Product Regulation
50 W. Town St., 3rd Fl
Suite 300
Columbus, OH 43215
(614) 644-2661
Fax # (614) 728-5238
www.insurance.ohio.gov

Ohio Department of Insurance

John R. Kasich – Governor
Mary Taylor – Lt. Governor/Director

Standardized Credentialing Form
Part B: Agency/Program/Organization Providers

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable or not available and why. Attach additional sheets when necessary. Separate forms may be required for each National Provider Identifier (NPI), practice location, and provider type.

You must include copies of the following documents, as applicable, with this completed application. Use this checklist as a guide:

☐	State License
☐	Local Business License
☐	Registrations or Certifications
☐	DEA and/or CDS Certificate
☐	CLIA Certificate
☐	Terminal Distributor License
☐	Current Certificate of General Liability Insurance
☐	Current Certificate of Professional Liability Insurance
☐	Form W-9
☐	Workers' Compensation Certificate of Coverage
☐	Accreditation Letter and Certificate
☐	Medicare Certification Letter
☐	Medicaid Certification Letter

If the Provider is not accredited, please include the following information:

☐	C.V. of Medical Director	NA ☐
☐	C.V. of Clinical Director	NA ☐
☐	Credentialing Plan	NA ☐
☐	Most recent CMS or State Surveys, Correction Action Plans and Revisit Reports	NA ☐
☐	Documented staff attendance at OSHA Training	NA ☐
☐	Documented compliance with OSHA record keeping rules regarding workplace injuries and illness	NA ☐
☐	Confidentiality Plan	NA ☐

Note: Please submit this form directly to health plans and other entities that credential facility providers for participation in their networks. DO NOT send this form to the Ohio Department of Insurance; the Department does not use the form for any reporting purposes.

Provider Identification

Legal Name of Applicant:			Federal Tax Identification Number:
Doing Business As (DBA):			
Type of Provider:			NPI:
Primary Office Address:			
Mailing Address (if different from business address):	City:	State:	Zip Code:
Date and State of Incorporation or Registration:			
List all other states in which applicant is approved to conduct external reviews:			Length of time in business with this legal name and Tax ID:
Credentialing Contact Name:	Year Applicant Opened:		
Address (If different from above):			
Phone:	Fax:	Email:	
Applicant Owner/Parent Company:			

Type of Entity (Check one) ☐ Corporation ☐ Partnership ☐ Limited Liability Company ☐ Joint Venture ☐ Other:

List all memberships in professional organizations and trade associations:

Medical Director

Name (Last, First, Middle):		
Degree:	Specialty:	
Office Address:		
Phone:	Fax:	Email:

☐ No Medical Director

Provider Practice Information

Name:							
Street Address/PO Box:							
City:			State:			Zip Code:	
Phone:		Fax:			Email:		
Website:							
Primary Contact Name and Title:							
Phone:		Fax:			Email:		
Hours of Operation:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
Included in Provider Directory? Yes ☐ No ☐		List language and sign language interpreters/ contractors:				Is teletype available? Yes ☐ No ☐	
Federal Tax ID number:		NPI:		Administrator/ Site Manager:			
Service Areas (Counties):							
Handicapped Access: ☐ Yes ☐ No		On Bus Route: ☐ Yes ☐ No		Number of Beds:			

Additional Practice Location

Name:							
Street Address/PO Box:							
City:			State:			Zip Code:	
Phone:		Fax:			Email:		
Website:							
Primary Contact Name and Title:							
Phone:		Fax:			Email:		
Hours of Operation:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
Included in Provider Directory? Yes ☐ No ☐		List language and sign language interpreters/ contractors:				Is teletype available? Yes ☐ No ☐	
Federal Tax ID number:		NPI:		Administrator/ Site Manager:			
Service Areas (Counties):							
Handicapped Access: ☐ Yes ☐ No		On Bus Route: ☐ Yes ☐ No		Number of Beds:			

Additional Practice Location

Name:							
Street Address/PO Box:							
City:			State:			Zip Code:	
Phone:		Fax:			Email:		
Website:							
Primary Contact Name and Title:							
Phone:		Fax:			Email:		
Hours of Operation:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
Included in Provider Directory? Yes ☐ No ☐		List language and sign language interpreters/ contractors:				Is teletype available? Yes ☐ No ☐	
Federal Tax ID number:		NPI:		Administrator/ Site Manager:			
Service Areas (Counties):							
Handicapped Access: ☐ Yes ☐ No		On Bus Route: ☐ Yes ☐ No		Number of Beds:			

Billing Information

To whom shall checks be made payable:							
Billing Address (Street/PO Box):							
City:			State:			Zip Code:	
Phone:		Fax:			Email:		
Type of Claim Form Used: ☐ CMS1500 ☐ UB04 ☐ UB92 ☐ Other							

Accreditation Status

Accrediting Agency Name:							
Accreditation Status:			Accreditation Date:				
Have you ever been denied accreditation by any accrediting body? ☐ Yes ☐ No							
If yes, please provide details:							

Licensure and Certifications

Medicaid Provider Number and Status:					Medicare Provider Number and Status:		
License Number and Status:	☐ NA		CLIA Number:		☐ NA		

Scope of Services

List all services offered (attach separate page if necessary):

Does the Provider have a toll free number? Yes ☐ No ☐

If Yes, please provide number:

Is the Provider staffed 24 hours a day? Yes ☐ No ☐	Is the Provider part of a national network of providers? Yes ☐ No ☐
If Yes, please describe:	
Does the Provider accept Worker's Compensation patients? Yes ☐ No ☐	What is the accepted age range of the Provider's patients?

Does the Provider subcontract with other Providers? Yes ☐ No ☐

If Yes, please provide names, addresses, description of services provided, and a copy of each contract:

Liability Insurance

General Liability Coverage (Attach certificate showing current coverage amounts and effective dates)

Name of Carrier:	Policy Number:	
Street Address/PO Box:		
City:	State:	Zip Code:
Coverage Type: ☐ Occurrence Based ☐ Claims Based		
Effective Date:	Expiration Date:	
Per Incident: $	Aggregate: $	

Professional Liability (Malpractice) Coverage

Name of Carrier:	Policy Number:	
Street Address/ PO Box:		
City:	State:	Zip Code:
Coverage Type: ☐ Occurrence Based ☐ Claims Based		
Effective Date:	Expiration Date:	
Per Incident: $	Aggregate: $	

Staffing

Provide a list of the types, numbers of professional disciplines, licensures and/or certifications represented on the staff.
Provide a list of any special certifications, accreditations, or licensures held by the professional staff of your organization.

Electronic Capabilities

What are the Provider's current electronic capabilities?

What billing and documentation software is the Provider currently using?	What version is the software?
Does the Provider use this to perform eligibility verification? Yes ☐ No ☐	Sent in groups (Batch)? ☐ Or one at a time (Real Time)? ☐
Does the Provider use this to perform electronic claim submissions? Yes ☐ No ☐	Sent in groups (Batch)? ☐ Or one at a time (Real Time)? ☐
Does the Provider use Electronic Medical Records (EMR)? Yes ☐ No ☐	What is the name of the EMR software?
What version is the EMR?	Is the EMR software compatible with your billing and documentation software? Yes ☐ No ☐

Disclosure Questions

Please answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.

Have criminal proceedings ever been initiated against the Provider or its authorized representatives? ☐ Yes ☐ No

Has the Provider 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 and military or Department of Health programs? ☐ Yes ☐ No

Has the Provider's professional liability 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? ☐ Yes ☐ No

Has the Provider ever been notified that information pertaining to anyone in the Provider's staff has been reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank or professional state licensing boards or registries? ☐ Yes ☐ No

In the last five years, have there been any professional liability suits, or are there currently any pending or threatened suits against the Provider, or have any judgments been made or settlements paid on its behalf? ☐ Yes ☐ No

Is there currently any pending or threatened licensing or disciplinary action against the Provider? ☐ Yes ☐ No

References

Please provide at least three references from Healthcare Providers, Organizations, or Managed Care Organizations that the Provider currently services.

Name:	Company:
Address:	Phone:
Name:	Company:
Address:	Phone:
Name:	Company:
Address:	Phone:

Standard Authorization, Attestation and Release

I am the authorized agent of the Applicant named below and have the authority to execute this document on behalf of the Applicant. I understand that as part of the credentialing application process to participate as a Provider (hereinafter, referred to as "Participation") with _____(insert name of Contracting Entity), all Applicants are required to provide sufficient and accurate information for the proper evaluation of all criteria used by the Contracting Entity for determining initial and ongoing eligibility for Participation. I acknowledge and understand that my cooperation in obtaining information in connection with this application and my consent to the release of information does not guarantee that the Contracting Entity will contract with the Applicant as a provider of services.

Authorization of Investigation Concerning Application for Participation.
The following individuals including, without limitation, the Contracting Entity, its representatives, employees, and/or designated agent(s); the Contracting Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Contracting Entity's designated professional credentials verification organization (collectively referred to as "Agents"), are hereby authorized to investigate information, which includes both oral and written statements, records, and documents, concerning this application for Participation. The Applicant agrees to allow the Contracting Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation.
The Applicant hereby authorizes any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Contracting Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning the qualifications of this Applicant, its credentials, accreditations, quality assurance and utilization data, or any other information reasonably having a bearing on the Applicant's qualifications for Participation with the Contracting Entity. This information shall also include the details of any action taken by a health care organization, Medicare and Medicaid, their administrators or their medical or other committees to revoke, deny, suspend, restrict, or condition the Applicant's Participation, impose a corrective action plan or terminate any contract to which the Applicant was a party. The Applicant further authorizes its current and past insurance carrier(s) to release this Applicant's history of claims that have been made and/or are currently pending against it. The Applicant specifically waives written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Release from Liability.
The Applicant hereby releases from all liability and holds harmless any Contracting Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Contracting Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. The Applicant further agrees not to sue any entity, any agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for credentialing activities.

In this Authorization, Attestation and Release, all references to the Contracting Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Contracting Entity and its affiliates or agents retain the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement.

The Applicant understands and agrees that this Authorization, Attestation and Release is irrevocable for any period during which the entity identified below is an Applicant or a Provider with the Contracting Entity. The Applicant agrees that it shall execute another form of consent if any law or regulation limits the application of this irrevocable authorization. The Applicant understands that its failure to promptly provide another form of consent may be grounds for termination or discipline by the Contracting Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Contracting Entity, or grounds for its termination of Participation with the Contracting Entity.

Standard Authorization, Attestation and Release (continued)

The undersigned certifies that all information provided in its application is current, true, correct, accurate and complete to the best of his/her knowledge and belief, and is furnished in good faith. The Applicant will notify the Contracting Entity and/or its Agent(s) within ten (10) days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) that has been provided in its application and /or is authorized to be released pursuant to the credentialing process. The Applicant understands that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by an authorized agent of the Applicant (may be a written or an electronic signature). The Applicant acknowledges that it is responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. The Applicant understands and agrees that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Contracting Entity and/or its Agent(s).

The undersigned acknowledges that he/she has read and understands the foregoing Authorization, Attestation and Release. A facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature (Do not stamp)

Name (print)

Date

Title (Print)

Name of Applicant (Print)

Please return this form using the submit button or return by email to OhioContracting@Centene.com

Submit To Buckeye Health