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.*	☐ Hospital/Facility Provider Credentialing Application *ONE per TIN*
☐ W-9 for each unique Tax ID	☐ 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.*
☐ 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
☐ 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.*	☐ Other applicable State/Federal/Licensures ***CLIA**, DEA, Pharmacy, or Department of Health*
Documents to upload to CAQH: *No document can expire within 30 days of the application.*	☐ 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 COI/Professional Malpractice *Certificate detailing amounts & dates of coverage. Minimum Requirement: $1M per occurrence and $3M per aggregate*	☐ Copy of General Liability coverage *Certificate detailing amounts & dates of coverage. Minimum Requirement: $1M per occurrence and $3M per aggregate*
☐ Copy License and DEA Controlled Substance Registration	☐ Copy of Medicaid/Medicare Certification
☐ Board Certification Certificate (*If applicable*)	☐ NPI matches NPPES and NPIs used on the app are consistent throughout.
☐ Education Certificate for Foreign Medical Graduates – ECFMG (*If applicable*)	☐ 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.

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.

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Provider Data Form – Single Practitioner

(*For Credentialing & Provider Directory Purposes*)

Date:	Individual NPI (*Type 1*): Group NPI (*Type 2*)	Medicaid ID# Group Medicare ID# Group	Individual: Individual:
Last Name:		First Name:	MI:
Date of Birth:	Social Security #:	Tax ID:	Title/Degree:
CAQH ID#:	Provider One ID#:	Ethnicity:	
Email Address:	Cultural Sensitivity Training: ☐ Yes ☐ No	Applying As: ☐ Specialist ☐ Primary Care (PCP) ☐ Behavioral Health	
Group/Practice Name:			
Practitioner Primary Specialty: Board Status: ☐ Board Certified ☐ Board Eligible ☐ Not Applicable ☐ Not Certified			
If Yes, Board Name:		Expiration Date:	
Practitioner Secondary Specialty: Board Status: ☐ Board Certified ☐ Board Eligible ☐ Not Applicable ☐ Not Certified			
If Yes, Board Name:		Expiration Date:	
Gender Restrictions: ☐ Yes ☐ No *If Yes, Indicate*: ☐ Female Only ☐ Male Only		Age Restrictions: ☐ Yes ☐ No *If yes, Indicate*: Lowest Age Highest Age	
Languages Spoken (*Non-English*): ☐ Yes ☐ No If Yes, please Indicate:			
Are you affiliated (do you have admitting or attending privileges at) with any Hospital? ☐ Yes ☐ No			
If Yes, please list:			
Privilege Type - please provide (*i.e. Active, Temporary, Provisional, Admitting, Attending*):			
If no, please list admitting arrangements (**required MD/DO/NP/PA**):			
Are you able to provide services to any of the following special needs population (check all of those that apply): ☐ Deaf/Hearing Impaired ☐ Physical Disability ☐ Blind/Vision Impaired ☐ Developmental Disability ☐ Other (please specify)			
Type of Services Provided (outside of Board Specialty(s) above):			
Do you provide Telemedicine Services: ☐ Yes ☐ No	Are you exclusively Telemedicine: ☐ Yes ☐ No If Yes to Telemedicine Services, please describe:		
Contract Contact Name (Enter the name of the person who we can contact for questions regarding your application/contract):			
Contract Contact Role (*Contract Admin, Billing Rep, Office Manager*):		Contact Phone.:	Contact Email:

1. Attestations must be current within 60 days of completion of this form/application to become a Coordinated Care/WellCare contracted provider. No documents can expire within 30 days of the application.
2. The HCA requires that all Managed Care Organizations ensure that providers we contract with, either have a Core Provider Agreement (CPA) with the HCA or register as a "non-billing provider". Providers register here: http://www.hca.wa.gov/medicaid/providerenroll/pages/enroll.aspx
3. Behavioral Health practitioners should complete the Provider Specialty Profile (CC_Behavioral Health Profile_v2) in addition to this Provider Data Form

Primary Location Name ☐ List in directory ☐ Do not list in directory/TeleHealth ONLY				
Location Address (Street):			Suite #	
City:	State:	County:		Zip:
Phone:		Fax:	Handicap Access: ☐ Yes	☐ No
Do you carry a panel (*are you available on an ongoing outpatient basis to see all members*) at this location: ☐Yes ☐ No If No, please explain below: ☐ Seeing existing members only ☐ Panel is temporarily closed ☐ Seeing Foster Care members only				
Office Hours. *Indicate the hours you are available for member appointments* (*24 hrs, hh:mmAM-hh:mmPM, Closed*)				
Monday:	Tuesday:	Wednesday:	Thursday:	
Friday:	Saturday:	Sunday:	*Notes*:	
Secondary Location ☐ List in directory ☐ Do not list in directory/TeleHealth ONLY				
Location Address (Street):			Suite #	
City:	State:	County:		Zip:
Phone:		Fax:	Handicap Access: ☐ Yes	☐ No
Do you carry a panel (*are you available on an ongoing outpatient basis to see all members*) at this location ☐ Yes ☐ No If No, please explain below: ☐ Seeing existing members only ☐ Panel is temporarily closed ☐ Seeing Foster Care members only				
Office Hours. *Indicate the hours you are available for member appointments* (*24 hrs, hh:mmAM - hh:mmPM, Closed*)				
Monday:	Tuesday:	Wednesday:	Thursday:	
Friday:	Saturday:	Sunday:	*Notes*:	
Additional Service Location Name ☐ List in directory ☐ Do not list in directory/TeleHealth ONLY				
Location Address (Street):			Suite #	
City:	State:	County:		Zip:
Phone:		Fax:	Handicap Access: ☐ Yes	☐ No
Do you carry a panel (*are you available on an ongoing outpatient basis to see all members*) at this location: ☐ Yes ☐ No If No, please explain below: ☐ Seeing existing members only ☐ Panel is temporarily closed ☐ Seeing Foster Care members only				
Office Hours. *Indicate the hours you are available for member appointments* (*24 hrs, hh:mmAM - hh:mmPM, Closed*)				
Monday:	Tuesday:	Wednesday:	Thursday:	
Friday:	Saturday:	Sunday:	*Notes*:	

Service Locations

Note: If you have already completed your application with CAQH, please ensure that you have authorized Coordinated Care of Washington, Inc., Coordinated Care Corporation and/or WellCare of Washington, Inc. to access your data. This can be done by logging into your account and adding Coordinated Care/Wellcare to your list of authorized plans. Using the CAQH Universal Credentialing Data Source does not grant participation or constitute applying for participation with Coordinated Care/WellCare. Please make sure that you have re-attested your account within the last 60 days and uploaded your current license and COI/malpractice.

Please submit this form along with the required supporting documents 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.