Health Partners Plans

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.

A. 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

B. 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:** _____

C. 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_____

_____

_____

2. 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 _____ Type of Accreditation Achieved _____
No _____

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.

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

Medicare Yes _____ No _____
Medical Assistance Yes _____ 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).

(a) 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.)

(3) 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).

(b) 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 _____**

4. Submit a copy of the most current face sheets for your general liability Insurance policies.

5. Please submit as <u>ATTACHMENT 3</u>, 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.

6. <u>SERVICE COVERAGE AREA</u>
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:		

If additional space is needed, please list separately and attach with the ancillary provider application.

7. MEDICAL SERVICES INFORMATION
Please include as ATTACHMENT 4, the following information as it applies to your organization.

(a) If your facility is not operational 24 hours/day, 7 day/week, please explain in detail your arrangements for after-hour coverage.

8. FINANCIAL INFORMATION

(a) 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.)

(b) Tax Identification Number: _____

10. Language(s) spoken by Patient-Care Staff: _____

11. 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)

Age ranges: _____

- ❑ **Nursing**
- ❑ **Chemotherapy**
- ❑ **AIDS Specialty**
- ❑ **Ventilator**
- ❑ **Rehabilitation Therapy (PT/OT/Speech)**
- ❑ **Nutritional Counseling**
- ❑ **Medical Social Services**

PEDIATRIC SERVICES: (Please Check)

Age ranges: _____

- □ **Nursing**
- □ **Shift Nursing Care/Continuous Nursing Care**
- □ **Ventilator**
- □ **Medical Social Services**
- □ **Apnea Monitoring**
- □ **Phototherapy**
- □ **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)

   _____

   _____

2. **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)