



Thank you for your interest in participating with Silver Summit Health Plan. We are excited that you selected our provider network as your network of choice. Once we have received all the requested information, we will begin the credentialing process.

Facility or Hospital Provider Checklist

Documents Needed	Facility or Hospital Provider
Hospital/Facility Provider Application	<input type="checkbox"/>
Provider Data form or Provider Roster (If Applicable)	<input type="checkbox"/>
Provider Statement to Release Information (Signed and dated within the last 180 days from submission) (ROI)	<input type="checkbox"/>
Disclosure of Ownership & Controlling Interest Statement	<input type="checkbox"/>
Behavioral Health Addendum (If Applicable)	<input type="checkbox"/>
Copy of W9	<input type="checkbox"/>
Copy of Current State Operational License	<input type="checkbox"/>
Copy of Declaration Page of General Liability Insurance (document showing the amounts and dates of coverage and the amounts 1 Million per occurrence / 3 Million Aggregate)	<input type="checkbox"/>
Copy of Current CLIA Waiver or Certificate (If Applicable)	<input type="checkbox"/>
Copy of current Controlled Substance License – CDS (If Applicable)	<input type="checkbox"/>
Copy of current Accreditation/certification (by a nationally-recognized accrediting body, e.g. TJC/JCAHO) (If Applicable)	<input type="checkbox"/>
Copy of current Site Evaluation Results by a government agency If not accredited by a nationally-recognized body	<input type="checkbox"/>
Copy of Medicaid/Medicare Certification (If not certified, provide proof of participation)	<input type="checkbox"/>

Provider Application (Ancillary, Clinic, Facility, Hospital)

Instructions: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each Legal Entity/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following to the completed application:

- State Operational License
- Other applicable State/Federal Licensures (e.g., CLIA, DEA, Pharmacy or Department of Health)
- Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO/CARF/COA/or AOA) Accreditation letter with dates of accreditation
- If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency
- W-9
- Ownership and Disclosure Form
- Other applicable State/Federal Licensures (See last page for list of state-required documents)

Initial Credentialing/ Assessment

Re-Credentialing/ Re-Assessment

Addition of new site to current contract

Legal Entity/TIN: _____

This application applies to the following **Provider Types**: (Choose all that apply)

<input type="checkbox"/> Hospital (Critical Access) NPI:	<input type="checkbox"/> Hospital (Swing Bed); NPI:	<input type="checkbox"/> Hospital (General Acute Care; NPI:
<input type="checkbox"/> Hospital (Rehabilitation) NPI:	<input type="checkbox"/> Hospital (Psychiatric) NPI:	<input type="checkbox"/> Hospital; NPI:
<input type="checkbox"/> Hospital (Substance Abuse); NPI:	<input type="checkbox"/> Clinic –Federally Qualified Health Center (FQHC); NPI:	<input type="checkbox"/> Intensive Family Intervention; NPI:
<input type="checkbox"/> Adult Day Care Center; NPI:	<input type="checkbox"/> Clinic – Indian Health (IHC); NPI:	<input type="checkbox"/> Outpatient Clinic; NPI:
<input type="checkbox"/> Adult Living Facility/Assisted Living Facility; NPI:	<input type="checkbox"/> Clinic – Rural Health Center (RHC); NPI:	<input type="checkbox"/> Outpatient Infusion / Chemotherapy; NPI:
<input type="checkbox"/> Agency (Dept. of Health, State Health); NPI:	<input type="checkbox"/> Diagnostic Imaging Center; NPI:	<input type="checkbox"/> Orthotics and Prosthetics; NPI:
<input type="checkbox"/> Ambulance; NPI:	<input type="checkbox"/> Dialysis; NPI:	<input type="checkbox"/> Pediatric Day Health Care Facilities (PDHC) ; NPI:
<input type="checkbox"/> Assisted Long-Term Care Facility; NPI:	<input type="checkbox"/> Durable Medical Equipment; NPI:	<input type="checkbox"/> Personal Care Assistant Facilities (PCAs); NPI:
<input type="checkbox"/> Ambulatory Surgical Center ; NPI:	<input type="checkbox"/> Family Planning Clinics; NPI:	<input type="checkbox"/> Residential Treatment Center; NPI:
<input type="checkbox"/> Autism Facility ; NPI:	<input type="checkbox"/> Home & Community Based Services (HCBS); NPI:	<input type="checkbox"/> Rehabilitation Facility (Outside of Hospitals); NPI:
<input type="checkbox"/> Behavioral Health Agency/Child Placing Agency ; NPI:	<input type="checkbox"/> Home Health Agency; NPI:	<input type="checkbox"/> Skilled Nursing Facility; NPI:
<input type="checkbox"/> Board of Health ; NPI:	<input type="checkbox"/> Hospice; NPI:	<input type="checkbox"/> Sleep Diagnostic; NPI:
<input type="checkbox"/> Cardiac Surgery Program; NPI:	<input type="checkbox"/> Laboratory; NPI:	<input type="checkbox"/> Surgical Services (OP or ASC); NPI:
<input type="checkbox"/> Cardiac Catheterization Services; NPI:	<input type="checkbox"/> Mammography; NPI:	Transplant <input type="checkbox"/> Heart/Lung <input type="checkbox"/> Kidney <input type="checkbox"/> Liver <input type="checkbox"/> Lung <input type="checkbox"/> Pancreas <input type="checkbox"/> Heart NPI:
<input type="checkbox"/> Critical Care Services – Intensive Care Units (ICU); NPI:	<input type="checkbox"/> Occupational Therapy; NPI:	<input type="checkbox"/> Urgent Care (Attached to Hospital); NPI:
<input type="checkbox"/> Chemical Dependency /Substance Abuse; NPI:	<input type="checkbox"/> Physical Therapy; NPI:	<input type="checkbox"/> Urgent Care (Free Standing); NPI:
<input type="checkbox"/> Community Mental Health Center (CMHC); NPI:	<input type="checkbox"/> Speech Therapy; NPI:	<input type="checkbox"/> Inpatient Psychiatric Services; NPI:

Taxonomy:

Contact Information:

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

Credentialing Contact Information:

Same as Contact Information

If questions about this application, contact:	Phone Number:
Email:	Fax Number:

Legal Entity Information (Name on Income Tax Return)

Tax ID Holder Name:	Federal Tax ID Number:	<input type="checkbox"/> Profit	<input type="checkbox"/> Non-Profit
Legal/Tax Address (where you want the 1099 sent):			

Insurance Information (Both facility general and professional liability if required). Minimum coverage requirement is \$1 million per occurrence and \$3 million aggregate)

Carrier:	Amount of Coverage:	Coverage Dates:
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Billing Information

How Does Provider Type Bill? (Please Circle One) ANCILLARY CLINIC RHC FQHC HOSPITAL

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

LTTS/HCBS/Home Health Agencies Servicing Counties: (if needed attach an additional sheet)

Servicing County 1:	Servicing County 2:	Servicing County 3:	Servicing County 4:
Servicing County 5:	Servicing County 6:	Servicing County 7:	Servicing County 8:
Servicing County 9:	Servicing County 10:	Servicing County 11:	Servicing County 12:

Complete for each Service Location that is part of this application.

Tax ID Number: _____

Service Location 1 of _____							
Group or Facility Name (to be displayed in the Directory)							
Tax ID Number: <input type="checkbox"/> Same as Legal Entity		Provider Type:			National Provider ID # (Group/Type 2):		
State License Number:		Medicaid Provider ID #:			Medicare Number:		
Service Location Address: <input type="checkbox"/> Same as Legal Entity							
Physical Street Address:				City, State, Zip:		County:	
Main Switchboard Phone Number:				Service Location Fax Number		Email:	
Website:							
Service Location Hours:							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5							
ADA Compliant? (Check all that apply). <input type="checkbox"/> Building <input type="checkbox"/> Bathroom(s) <input type="checkbox"/> Parking <input type="checkbox"/> Therapy Room(s) <input type="checkbox"/> Equipment					Service Location Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you located on a Public Transportation route? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Crisis Intervention/ Emergency Services Offered? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, explain:		Do you provide services to both Males & Females? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:							
Do you provide services to any of the following special needs population? (Check all that apply): <input type="checkbox"/> Deaf/Hearing Impaired <input type="checkbox"/> Physical Disability <input type="checkbox"/> Blind/Vision Impaired <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other (Please specify: _____)							
Is your practice limited to certain ages? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, specify age restrictions: <input type="checkbox"/> None <input type="checkbox"/> 0-2 years <input type="checkbox"/> 0-6 years <input type="checkbox"/> 0-12 years <input type="checkbox"/> 0-17 years <input type="checkbox"/> 0-20 years <input type="checkbox"/> 6-12 years <input type="checkbox"/> 13+ years <input type="checkbox"/> 13-17 years <input type="checkbox"/> 13-20 years <input type="checkbox"/> 3+ years <input type="checkbox"/> 17+ years <input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years <input type="checkbox"/> Other _____							
Behavioral Health Services Provided for Service Location 1 of _____: (check all that apply)							

<input type="checkbox"/> Inpatient Mental Health <input type="checkbox"/> Inpatient Substance Abuse <input type="checkbox"/> Day Treatment – Mental Health <input type="checkbox"/> Day Treatment – Substance Abuse <input type="checkbox"/> Intensive Outpatient Program (IOP) – Mental Health <input type="checkbox"/> Intensive Outpatient Program – Substance Abuse <input type="checkbox"/> Observation <input type="checkbox"/> Residential Treatment – Mental Health (PRTF) <input type="checkbox"/> OP Treatment Services – Mental Health <input type="checkbox"/> OP Treatment Services – Substance Abuse	<input type="checkbox"/> Inpatient – Eating Disorder <input type="checkbox"/> Electroconvulsive Therapy (ECT) – Inpatient <input type="checkbox"/> Electroconvulsive Therapy (ECT) - Outpatient <input type="checkbox"/> Partial Hospitalization Program (PHP) – Mental Health <input type="checkbox"/> Partial Hospitalization Program (PHP) – Substance Abuse <input type="checkbox"/> Residential Treatment – Chemical Dependency <input type="checkbox"/> Community Based Services <input type="checkbox"/> Targeted Case Management <input type="checkbox"/> Crisis Stabilization <input type="checkbox"/> Detox; Ages Served: _____ <input type="checkbox"/> Other (please specify): _____
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LTSS/HCBS Services Provided for Service Location 1 of _____ : (check all that apply)

<input type="checkbox"/> Adult Daily Living <input type="checkbox"/> Assistive Technology <input type="checkbox"/> Benefits Counseling <input type="checkbox"/> Career Assessment <input type="checkbox"/> Community Integration <input type="checkbox"/> Community Transition Services <input type="checkbox"/> Durable Medical Equipment <input type="checkbox"/> Education Support <input type="checkbox"/> Employment Skills Development <input type="checkbox"/> Exceptional DME <input type="checkbox"/> Family Support Services <input type="checkbox"/> Financial Management Services <input type="checkbox"/> Home Adaptations <input type="checkbox"/> Home Delivered Meals <input type="checkbox"/> Home Health Aide Services <input type="checkbox"/> I & A: Service Coordinators/Care Managers <input type="checkbox"/> Job Coaching <input type="checkbox"/> Job Finding <input type="checkbox"/> Non-Medical/Non-Emergency Transportation <input type="checkbox"/> Nursing Facility Services <input type="checkbox"/> Nursing Services <input type="checkbox"/> Nutritional Counseling/SNAP	<input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Participant-Directed Community Support <input type="checkbox"/> Participant-Directed Goods and Services <input type="checkbox"/> Personal Assistance Services <input type="checkbox"/> Personal Emergency Response System (PERS) <input type="checkbox"/> Pest Eradication <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Prevocational Services <input type="checkbox"/> Residential Habilitation <input type="checkbox"/> Respite <input type="checkbox"/> Special Diet Preparation <input type="checkbox"/> Specialized Medical Equipment and Sales <input type="checkbox"/> Speech Therapy <input type="checkbox"/> Structured Day Habilitation <input type="checkbox"/> Supported Employment <input type="checkbox"/> Telecare Services <input type="checkbox"/> Temporary Crisis Services <input type="checkbox"/> Therapeutic and Counseling Services <input type="checkbox"/> Transportation <input type="checkbox"/> Vehicle Modifications <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____
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Billing Information for Service Location 1 of _____ :
 Same as indicated on Page 3 (If different, complete below)

Pay To Name (Issue check to): Note: May be different than name on the 1099.

Pay To Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

Insurance Information for Service Location 1 of _____ :

Same as indicated on Page 3 (If different, complete below)

Professional Carrier:	Amount of Coverage: Per Occurrence: Per Aggregate:	Coverage Dates:
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Worker's Compensation Carrier:	Coverage Dates:
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Has the Provider Office completed Cultural Training? Yes No

If Yes, did the training include the following?

- African American Yes No Asian Yes No
 Alaskan Native Yes No Hispanic/Latino Yes No
 American Indian Yes No Pacific Islander Yes No
 Other _____ Yes No

Service Location 1 of _____ - Accreditation/Certification Type

Same as Legal Entity

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 1 of _____ – Sanctions Same as Legal Entity*If yes, to any question below, please explain on a separate sheet of paper.*

Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the corporation, an officer or board member ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Complete for each Service Location that is part of this application. .

Service Location 2 of _____							
Group or Facility Name (to be displayed in the Directory)							
How Does Provider Bill? Please Circle One. GROUP ANCILLARY CLINIC HOSPITAL							
Tax ID Number: <input type="checkbox"/> Same as Legal Entity		Provider Type:			National Provider ID # (Group/Type 2):		
State License Number:		Medicaid Provider ID #:			Medicare Number:		
Service Location Address:							
<input type="checkbox"/> Same as Legal Entity							
Physical Street Address:				City, State, Zip:		County:	
Main Switchboard Phone Number:			Service Location Fax Number		Email:		
Website:							
Service Location Hours:							
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5							
ADA Compliant? (Check all that apply). <input type="checkbox"/> Building <input type="checkbox"/> Bathroom(s) <input type="checkbox"/> Parking <input type="checkbox"/> Therapy Room(s) <input type="checkbox"/> Equipment					Service Location Accepting New Patients? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you located on a Public Transportation route? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Crisis Intervention/ Emergency Services Offered? <input type="checkbox"/> Yes <input type="checkbox"/> No		If Yes, explain:		Do you provide services to both Males & Females? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:							
Do you provide services to any of the following special needs population? (Check all that apply): <input type="checkbox"/> Deaf/Hearing Impaired <input type="checkbox"/> Physical Disability <input type="checkbox"/> Blind/Vision Impaired <input type="checkbox"/> Developmental Disability <input type="checkbox"/> Other (Please specify: _____)							
Is your practice limited to certain ages? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, specify age restrictions: <input type="checkbox"/> None <input type="checkbox"/> 0-2 years <input type="checkbox"/> 0-6 years <input type="checkbox"/> 0-12 years <input type="checkbox"/> 0-17 years <input type="checkbox"/> 0-20 years <input type="checkbox"/> 6-12 years <input type="checkbox"/> 13+ years <input type="checkbox"/> 13-17 years <input type="checkbox"/> 13-20 years <input type="checkbox"/> 3+ years <input type="checkbox"/> 17+ years <input type="checkbox"/> 21+ years <input type="checkbox"/> 65+ years <input type="checkbox"/> Other _____							

Behavioral Health Services Provided for Service Location 2 of _____: (check all that apply)

- Inpatient Mental Health
- Inpatient Substance Abuse
- Day Treatment – Mental Health
- Day Treatment – Substance Abuse
- Intensive Outpatient Program (IOP) – Mental Health
- Intensive Outpatient Program – Substance Abuse
- Observation
- Residential Treatment – Mental Health (PRTF)
- OP Treatment Services – Mental Health
- OP Treatment Services – Substance Abuse

- Inpatient – Eating Disorder
- Electroconvulsive Therapy (ECT) – Inpatient
- Electroconvulsive Therapy (ECT) - Outpatient
- Partial Hospitalization Program (PHP) – Mental Health
- Partial Hospitalization Program (PHP) – Substance Abuse
- Residential Treatment – Chemical Dependency
- Community Based Services
- Targeted Case Management
- Crisis Stabilization
- Detox; Ages Served: _____
- Other (please specify): _____

LTSS/HCBS Services Provided for Service Location 2 of _____: (check all that apply)

- Adult Daily Living
- Assistive Technology
- Benefits Counseling
- Career Assessment
- Community Integration
- Community Transition Services
- Durable Medical Equipment
- Education Support
- Exceptional DME
- Family Support Services
- Financial Management Services
- Home Adaptations
- Home Delivered Meals
- Home Health Aide Services
- I & A: Service Coordinators/Care Managers
- Job Coaching
- Job Finding
- Non-Medical/Non-Emergency Transportation
- Nursing Facility Services
- Nursing Services
- Nutritional Counseling/SNAP
- Occupational Therapy

- Occupational Therapy
- Participant-Directed Community Support
- Participant-Directed Goods and Services
- Personal Assistance Services
- Personal Emergency Response System (PERS)
- Pest Eradication
- Physical Therapy
- Prevocational Services
- Residential Habilitation
- Respite
- Special Diet Preparation
- Specialized Medical Equipment and Sales
- Speech Therapy
- Structured Day Habilitation
- Supported Employment
- Telecare Services
- Temporary Crisis Services
- Therapeutic and Counseling Services
- Transportation
- Vehicle Modifications
- Other _____
- Other _____

Billing Information for Service Location 2 of _____:

Same as indicated on Page 3 (If different, complete below)

Pay To Name (Issue check to): Note: May be different than name on the 1099.

Pay To Address (Send remittance to):	City, State, Zip:	Phone Number:
Billing Contact Name:	Billing Contact Email:	Fax Number:

Insurance Information for Service Location 2 of _____ :

Same as indicated on Page 3 (If different, complete below)

Professional Carrier:	Amount of Coverage: Per Occurrence: Per Aggregate:	Coverage Dates:
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Worker's Compensation Carrier:	Coverage Dates:
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Has the Provider Office completed Cultural Training? Yes No

If Yes, did the training include the following?
 African American Yes No Asian Yes No
 Alaskan Native Yes No Hispanic/Latino Yes No
 American Indian Yes No Pacific Islander Yes No
 Other _____ Yes No

Service Location 2 of _____ - Accreditation/Certification Type
 Same as Legal Entity
Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 2 of _____ – Sanctions Same as Legal Entity*If yes, to any question below, please explain on a separate sheet of paper.*

Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the corporation, an officer or board member ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current **Silver Summit 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 **Silver Summit Health Plan** Credentials Committee for their review and approval, and, absent such affirmative approval, **Silver Summit 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 **Silver Summit 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 **Silver Summit 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 **Silver Summit 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.

Name of Provider: _____ Date: _____

Print or type name

Signature of Provider or Authorizing Representative

Title

A stamp signature is not acceptable



Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

Practice Information

Check one that most closely describes you: <input type="checkbox"/> Individual <input type="checkbox"/> Group Practice <input type="checkbox"/> Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity
Entity: DBA Name:
Address:
Federal Tax Identification Number:

Section I

<p><u>For individuals</u>, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.</p> <p><u>For entities</u>, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)</p>			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

<p>Are any of the individuals listed above related to each other? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)</p>	
Names	Type of relation

Section III

<p>Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)</p>			
Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)



Disclosure of Ownership And Control Interest Statement

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? Yes No (verify through OIG Website)
 If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than \$25,000 or any significant business transactions with any subcontractors? Yes No
 If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than \$25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
 Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? Yes No
 If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____
Title (or indicate if authorized Agent)

Name (please print) _____
Date

Please return the form by fax to *(insert Fax #)* or by mail in the enclosed postage paid envelope to:
(insert Address here)

Behavioral Health Addendum



Instructions: This Behavioral Health Addendum must be completed in its entirety for any Behavioral Health agreement.

Date Completed:	Name:
Do you provide services to the following populations? (Check all that apply)	
<input type="checkbox"/> Serious Mental Illness (SMI)	<input type="checkbox"/> Serious Emotional Disturbance (SED)
<input type="checkbox"/> Severe Persistent Mentally Ill (SPMI)	
Are you able to provide services to any of the following special needs populations? (Check all that apply)	
<input type="checkbox"/> Deaf/Hearing Impaired	<input type="checkbox"/> Blind/Vision Impaired
<input type="checkbox"/> Developmental Disability	<input type="checkbox"/> Physical Disability
<input type="checkbox"/> Other _____	
Are the following areas in your office ADA Compliant? (Check all that apply)	
<input type="checkbox"/> Building	<input type="checkbox"/> Bathroom(s)
<input type="checkbox"/> Therapy Room(s)	<input type="checkbox"/> Parking
<input type="checkbox"/> Equipment	
Please select the types of services you offer. (Check all that apply)	
Types of Services	
<input type="checkbox"/> Individual Therapy	<input type="checkbox"/> Intensive Outpatient
<input type="checkbox"/> Couples Therapy	<input type="checkbox"/> Psychological Testing
<input type="checkbox"/> Family Therapy	<input type="checkbox"/> Neuropsychological Testing
<input type="checkbox"/> Group Therapy	<input type="checkbox"/> Other (please specify):

Please select the types of disorders you treat and the modalities you practice. (Check all that apply)	
Treatment Modalities/Approaches	Disorders/Issues
<input type="checkbox"/> ABA (Applied Behavior Analysis)	<input type="checkbox"/> ADD/ADHD
<input type="checkbox"/> Biofeedback	<input type="checkbox"/> Adjustment Disorders
<input type="checkbox"/> Client Centered Therapy	<input type="checkbox"/> Anxiety Disorders
<input type="checkbox"/> Cognitive Behavioral Therapy	<input type="checkbox"/> Attachment Disorders
<input type="checkbox"/> Dialectical Behavioral Therapy	<input type="checkbox"/> Autism Spectrum
<input type="checkbox"/> EMDR	<input type="checkbox"/> Disruptive Behavior Disorders
<input type="checkbox"/> Family Systems	<input type="checkbox"/> Dissociative Disorders
<input type="checkbox"/> Gestalt	<input type="checkbox"/> Eating Disorders
<input type="checkbox"/> Hypnosis	<input type="checkbox"/> Impulse Disorders
<input type="checkbox"/> NLP	<input type="checkbox"/> Mood Disorders
<input type="checkbox"/> Outcomes Oriented Therapy	<input type="checkbox"/> Personality Disorders
<input type="checkbox"/> Play Therapy	<input type="checkbox"/> Physical Abuse
<input type="checkbox"/> Psychoanalytic	<input type="checkbox"/> PTSD
<input type="checkbox"/> Rationale Emotive Therapy	<input type="checkbox"/> Schizophrenia
<input type="checkbox"/> Solution Focused Therapy	<input type="checkbox"/> Sexual Abuse (Adults)
<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Sexual Abuse (Children)
<input type="checkbox"/> Trauma Focused – CBT	<input type="checkbox"/> Sexual Disorders
<input type="checkbox"/> Methadone/Suboxone Medication Services	<input type="checkbox"/> Substance Abuse/Dependence Disorders
<input type="checkbox"/> Other (please specify):	<input type="checkbox"/> Other (please specify):

Practitioner Data Form



Instructions:

- Information on this Data Form must be provided and completed in its entirety for each Practitioner seeing patients within the Group or Facility.
- Please submit a copy of the Provider’s W-9 (one per tax entity).
- Please make copies and attach additional Location Information pages, if necessary.
- Please ensure to include the Medicaid ID number.
- Please attach the Ownership and Disclosure Form.
- If a Practitioner participates with CAQH, you may optionally provide this information and allow Centene Corporation access to your application information. (Attested within 120 days)
- Behavioral Health Providers must complete Behavioral Health Addendum.

Date Completed:		Individual NPI:	
Are you registered with CAQH? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, CAQH Provider ID:	
Last Name:	First Name:	Middle Initial:	
Date of Birth:	Social Security #:	Medicaid ID (11 digits):	
Medicare #			
Title/Degree (MD, DO, PhD, LCSW, LPC, NP, etc.):			
Has Provider completed Cultural Competency Training? <input type="checkbox"/>Yes <input type="checkbox"/>No			
If Yes, did the training include the following?			
African American- <input type="checkbox"/> Yes <input type="checkbox"/> No		Asian - <input type="checkbox"/> Yes <input type="checkbox"/> No	
Alaskan Native- <input type="checkbox"/> Yes <input type="checkbox"/> No		Hispanic/Latino- <input type="checkbox"/> Yes <input type="checkbox"/> No	
American Indian- <input type="checkbox"/> Yes <input type="checkbox"/> No		Pacific Islander- <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other _____ <input type="checkbox"/> Yes <input type="checkbox"/> No			

Billing Information (Complete this section if different than the W9):

Pay to Name (Issue Check to): Note: May be different than the name on the 1099.		
Pay to Address (Send remittance to):	City State, Zip:	Phone Number :
Billing Contact Name:	Billing Contact Email:	Fax Number:

Location Information 1 of _____

Location Name:		Group NPI:			Tax ID:		
Location Street Address:		Location City/State:			Location Zip Code:		
Location County:		Primary Phone:			Primary Fax:		
Email Address:				Website URL: (www.)			
Credentialing Contact Information (Name, Address, E-mail):							
Applying as: <input type="checkbox"/> Specialist (includes Behavioral Health) <input type="checkbox"/> Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)							
Primary Specialty:		Taxonomy:		Display in Find-A-Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Languages Spoken (including American Sign Language):	
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5 Monday - Friday							
License Number:			License State:			Exp. Date:	
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No			If yes, board name:			Exp. Date:	
If PCP, are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, existing patients only			Gender or Age restrictions? Gender: <input type="checkbox"/> None <input type="checkbox"/> Female Only <input type="checkbox"/> Male Only Ages treated: <input type="checkbox"/> None <input type="checkbox"/> Age Limits: Lowest Age ____ Highest Age ____ Ages treated for Psychiatrists/Psychologists who treat child/adolescent members: <input type="checkbox"/> 0-6 <input type="checkbox"/> 7-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-21				
Are the following areas in your office ADA Compliant? (Check all that apply) <input type="checkbox"/> Building <input type="checkbox"/> Bathroom(s) <input type="checkbox"/> Therapy Room(s) <input type="checkbox"/> Parking <input type="checkbox"/> Equipment							

Location Information _____ of _____

Location Name:		Group NPI:		Tax ID:			
Location Street Address:		Location City/State:		Location Zip Code:			
Location County:		Primary Phone:		Primary Fax:			
Email Address:			Website URL: (www.)				
Credentialing Contact Information (Name, Address, E-mail):							
Applying as: <input type="checkbox"/> Specialist (includes Behavioral Health) <input type="checkbox"/> Primary Care Provider (e.g., Primary Care Physician, Mid-Level Provider, etc.)							
Primary Specialty:		Taxonomy:		Display in Find-A-Provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		Languages Spoken (including American Sign Language):	
Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<input type="checkbox"/> 24 Hours <input type="checkbox"/> 8 – 5 Monday - Friday							
License Number:		License State:		Exp. Date:			
Are you board certified? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, board name:		Exp. Date:			
If PCP, are you accepting new patients? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes, existing patients only		Gender or Age restrictions? Gender: <input type="checkbox"/> None <input type="checkbox"/> Female Only <input type="checkbox"/> Male Only Ages treated: <input type="checkbox"/> None <input type="checkbox"/> Age Limits: Lowest Age ____ Highest Age ____ Ages treated for Psychiatrists/Psychologists who treat child/adolescent members: <input type="checkbox"/> 0-6 <input type="checkbox"/> 7-12 <input type="checkbox"/> 13-17 <input type="checkbox"/> 18-21					
Are the following areas in your office ADA Compliant? (Check all that apply) <input type="checkbox"/> Building <input type="checkbox"/> Bathroom(s) <input type="checkbox"/> Therapy Room(s) <input type="checkbox"/> Parking <input type="checkbox"/> Equipment							