth Intensive Outpatient

Beds (IMD / Non IMD) Total # of Beds: _____					
☐	Adult Residential Beds:	☐	Youth Residential Beds:	☐	ITA IMD (Involuntary Treatment Act):
☐	Pregnant Women's Services:	☐	Parenting Women's Services[1]:	☐	Adult Detox IMD:
☐	Adult Detox non-IMD:	☐	Youth Detox IMD:	☐	Youth Detox non-IMD:

1. To include children's beds

E & T (Evaluation and Treatment, IMD and non-IMD)			
	E& T Beds		Number of Available E & T Beds:

Service Location 1 of ____ : Accreditation/Certification Type

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Acronym	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC			
American Association of Ambulatory Health Centers	AAAHC			
American Board for Certification in Orthotics & Prosthetics, Inc.	ABCOP			
American College of Radiology	ACR			
American Osteopathic Hospital Association	AOHA			
Board of Orthotist / Prosthetist Certification	BOCUSA			
Clinical Laboratory Improvement Act	CLIA			
Commission on Accreditation for Rehab Facilities	CARF			
Community Health Accreditation Program	CHAP			
Healthcare Quality Association on Accreditation	HQAA			
Joint Commission on Accreditation of Healthcare	JCAHO			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations	DNV/NIAHO			
National Association of Boards of Pharmacy	NABP			
National Committee for Quality Assurance	NCQA			
The National Board of Accreditation for Orthotic Suppliers	NBAOS			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc.	URAC			
State Operating License				
Others (please list):				

Service Location 1 of _____: Sanctions

If yes, to any question below, please explain on a separate sheet of paper.

Have there been any settled malpractice claims, suites, settlements or proceedings involving your organization within the past five years?	☐ **Yes** ☐ **No**
Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐ **Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐ **Yes** ☐ **No**

***IMPORTANT REMINDER**: Contracted providers MUST have a signed Core Provider Agreement with HCA within one hundred twenty (120) calendar days of contracting. A provider may enroll with HCA as a "non-billing" provider if he or she does not wish to serve fee for service Medicaid clients, but the provider must have an active NPI number with HCA.*

Complete Pages 4 & 5 for each additional Service Location that is part of this application.

Service Location ___ of ____			
Group or Facility Name (to be displayed in the Directory)			
Tax ID Number:		**Provider Type:**	**National Provider ID # (NPI):**
State License Number:	**ProviderOne ID:**	**Medicaid Number:**	**Medicare Number:**
Service Location Address:			
Physical Street Address:		**City, State, Zip:**	**County**
Main Switchboard Phone Number: ( )		**Service Location Fax Number:** ( )	**Email:**

Service Location Office Hours: Please indicate 00:00 AM – 00:00 PM or 24hrs as appropriate

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Service Location Handicap Access? ☐ **Yes** ☐ **No**	**Service Location Accepting New Patients?** ☐ **Yes** ☐ **No**	**ADA Compliant?** ☐ **Yes** ☐ **No**
Please list any Foreign Languages spoken at this location:		
Is your practice limited to certain ages? ☐ **Yes** ☐ **No** **If Yes, specify age restrictions: From _____(**Years**) To: _____(**Years**)**		
Billing Information for Service Location 1 of _____ : ☐Same as indicated on Page 2 (If different, complete below)		
Pay To Name (Issue check to): Note: May be different than name on the 1099**.**		
Pay To Address (Send remit to):	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**
Insurance Information for Service Location 1 of _____: ☐Same as indicated on Page 2 (If different, complete below)		
Carrier:	**Amount of Coverage:**	**Dates:**

CMHA (Community Mental Health Agency					
☐	PACT (Program of Assertive Community Treatment	☐	WISe Services	☐	Peer Counseling Services

Substance Use Disorder Facility					
☐	Opiate Substitution Treatment	☐	Adult Outpatient	☐	Adult Intensive Outpatient
☐	Adult Intensive Inpatient (IIP)	☐	Adult Long Term (LT)	☐	Adult ITA (Involuntary Treatment Act)
☐	PPW (Pregnant Parenting Women)	☐	Adult Recovery House	☐	Youth Outpatient
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Beds (IMD / Non IMD) Total # of Beds: _____					
☐	Adult Residential Beds:	☐	Youth Residential Beds:	☐	ITA IMD (Involuntary Treatment Act):
☐	Pregnant Women's Services:	☐	Parenting Women's Services[1]:	☐	Adult Detox IMD:
☐	Adult Detox non-IMD:	☐	Youth Detox IMD:	☐	Youth Detox non-IMD:

1. To include children's beds

E & T (Evaluation and Treatment, IMD and non-IMD)		
	E& T Beds	Number of Available E & T Beds:

Service Location __of ____ : Accreditation/Certification Type

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Acronym	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC			
American Association of Ambulatory Health Centers	AAAHC			
American Board for Certification in Orthotics & Prosthetics, Inc.	ABCOP			
American College of Radiology	ACR			
American Osteopathic Hospital Association	AOHA			
Board of Orthotist / Prosthetist Certification	BOCUSA			
Clinical Laboratory Improvement Act	CLIA			
Commission on Accreditation for Rehab Facilities	CARF			
Community Health Accreditation Program	CHAP			
Healthcare Quality Association on Accreditation	HQAA			
Joint Commission on Accreditation of Healthcare	JCAHO			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations	DNV/NIAHO			
National Association of Boards of Pharmacy	NABP			
National Committee for Quality Assurance	NCQA			
The National Board of Accreditation for Orthotic Suppliers	NBAOS			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc.	URAC			
State Operating License				
Others (please list):				

Service Location _____ of _____: Sanctions *If yes, to any question below, please explain on a separate sheet of paper.*	
Have there been any settled malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐**Yes** ☐ **No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐ **No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current **Coordinated Care Health Plan** provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to **Coordinated Care Health Plan** Credentials Committee for their review and approval, and, absent such affirmative approval, **Coordinated Care Health Plan** members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from **Coordinated Care Health Plan**. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying **Coordinated Care Health Plan** in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy **Coordinated Care Health Plan** credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ Date: _____
Print or type name

_____
Signature of Provider or Authorizing Representative **Title**
A stamped or typed signature is not acceptable

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 Coordinated Care within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

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 (individual or entity) 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 IUIS-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 than $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 above) 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 (cannot be typed or stamped) _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Return the completed form by email to JoinOurNetwork@coordinatedcarehealth.com. Please note that *if requested by a specific person*, the form should be emailed directly back to the requestor to not delay processing.