



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
- Copy of W9

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



Provider Identification	
Legal business name:	
Doing business as (if applicable):	
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):			
Pay To Address:			
City:	State:	ZIP+4 (Optional):	Phone:

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

ADA Requirements	
Access & Availability <input type="checkbox"/> Yes <input type="checkbox"/> No	Appropriate Equipment Available <input type="checkbox"/> Yes <input type="checkbox"/> No

Provider Types

Please check the applicable provider type below:

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



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 (attached a copy of current accreditation, certificate or survey, if applicable)

- American Association of Blood Banks (AABB)
- 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 (ABC)
- American College of Radiology (ACR)
- American Society for Histocompatibility and Immunogenetics
- American Association for Laboratory Accreditation (A2LA)
- Board Certification/Accreditation International (BOC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Clinical Laboratory Improvement Amendments (CLIA)
- CMS Certification
- College of American Pathologists (CAP)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Commission on Office Laboratory Accreditation (COLA)
- Community Health Accreditation Partner (CHAP)
- Det Norske Veritas Healthcare GL (DNV GL)
- Healthcare Facility Accreditations Program (HFAP)
- Healthcare Quality Association on Accreditation (HQAA)
- Intersocietal Accreditation Commission (IAC)
- National Association of Boards of Pharmacy (NABP)
- National Dialysis Accreditation Commission (NDAC)
- The Compliance Team (TCT)
- The Joint Commission (TJC)
- RadSite
- Utilization Review Accreditation Commission (URAC)
- Public Health Accreditation Board (PHAB)



Unaccredited Organizations:

Site Survey — Visit May Be Required

Non-Accredited 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 the 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

General liability insurance

General liability coverage - Please submit a copy of your certificate of insurance	
Current carrier name:	
Policy number:	Coverage type: <input type="checkbox"/> Occurrence-based <input type="checkbox"/> Claims-based
Effective date:	Expiration date:
Per incident: \$	Aggregate: \$



Aetna, Molina, and WellCare Credentialing Made Easy

Professional Disclosure Questions

- Has your organization or any of its authorized representatives ever been convicted of, pled guilty to, or pled nolo contendere to any legal actions (excluding medical malpractice and misdemeanors)?
 No Yes (provide an explanation): _____
- Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?
 No Yes (provide an explanation): _____
- Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs?
 No Yes (provide an explanation): _____
- At any time, has any license or certification held by the organization ever been revoked, denied or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which may lead to one of these outcomes?
 No Yes (provide an explanation): _____
- Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?
 No Yes (provide an explanation): _____
- At any time, has any third-party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management or quality of care issues?
 No Yes (provide an explanation): _____
- Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?
 No Yes (provide an explanation): _____

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: _____

