KANSAS ORGANIZATIONAL PROVIDER CREDENTIALING/RECREDENTIALING APPLICATION

ATTACHMENTS NEEDED. Please include with your completed application the following items for each location.

- Form W-9 completed, signed, and dated
- Disclosure of Ownership and Control Interest Statement form completed, signed, and dated
- Copy of current State License/Approval, as applicable
- Copy of Medicare Participation Certification, as applicable
- Copy of Certifications and/or Accreditation Certificates (e.g. TJC, Medicare)
- Copy of CLIA certification, as applicable
- Copy of all CDDO Affiliate Agreements (I/DD providers)
- Copy of State certification for HCBS services, as applicable (e.g. atypical, non BCBA autism providers, and letter of documentation for 1,000 hours of treatment)
- Copy of Declaration Sheet and/or Certificate of Insurance
    - **For I/DD-TCM and PBS and HCBS providers** who are not providing medical or behavioral health services: **General** Liability Insurance Policies
    - **All other provider types: BOTH** current **Professional** Malpractice and comprehensive **General** Liability Insurance Policies
- Copy of completed HCBS Supplemental Form (HCBS providers)

***Note*:**

- ☐ All applicants must complete all questions (unless otherwise noted).
- ☐ Please check the N/A box if not applicable.
- ☐ Applications that do not include all requested documents and responses to questions will not be able to be processed.

Return all documents via the method below:

- **Sunflower**: Contracting Department, Four Pine Ridge Plaza, 8325 Lenexa Drive, Lenexa, KS 66214
  Cenpatico (Behavioral Health): Attn: Credentialing, 12515-8 Research Blvd., Ste. 400, Austin, TX 78759
- **UnitedHealthcare**: Return this application along with your contract to the address provided on your cover letter or directly to your assigned UnitedHealthcare contractor.
- **Amerigroup**: ATTN: Credentialing Department, Amerigroup Kansas, Building 32, Suite 400, 9225 Indian Creek Parkway, Overland Park, KS 66210
- **Aetna Better Health**: Return requested documents to the address provided on your cover letter or directly to your assigned Aetna Provider Experience liaison.

1. **Facility/Provider Name & Address**
   ***Note*: Legal name and DBA name must match Form W-9.**

   Legal Name: _____

   DBA Name: _____

   Corporate Name (if different): _____

   Federal Tax ID Number: _____ Is this Tax ID used for all locations? ☐ YES ☐ NO*
   *If NO, list on a separate sheet of paper all Tax ID numbers and the Legal Name for each.

   Primary Address: _____

   City: _____ County: _____

   State: _____ ZIP code: _____

   Phone: _____ Ext: _____ Fax: _____

   Handicap accessible: ☐ YES ☐ NO

   ADA compliant: ☐ YES ☐ NO

   Credentialing Contact/Office Manager: _____

   Phone: _____ Ext: _____ Fax: _____

   Email Address: _____

PANEL/CAPACITY Status:

For individual providers or clinics, answer the following questions:

1. **How many Medicaid members are you currently seeing?** _____
2. **Is your panel Open or Closed to additional Medicaid Members?** ☐ **OPEN** ☐ **CLOSED**
3. **How many additional Medicaid members do you have the capacity to see, in each county, by specialty?**

2. Type of Component (as listed on License or Accreditation)
Check all that apply.

MEDICAL/LONG-TERM SUPPORT SERVICES (LTSS)

Adult Care Home Nursing Facility (SNF/NF)	Federally Qualified Health Center (FQHC)	Positive Behavioral Supports
Adult Care Home Nursing Facility Mental Health (NFMH)*	HCBS*	Public Health or Welfare Agency and Clinic
Adult Care Home Assisted Living Facility*	Head Injury Rehabilitation	Rehabilitation Facility
Adult Care Home Home Plus*	Hearing Aid Dealer	Renal Dialysis Center
Adult Care Home Residential Health Care Facility (RHCF)*	Home Health Agency	Rural Health Clinic (RHC)
Adult Care Home Adult Day Care*	Hospice	Specialized Home Nursing Services
Ambulance	Hospital/Psychiatric	Targeted Case Management
Ambulatory Surgical Center	Hospital/Long-Term Acute Care Hospital (LTACH)	Tribe/Tribal Organization/Urban Indian Organization/Indian Health Services (IHS)
Autism –Interpersonal Communication Therapy	Intermediate Care Facility/Intellectually Developmentally Disabled (ICF/IDD)	Vaccine Administration
Diagnostic Imaging Center	Laboratory	WORK Program Independent Living Counseling
DME/Medical Supply Dealer	Money Follows the Person Transition Coordination Services – HCBS	WORK Program Assistive Services
Family Planning Clinic	Money Follows the Person Transition Coordination Services – Home Health	

* **Please also complete HCBS Supplemental Form, if providing HCBS services.**

BEHAVIORAL HEALTH SERVICES

Identify what best describes the organization (check).

MH	SA		MH	SA	
☐	☐	Community Mental Health Center (CMHC)	☐	☐	Outpatient Clinic
☐	☐	Day Treatment (free standing)	☐	☐	Peer Support
☐	☐	Detox Facility	☐	☐	Psychiatric Residential Treatment Facility (PRTF)
☐	☐	Intensive Outpatient (IOP) (freestanding)	☐	☐	Residential Treatment Facility/Center
☐	☐	Methadone Maintenance	☐	☐	Substance Use Disorder (SUD)
☐	☐	Consultative Clinical & Therapeutic Service (CCTS)	☐	☐	Intensive Individual Support Services (IIS)

Age Range Served		
Geriatric (65 years or more)	YES ☐	NO ☐
Adult (18 – 64 years)	YES ☐	NO ☐
Adolescent (13 – 17 years)	YES ☐	NO ☐
Child (12 years or less)	YES ☐	NO ☐

Are in-home services offered? ☐ YES ☐ NO

Number of total Nursing Facility Beds: _____

Number of total Assisted Living Facility Beds: _____

Office Hours
Open 24 hours? ☐ YES ☐ NO
If NO, complete hours of operation below.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing Address:	**Same as Primary** ☐ YES ☐ NO	**If Yes, do not complete this section.**
Indicate all billing addresses used and include ZIP plus four if used.		
Address		
City	State	ZIP
Phone	Ext	Fax

Mailing Address:	**Same as Primary** ☐ YES ☐ NO	**If Yes, do not complete this section.**
Indicate all billing addresses used and include ZIP plus four if used.		
Address		
City	State	ZIP
Phone	Ext	Fax

3. CORPORATE/SYSTEM OWNER (as provided on Form W-9) ☐ **N/A**

Name: _____

DBA Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Ext: _____ Fax: _____

4. ADDITIONAL PRACTICE/OFFICE LOCATIONS

Do you have additional practice/office locations? ☐ YES ☐ NO

If YES, list other practice/office addresses. If additional space is needed, attach a separate page.

1	Address					
	City	County	State	ZIP		
	Phone		Fax			
	Handicap accessible ☐ YES ☐ NO ☐ N/A		ADA compliant ☐ YES ☐ NO ☐ N/A			

Office Hours **Open 24 hours?** **YES** **NO** **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

2	Address					
	City	County	State	ZIP		
	Phone		Fax			
	Handicap accessible ☐ YES ☐ NO ☐ N/A		ADA compliant ☐ YES ☐ NO ☐ N/A			

Office Hours **Open 24 hours?** **YES** **NO** **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

3	Address					
	City	County	State	ZIP		
	Phone		Fax			
	Handicap accessible ☐ YES ☐ NO ☐ N/A		ADA compliant ☐ YES ☐ NO ☐ N/A			

Office Hours **Open 24 hours?** **YES** **NO** **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

5. LICENSURE/CERTIFICATIONS

Medicare Certified: ☐ YES ☐ NO
If YES, attach a copy of the CMS letter indicating the Medicare number(s) and effective date(s).

Medicare numbers:_____ _____ _____ _____

Number of Medicare Beds: _____

Medicaid Certified: ☐ YES ☐ NO
If YES, list active KMAP ID number(s).

Active KMAP ID numbers:_____ _____ _____ _____

Number of Medicaid Beds: _____

LICENSE TYPE	STATE	LICENSE NUMBER	EXPIRATION DATE
CLIA NUMBER			**EXPIRATION DATE**
OTHER LICENSE/CERTIFICATE – TYPE		**NUMBER**	**EXPIRATION DATE**

6. INSURANCE

Complete Section A, B, or both as applicable.

Professional Liability/Malpractice Liability **No Coverage**
Malpractice not required for HCBS providers who are not providing medical or behavioral health services.

Name of Corporate Entity on Declaration Sheet and/or Certificate of Insurance:

_____

Name of Carrier	Effective Date	Expiration Date	Coverage Amount per Occurrence	Coverage Amount Aggregate	Policy Number

Comprehensive General Liability **No Coverage**

Name of Carrier	Effective Date	Expiration Date	Coverage Amount per Occurrence	Coverage Amount Aggregate	Policy Number

QUESTIONAIRE

Please answer all questions and provide an explanation for affirmative answers.

Applications that do not include all requested responses and explanations will not be processed.

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed? ☐ YES ☐ NO
2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? ☐ YES ☐ NO
3. Has the business ever had its professional liability coverage cancelled but not renewed? ☐ YES ☐ NO
4. Has the business been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ☐ YES ☐ NO ☐ N/A

ACCREDITATION/CERTIFICATION

SECTION A

Section to be completed by non-HCBS providers only. Attach a copy of current Accreditation certificate or survey.

AASM	AAAHC	AAAASF	ABC	ACHC	ACR	AOA	ASDA	BOC Intl
CABC	CACH	CAP	CARF	CCAC	CHAP	COA	COLA	CORF
ABPCO	DNVHCU	HFAP	HQAA	IAC	NABP	NBAOS	TJC	NCQA
URAC	OTHER Not Accredited*							

*Complete Section B below.

Date of initial accreditation: _____ Date of next survey: _____

Date of last survey: _____

SECTION B

Has the provider had an onsite survey by CMS or State agency? ☐ YES ☐ NO

Date of last State survey: _____

If No, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.

Nonaccredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with their Corrective Action Plan (if deficiencies were cited), OR attach a letter from a government agency stating the Facility is in substantial compliance with the most recent survey standards. Facilities who 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.

Component Attestation/Consent & Release Form

Sunflower State Health Plan

☐ **Accept Sunflower State Health Plan** ☐ **Decline Sunflower State Health Plan**

I hereby understand that as a prospective/current Sunflower State Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunflower State Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Sunflower State Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunflower State Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunflower State Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunflower State Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials, and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

UnitedHealthcare

☐ **Accept UnitedHealthCare** ☐ **Decline UnitedHealthCare**

ANY ALTERATION OR FAILURE TO SIGN AND DATE THIS FORM WILL RESULT IN THE DELAY OF PROCESSING THIS APPLICATION

By signing below, I attest that I am the duly authorized representative of the Component, that all information on the Application pertains to the above-named Component, and that such information is current, complete, and correct.

Your signature is required to complete this application. Stamped signatures are NOT acceptable.

Amerigroup

☐ **Accept Amerigroup** ☐ **Decline Amerigroup**

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup of any changes thereto. I understand that this application does not entitle me to participation in Amerigroup. By applying for appointment as an Amerigroup Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Amerigroup's Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for Participating Provider status with Amerigroup. I consent and agree that Amerigroup will complete a criminal history background check to determine if I or any Subcontracted Providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my Subcontracted Providers to undergo such background checks. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between me or my group and Amerigroup, as such terms may be applicable to me.

I understand that as an applicant for participation in Amerigroup, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Amerigroup, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Aetna Better Health

☐ **Accept Aetna Better Health** ☐ **Decline Aetna Better Health**

By signing below, I consent and authorize the release of any and all information to Aetna that may be relevant and necessary to the process of reviewing and evaluating the qualifications of the Organizational Provider for Credentialing, including any applicable information about disciplinary actions and information that might otherwise be considered confidential or privileged. I release Aetna and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials.

I know that it is my responsibility to give enough information to Aetna to show that the organization is compliant with Aetna's credentialing process. I know that any false statement or mistake in this questionnaire will be a reason to reject or end the organization's participation in the network. If there are any changes in the information I provided, making the above information no longer correct and complete, I understand and agree that it is my responsibility to let Aetna know within (30) days of the occurrence. I know if I don't provide the necessary information on the organization's behalf within the 30-day timeframe, the organization may not be part of the Aetna network.

I certify that the information contained in this survey and all attachments is accurate, complete, and true.

Pursuant to the Participating Health Provider Agreement with Aetna Better Health of Kansas and in compliance with Aetna Medicaid requirements, under which the provider entity listed below ("Provider") provides direct support and/or services to Aetna Better Health of Kansas members, I attest that I am duly authorized to sign and attest on behalf of Provider. By my signature below, I **attest** that the Provider represents and warrants the accuracy and compliance of the above representations and that Provider agrees to submit its policies, upon request, to the Aetna Better Health of Kansas Provider Experience Department.

Please remember to complete the below information, including signature and date (print or type).

Business Name: _____

Authorized Representative Name: _____

Title: _____

Signature: _____

Date: _____

NPI Information (as applicable)

If you have multiple NPI numbers, please list all that apply:

NPI Number	Organization/ Sub-Part Name	Address	Taxonomy Code	Level Information	NPI Issue Date	NPI Cancelled*

*Please explain.

Authenticare Information

Organization	Tax ID	NPI	Medicaid ID Number