Organizational Provider Credentialing Application

AmeriHealth Caritas Texas

Organizational provider identification	
Legal business name (as reported to the IRS):	
Doing business as (DBA), if applicable:	
Medicaid number:	
Medicare number:	
Health system affiliation (if applicable):	
Tax identification number (TIN):	
Length of time in business with this name and TIN (in years and months):	
National Provider Identifier (NPI):	

Organizational provider information (Please refer to Attachment A for services provided at this location/site and additional locations.)	
Organizational provider name:	
Address line 1:	
Address line 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Website:	
Credentialing contact name:	
Phone:	Fax:
Email:	
Organizational provider administrator name:	
Phone:	Fax:
Email:	

Office hours (use HH:MM format)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							

Services at this location	
☐ ADA accessibility requirements	☐ 24/7 phone coverage
☐ Handicapped accessibility	☐ Answering service

Mailing address	
☐ Check here if all correspondence can be directed to the organizational provider location above. If not, complete the section below:	
Name:	
Address 1:	
Address 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Email:	

Remit/billing address	
Name:	
Address 1:	
Address 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Email:	

Organizational provider type

- ☐ Ambulatory surgical center — freestanding only
- ☐ Behavioral health and social services
- ☐ Behavioral rehabilitation
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Community mental health center
- ☐ Durable medical equipment supplier
- ☐ Diabetic education program
- ☐ Dialysis center
- ☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinic
- ☐ Federally qualified health center (FQHC)
- ☐ FQHC (behavioral health only)
- ☐ Freestanding sleep center or sleep lab
- ☐ Freestanding radiology center
- ☐ Home health care agency providing skilled services only and no PCA services
- ☐ Home health care agency providing both skilled services and PCA services
- ☐ Home health hospice
- ☐ Home infusion
- ☐ Hospital (acute care and acute rehabilitation)
- ☐ Hospital (psychiatric geriatric)
- ☐ Intermediate care facility — mental health
- ☐ Mental health clinic
- ☐ Nursing home
- ☐ Portable X-ray supplier
- ☐ Rural health clinic (RHC)
- ☐ Skilled nursing facility or nursing home
- ☐ Skilled nursing facility providing sub-acute services
- ☐ Other (please indicate): _____

Health care licensure — **Attach a copy of each organizational provider licensure. Do not submit practitioner licensures.**

License number	State or city	Licensing agency	Initial issue date (MM/DD/YYYY)	Renewal date (MM/DD/YYYY)	Expiration date (MM/DD/YYYY)

Medicare status

1. Is this organizational provider participating in the Medicare program? ☐ Yes ☐ No ☐ Pending

   If yes, provide Medicare number: _____

2. Is this organizational provider certified by the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No ☐ Pending

   If yes, provide date of initial CMS certification: _____

   and

   Medicare certification number: _____

   ☐ Check here if organizational provider is **not eligible** for CMS certification

Accreditation

Select accrediting agency from the list below and attach a copy of current accreditation certificate.
If not accredited, skip checklist and go to the site visit requirement section.

☐ American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF)
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ American Academy of Sleep Medicine (AASM)
☐ Accreditation Commission for Health Care (ACHC)
☐ American College of Radiology (ACR)
☐ American Osteopathic Association (AOA)
☐ Board of Certification (BOC)
☐ The Commission on Accreditation of Birth Centers (CABC)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ Continuing Care Accreditation Commission (CCAC)
☐ Community Health Accreditation Program (CHAP)
☐ Council on Accreditation (COA)
☐ Det Norske Veritas Healthcare Inc. (DNVHC)
☐ National Integrated Accreditation for Healthcare Organizations (NIAHO)
☐ The Joint Commission (previously known as JCAHO)

Date of initial accreditation: _____

Date of last full survey: _____

Site visit requirement

Attach a copy of most recent on-site survey for each location (with Corrective Action Plan [CAP], if citations were issued) or attach cover letter from government agency stating organizational provider is in substantial compliance.

1. Has organizational provider had a post-licensing on-site visit by a government agency, such as the Department of Health (DOH) or CMS, within the past 36 months?

   ☐ Yes — Date of most recent standard survey: _____
   ☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey?
   ☐ Yes
   ☐ No
   ☐ N/A — no recent survey

   If **yes**, have all deficiencies been corrected?
   ☐ Yes — **Provide evidence of state acceptance of your CAP.**
   ☐ No — **Provide explanation and your plan to correct all deficiencies.**

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies.**

Provider credentialing
Does the organizational provider validate, for each licensed provider employed or contracted at the organizational provider, the credentials necessary to perform health care services? ☐ Yes ☐ No If yes, indicate how the organizational provider conducts the credentialing process for each provider. ☐ Credentialing procedures are performed internally. ☐ Credentialing procedures are outsourced/delegated to: _____ ☐ Other, specify: _____ If no, please explain: _____

Insurance **General liability coverage**	**Both organizational provider general and professional liability are required. Minimum coverage requirement is $1 million per occurrence and $3 million aggregate.** **Attach certificate showing policy number, coverage amounts, and effective and expiration dates.**
Current carrier name:	Policy number:
Street/P.O. Box:	City:
State:	ZIP code:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence based ☐ Claims based	

Professional liability coverage	**Attach certificate showing policy number, coverage amounts, and effective and expiration dates.**
Current carrier name:	Policy number:
Street/P.O. Box:	City:
State:	ZIP code:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence based ☐ Claims based	

Attachments
Indicate which documents are being included with this completed application.

- ☐ Copy of all federal, state, and/or local licenses required to operate as a health care organizational provider
- ☐ Copy of organizational provider's general liability insurance certificate
- ☐ Copy of professional liability insurance certificate covering all organizational provider employees
- ☐ Copy of accreditation certificates, if applicable
- ☐ Copy of CMS letter certifying or recertifying organizational provider to provide partial hospitalization services, if applicable
- ☐ Copy of most recent CMS or DOH survey including your CAP, if deficiencies were cited, or cover letter from CMS or DOH stating organizational provider is in compliance

Disclosure questions
Answer every question **yes** or **no**.
Provide a detailed explanation on a separate sheet for any questions answered **yes**.

1.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been convicted of any health care-related criminal offense, had adjudication withheld on any health care-related criminal offense, pleaded no contest to any health care-related criminal offense, or entered into a pre-trial agreement for any health care-related criminal offense?	☐ Yes ☐ No
2.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	☐ Yes ☐ No
4.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had his or her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a consent order issued by a licensing, certifying, or professional standards board or agency?	☐ Yes ☐ No
5.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been denied enrollment in or suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	☐ Yes ☐ No
6.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any federal executive branch procurement or non-procurement program?	☐ Yes ☐ No
7.	Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	☐ Yes ☐ No

8. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fines have been paid in full?	☐ Yes ☐ No
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the organizational provider, under any current or former name or business identity?	☐ Yes ☐ No
10. Does the organizational provider or any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	☐ Yes ☐ No
11. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care item or service?	☐ Yes ☐ No
12. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to the delivery of an item or service under Medicare or state health care program?	☐ Yes ☐ No
13. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
14. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been found to have violated federal or state laws, rules, or regulations in any program established under Medicare, any other state's Medicaid program, or Title XX; any other publicly funded federal or state health care program; or any other health insurance program?	☐ Yes ☐ No

Attestation

I certify that the information contained in this application is correct and complete to the best of my knowledge. I hereby authorize AmeriHealth Caritas 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 AmeriHealth Caritas. I authorize and agree that AmeriHealth Caritas and its agents, employees, and representatives may provide AmeriHealth Caritas' subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing, or peer review. I release AmeriHealth Caritas and its affiliates, agents, employees, and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize AmeriHealth Caritas and its applicable subsidiaries and affiliates to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as appropriate.

Authorized signature

Print name

Title

Date

ATTACHMENT A: ADDITIONAL LOCATION/SITE ADDENDUM

Copy page for additional locations/sites.

Complete Section C only if you are an accredited or deemed behavioral health provider organization. List services by site.

Section A — Demographics (If primary location/site, please skip to Section C.)	
Location/site name:	
Service site address (no P.O. box):	
Billing NPI or atypical number:	Medicaid number (if applicable):
Remit/billing address (if different from primary location/site address):	

Office hours (use HH:MM format)							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Open							
Close							

Services at this location:	
☐ ADA accessibility requirements	☐ Answering service
☐ Handicapped accessibility	☐ 24/7 phone coverage

Section B — Site visit requirement (Attach a copy of most recent on-site survey for each location with CAP.)

1. Has organizational provider had a post-licensing on-site visit by a government agency such as the DOH or CMS within the past 36 months?

   ☐ Yes — Date of most recent standard survey: _____

   ☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A — no recent survey

   If yes, have all deficiencies been corrected?

   ☐ Yes — Provide evidence of state acceptance of your CAP.

   ☐ No — Provide explanation and your plan to correct all deficiencies.

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies**.

Section C — Services available at this location/site (Check all that apply.)

Behavioral health type and description (Please indicate service type — mental health (MH), substance use (SU), or both.)

☐ MH ☐ SU ☐ Both Behavioral health day treatment
☐ MH ☐ SU ☐ Both Behavioral therapy under EPSDT
☐ MH ☐ SU ☐ Both Case management
☐ MH ☐ SU ☐ Both Community-based Residential Level A
☐ MH ☐ SU ☐ Both Community-based Residential Level B
☐ MH ☐ SU ☐ Both Crisis intervention
☐ MH ☐ SU ☐ Both Crisis residential
☐ MH ☐ SU ☐ Both Crisis stabilization
☐ MH ☐ SU ☐ Both Day treatment or partial hospitalization services for adults
☐ MH ☐ SU ☐ Both DD case management
☐ MH ☐ SU ☐ Both Electroconvulsive therapy (ECT)
☐ MH ☐ SU ☐ Both Individual, group, and family therapy
☐ MH ☐ SU ☐ Both Inpatient psychiatric hospital services — freestanding psychiatric hospital
☐ MH ☐ SU ☐ Both Integrated health home
☐ MH ☐ SU ☐ Both Intensive community treatment
☐ MH ☐ SU ☐ Both Intensive in-home services
☐ MH ☐ SU ☐ Both Medication management by psychiatrist
☐ MH ☐ SU ☐ Both Health skill-building services
☐ MH ☐ SU ☐ Both Multi-systemic therapies
☐ MH ☐ SU ☐ Both In-home behavioral therapies (including, but not limited to, ABA)
☐ MH ☐ SU ☐ Both Neuropsychological testing
☐ MH ☐ SU ☐ Both Opioid teatment
☐ MH ☐ SU ☐ Both Outpatient psychiatric services
☐ MH ☐ SU ☐ Both Partial hospitalization
☐ MH ☐ SU ☐ Both Psychosocial rehabilitation
☐ MH ☐ SU ☐ Both Peer support
☐ MH ☐ SU ☐ Both Psychological testing
☐ MH ☐ SU ☐ Both Telepsychiatry
☐ MH ☐ SU ☐ Both Therapeutic day treatment for children and adolescents
☐ MH ☐ SU ☐ Both Treatment foster care case management

Substance use disorder services
☐ Outpatient substance use disorder services
☐ Residential substance use disorder treatment for pregnant and postpartum women
☐ Substance use disorder day treatment
☐ Substance use disorder day treatment for pregnant and postpartum women
☐ Substance use disorder intensive outpatient treatment

Waiver services and approval date (Check box for services for which you are approved by HHSC and indicate approval date.)

☐ AIDS/HIV_____

☐ Brain injury _____

☐ Children's mental health _____

☐ Elderly _____

☐ Health and disability _____

☐ Physical disability _____

☐ Intellectual disability _____

Other services

Mental health	Substance use disorder