Facility, HealthCare Delivery Organizations (HDO), Long Term Special Services Credentialing and Recredentialing Application Instructions

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

- Copy of all federal, state and/or local licenses required to operate as a healthcare facility (by location)
- Copy of all accreditation certificate(s) or letter(s).
- Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited
- Copy of CLIA certificate for each location, as applicable
- Copy of current DEA certificate (if applicable);
- Professional/Malpractice liability declaration sheet or certificate of Insurance

Please submit completed application, along with all required documentation

If any of your locations has a unique NPI, a unique Tax ID number, or a unique license, a separate credentialing event and application is required

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Provider Identification	
Legal business name:	
Doing business as (if applicable):	
Credentialing Contact:	Credentialing Contact Email:
Credentialing Contact Phone:	Secure Fax:
TIN:	NPI:

Primary Office/Service Address to be credentialed			
Practice location name:			
Medicaid Number:	Medicare Number:		
Address line 1:			
Address line 2:			
City:	State:	ZIP+4 (Preferred):	County:
Phone:	Fax:	Primary contact:	
Administrator (full name):			

Credentialing Address (Verisys will send credentialing correspondence to this address)		
Credentialing Contact Name:		
Address line 1:		
Address line 2:		
City:	State:	ZIP+4 (Optional):

ADA Requirements

Access & Availability ☐ Yes ☐ No Appropriate Equipment Available ☐ Yes ☐ No

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Provider Types

Please circle the applicable provider type below:

Adaptive Aids/Medical Equipment (LTSS)
Adult Day Care
Adult Foster Care
Ambulance Service/Transportation Company
Ambulatory Surgical Center
Assisted Living
Behavioral Health Facility
Birthing Center
Cardiac Rehab Center
Case Management
Certified Community Behavioral Health Clinic
Chemical Dependency Treatment Facility (CDTF)
Clinic/Group Practice
Community Mental Health Center
Comprehensive Outpatient Rehab Facility (CORF)
Day Habilitation (LTSS)
Durable Medical Equipment
Early Childhood Intervention (ECI)
Emergency Response Service/System
End Stage Renal Disease Facility (ESRD)
Endoscopy Facility
Family Planning Clinic
Federal Qualified Health Center (FQHC)
Financial Management Service Agency
Hearing Aid Equipment
Home Health Agency
Home Infusion
Home Modification/Minor Home Modification
Hospice
Hospital
Hospital, Behavioral Health
Infusion Therapy Clinic
Laboratory
Magnetic Resonance Imaging (MRI)
Meals, Home Delivered Meals
Mobile X-Ray/Mobile Diagnostic Provider
Non-Emergent Transportation Services
Nursing Home
Nursing/Healthcare Staffing Service
Orthotics/Prosthetics
Outpatient Rehab Facility (ORF)
Pediatric Day Health Care
Personal Assistance Services Agency
Personal Care Services
Pharmacy
Pharmacy-Home Health IV LTC
Physiological-Independent Diagnostic Testing (IDTF)
Psychiatric Residential Treatment Facility
Public Health Agency
Radiation/Cancer Treatment Centers
Rehab Behavioral Hlth Serv Assisted Long-Term Care
Residential-Based Supported Community Living Serv
Rural Health Clinic
Skilled Nursing Facility (SNF)
Sleep Medicine Center
Transition Assistance Services (LTSS)
Urgent Care Center
Vehicle Modification (LTSS

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Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)			
Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Type of License: State:	License issuance date:	License number:	Expiration date:
Radiology Certificate #:		Radiology Expiration Date:	
CLIA Certificate #:		CLIA Expiration Date:	

Accreditation/Certification (attach a copy of current accreditation, certificate or survey, if applicable)

Accreditation Association of Ambulatory Health Care (AAAHC)

Accreditation Commission for Health Care (ACHC)

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

American Board for Certification in Orthotics & Prosthetics

American College of Radiology (ACR)

Board of Certification

Center for Improvement in Healthcare Quality

Clinical Laboratory Improvement Amendments (CLIA)

Commission on Accreditation of Rehabilitation Facilities (CARF)

The Compliance Team

Utilization Review Accreditation Commission (URAC)

Commission on Office Laboratory Accreditation (COLA)

Community Health Action Partnership (CHAP)

Council on Accreditations (COA)

Det Norske Veritas Healthcare, Inc (DNV)

Healthcare Facility Accreditation Program (HFAP)

Healthcare Quality Association on Accreditation

Intersocietal Accreditation Commission (IAC)

Joint Commission for the Accreditation of HealthCare Organization (TJC or JCAHO)

National Association of Boards of Pharmacy (NABP)

National Board of Accreditation for Orthotic Suppliers

RadSite

Unaccredited Organizations:

Site Survey — Visit May Be Required

Nonaccredited providers must provide a copy of:

- Most recent government agency survey (may not be older than 36 months),
- Corrective action plan (if deficiencies were cited) and attach the proof from the government agency stating facility is in substantial compliance with most recent survey standards.

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

- Has a site survey been completed by CMS or a state agency?

  ☐ Yes, If Yes: Date of Most Recent Full Survey_____

  ☐ No

- Is accreditation being pursued?

  ☐ Yes, If Yes: Expected Date of Accreditation (MM/DD/YYYY) _____

  ☐ No

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General and professional liability insurance – Please submit a copy of your certificate of insurance.	
General liability coverage	
Current carrier name:	
Policy number:	Coverage type: ○ Occurrence-based ○ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Professional/Malpractice liability coverage – Please submit a copy of your certificate of insurance	
Current carrier name:	
Policy number:	Coverage type: ○ Occurrence-based ○ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Professional Disclosure Questions

1. Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? ☐ Yes ☐ No
2. Has the organization's license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? Yes No ☐ ☐
3. Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institution? Yes ☐ No ☐
4. Has the organization ever been convicted of a felony? ☐ Yes ☐ No
5. Have any malpractice suits, arbitration or other proceedings ever been instituted against the organization (regardless of outcome)? ☐ Yes ☐ No
6. Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by the Medicare or Medicaid program? ☐ Yes ☐ No
7. Has the organization's liability insurance policy ever been canceled? ☐ Yes ☐ No
8. Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? ☐ Yes ☐ No

Please provide explanation of "Yes" answers to attestation questions Credentialing Questionnaire

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Attestation/Consent and Release

I, the undersigned authorized agent, hereby attest that the information submitted in, or in support of this application is true, accurate and complete to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment or participating practitioner agreement.

I release from liability, Kentucky Health Alliance participating plans and all representatives of Kentucky Health Alliance for their acts in good faith, and without malice, in connection with evaluating this application and the information provided to Kentucky Health Alliance. I hereby authorize Kentucky Health Alliance to review and inspect all documents and information bearing the organization's qualifications, and consent to the release and authorize the exchange of information relating to any claims, disciplinary actions, suspensions, restriction, or termination of professional associations to Kentucky Health Alliance.

A photocopy of this document shall be as effective as the original.

Preparer's Name:	Title:
Signature:	Date:

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