ConnectiCare

Organizational Provider Credentialing Application

Please complete and submit this form with any required attachments to **ccicredentialing@connecticare.com**. You may also submit this to your contracting representative. After we receive your completed application, we will credential or recredential your facility in our networks. Contracts will not be completed until credentialing is approved. Credentialing approval DOES NOT mean your contract and network participation has been finalized and approved. Please remember to sign and date your application and submit it with required documents shown in Section VIII below.

Name of Entity:	
Name (please print):	Date:
Title:	

I. PROVIDER IDENTIFICATION

A. Corporate Identification Information

Supply the provider's legal business name (as reported to the IRS), the "doing business as" (DBA) name (other trade name or public name), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

Legal Business Name (as reported to the IRS; claims will be paid to this name):		
DBA Name for Directory Listing (if applicable):	County Where DBA Name Is Registered (if applicable):	
Address:		Tax ID:

B. Primary Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

C. First Additional Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

PRINT RESET

Organizational Provider Credentialing Application (continued)

D. Second Additional Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

E. If you have more than two additional locations, please provide the same information for each on a separate sheet as an attachment.

Hours of Operation:

Mon.: _____ to_____ Tues.: _____ to_____ Wed.: _____ to_____ Thurs.: _____ to_____ Fri.: _____ to_____ Sat.: _____ to_____ Sun.: _____ to_____

Phone:	Fax:	Email:
Administrator (Full Name):		

F. Mailing/Correspondence Address

☐ Check here if all correspondence should be directed to the practice location in Section B. Otherwise, supply an address where the provider may be contacted directly.

Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	ZIP:	County:

II. WHAT TYPE OF ENTITY IS YOUR ORGANIZATION?

- ☐ Adult day health care
- ☐ AIDS adult day care
- ☐ Ambulatory surgery center
- ☐ Assisted living
- ☐ Birthing center
- ☐ Certified home health agency
- ☐ Clinical laboratory
- ☐ Comprehensive outpatient rehabilitation center
- ☐ Dialysis center
- ☐ Durable medical equipment provider
- ☐ Federally qualified health center
- ☐ Free-standing imaging center
- ☐ Home infusion therapy
- ☐ Hospice
- ☐ Hospital
- ☐ Licensed home health agency
- ☐ Meals (home and congregate)
- ☐ Outpatient diabetes self-management center/national diabetes prevention program (NDPP) center
- ☐ Pathology center
- ☐ Personal care services (chores and housekeeping)
- ☐ Personal emergency response services
- ☐ Portable x-ray supplier
- ☐ Rural health clinic
- ☐ Skilled nursing facility
- ☐ Social and environmental services
- ☐ Social day care
- ☐ Transportation
- ☐ Urgent care center
- ☐ Urgent care (retail convenience health clinic)
- ☐ Urgent care (walk-in medical office)

Identification Numbers

NPI Number:	PFI Number:	Operating Cert./License Number:
Medicare Number:	Medicaid Number:	

III. ACCREDITATION AND CERTIFICATION

Attach a copy of verification for each accreditation and certification that your facility has. If your facility received less than full accreditation, please attach a copy of a recommendation.

- ☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Number/ID: _____ Expiration Date: _____
- ☐ Dot Norske Veritas (DNV) Number/ID: _____ Expiration Date: _____
- ☐ Accreditation Association for Ambulatory Health Care (AAAHC) Number/ID: _____ Expiration Date: _____
- ☐ Commission on Accreditation of Rehabilitation Entities (CARF)
- ☐ Council on Accreditation
- ☐ Community Health Accreditation Program (CHAP)
- ☐ Continuing Care Accreditation Commission, American Association of Diabetes Educators (AADE)
- ☐ American College of Radiology (ACR)
- ☐ American Institute of Ultrasound in Medicine (AIUM), Intersocietal Commission on Accreditation of Nuclear Laboratories (ICANL), American Association of Clinical Endocrinologists (AACE), Nuclear Medicine Technology Certification Board (NMTCB), American Academy of Urgent Care Medicine (AAUCM), Urgent Care Association of America (UCAOA), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- ☐ Clinical Laboratory Improvement Amendments (CLIA) Number: _____ Expiration (if applicable): _____

CARF Expiration Date:	CHAP Expiration Date:
DNV Expiration Date:	JCAHO Expiration Date:
Other: Expiration Date:	Other: Expiration Date:

IV. GENERAL AND PROFESSIONAL LIABILITY INSURANCE

Attach a copy of your facility's general and professional liability insurance policy certificate of coverage and malpractice claims history details.

☐ Check box if facility does not have a general liability insurance policy.

Current general liability insurance carrier:

Address:	City:	State:	ZIP:
Policy Number:	Initial Date:		
Limits of Liability:	Expiration Date:		

☐ Check box if facility does not have a professional liability insurance policy.

Current general liability insurance carrier:

Address:	City:	State:	ZIP:
Policy Number:	Initial Date:		
Limits of Liability:	Expiration Date:		

V. HEALTH SERVICE DELIVERY AND QUALITY MANAGEMENT INFORMATION

Do you subcontract for medical services with other organizations or individuals? ☐ Yes ☐ No

If yes, please provide their names and addresses and describe your relationship(s): _____

_____

Do you have a quality improvement process in place? ☐ Yes (Please attach a summary.) ☐ No

Do you have a process to measure and collect patient satisfaction? ☐ Yes ☐ No

If yes, please describe your most recent patient satisfaction measure and instrument used: _____

_____

VI. PRIMARY OFFICER/CONTACT PERSON

Name:		Title:
Phone:	Fax:	Email:

I attest that the information given or attached to this application is accurate. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, will cause automatic and immediate rejection of the application, resulting in denial or nonrenewal of a contract. If a contractual arrangement is in effect prior to discovery of a misrepresentation, misstatement, or omission, such discovery may result in immediate termination of the contract.

Sign:		
Print Name:	Title:	Date:

VII. MEDICAID AMERICANS WITH DISABILITIES ACT (ADA) ATTESTATION

If your practice has more than one location, please complete a Medicaid ADA Attestation form for each location. Additional forms can be downloaded from the "Join Our Networks" page at emblemhealth.com. Once submitted, please notify EmblemHealth within 10 business days of any change to your answers below.
Note: If you do not see patients at the address on the credentialing application (e.g., you're an inpatient provider only or administrative only), please check N/A and sign at the bottom of this section below. ☐ N/A

1.	Does the office have at least one wheelchair-accessible path from an entrance to an exam room?	☐ Yes	☐ No	☐ N/A
2.	Are examination tables and all equipment accessible to people with disabilities?	☐ Yes	☐ No	☐ N/A
3.	If parking is provided, are spaces reserved for people with disabilities and pedestrian ramps at sidewalks and drop-offs?	☐ Yes	☐ No	☐ N/A

I hereby attest that I am a provider that occupies a physical site at which participants might possibly be physically present and that the answers provided are true and accurate and that I hold the authority to make these attestations.

Name:	Date:
Signature:	

VIII. Supporting Documentation

In addition to this Organizational Provider Credentialing Application, applicants must submit additional documents as applicable to the provider types noted.

1. **All applicants must submit the following documents with this application. See below for additional provider-type specific documents. Check box next to each item below to confirm it is being sent with the application.**

   - ☐ Current operating certificate or state license.
   - ☐ Drug Enforcement Agency/Controlled Dangerous Substance (DEA/CDS) certificate (if applicable).
   - ☐ Evidence of accreditation.
     If the entity is not accredited by Joint Commission or other accreditation agency, please send a statement of deficiencies, along with a plan of correction, from the facility's most recent State Survey (i.e., DOH, CMS, NSOFA [New York State Office of the Aging]). See section III Accreditation and Certification above.
   - ☐ General liability insurance certificate of coverage sheet.
   - ☐ Letter verifying approval of CMS participation.
   - ☐ Malpractice claims history details.
   - ☐ Medicare certification.
   - ☐ Professional liability insurance certificate of coverage.
   - ☐ Roster of independent practitioners employed by your organization (First, Middle, Last, NPI, and State License Number).
   - ☐ W-9 form (for billing).

2. **Adult day care, AIDS adult day care, assisted living, personal care services, personal emergency response services, social and environmental supports, and social day care providers must submit the following in addition to the items in sub-section one above. Initial to confirm it is being sent with the application.**

   _____ Drug policy for employees.

3. **Durable medical equipment and outpatient physical therapy providers must submit the following in addition to the items listed in sub-section one above. Initial to confirm they are being sent with the application.**

   _____ A roster of all employees (First, Middle, Last, NPI, and State License Number).
   _____ Drug policy for employees.

4. **Meal (home and congregate) providers must submit the following in addition to the items in sub-section one above. Initial to confirm it is being sent with the application.**

   _____ Food handling certification for employed individuals.

5. **Transportation service providers must submit the following in addition to the items listed in sub-section one above. Initial to confirm it is being sent with the application.**

   _____ A roster of all employees (First, Middle, Last, NPI, and State License Number).
   _____ General liability and vehicle insurance coverage.
   _____ Safe vehicle maintenance protocol tracking program.
   _____ Drug policy for employees.

6. **Urgent Care providers must submit the following in addition to the items in sub-section one above. Initial to confirm the roster is being sent with the application.**

   _____ A roster of all employees (First, Middle, Last, NPI, and State License Number).

I certify that the information contained herein is true and accurate to the best of my knowledge and belief.	
Name of Authorized Representative (please type):	Job Title:
Signature:	Date: