Behavioral Health Facility/Agency Credentialing Application

INSTRUCTIONS

Please complete the application thoroughly in its entirety complete the credentialing process.

return by email to OhioContracting@Centene.com Or use the submit button at the bottom of this document.

The checklist below is provided as a guide for the documents required to complete the credentialing process.

Please enclose the following with your completed Facility & Ancillary Provider Application:

- ☐ Staff Roster for all behavioral health treatment staff. Must be submitted in excel format on the template provided on the "Provider Resources" page under 'Forms', 'Behavioral Health CMHC_SUD Roster' for CMHC's or SUD facilities. 'Standard Direct Practitioner Roster' for all other facility types at: https://www.buckeyehealthplan.com/providers/resources/forms-resources.html
- ☐ Copy of the completed Disclosure of Ownership Form – Found on the "Provider Resources" page under 'Forms', 'Disclosure of Ownership and Control Interest Statements Form' at: https://www.buckeyehealthplan.com/providers/resources/forms-resources.html
- ☐ W9 Form
- ☐ A copy of your JCAHO/CARF/COA/or AOA accreditation letter with dates of accreditation
- ☐ A copy of the state or local license(s) and/or certificate(s) under which your facility operates. Include all documentation for multiple facility locations
- ☐ Medicaid enrollment/certification letter with Medicaid number
- ☐ Medicare enrollment/certification letter with Medicare number
- ☐ A copy of your CLIA license (If applicable)
- ☐ A copy of your Pharmacy license (If applicable)
- ☐ A copy of your professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year)
- ☐ A copy of your NDMS agreement (If applicable)
- ☐ A copy of your state or local fire/health certificate (Non-accredited facilities only)
- ☐ A copy of your Quality Assurance Plan (Non accredited facilities only)
- ☐ A copy of your Credentialing Procedures (Accredited and Non-accredited facilities)
- ☐ Description of Aftercare or Follow up Program (Non-accredited facilities only)
- ☐ Organizational Charts including staff to Patient Ratios (Non accredited facilities only)

***Please Note: A separate Facility & Ancillary Credentialing Application must be completed for each facility with a unique Federal Tax ID.**

Facility and Ancillary Credentialing Application

☐ Initial Credentialing ☐ Addition of a new site/service to a current contract

☐ Recredentialing

Legal Name: _____

Parent Company Health System Name (If Applicable): _____

D/B/A: _____

Facility Type

☐ Hospital
☐ Intensive Family Intervention
☐ Adult Living Facility
☐ Home Health Agency
☐ Federally Qualified Health Center/RHC
☐ Community Mental Health Center
☐ Rehabilitation Center
☐ Rehabilitative Behavioral Health Services
☐ (RBHS) Assisted Long-Term Care Facility
☐ Outpatient Clinic
☐ Substance use Treatment Facility
☐ Other: _____

Accreditation Information

Is this Facility Accredited? ☐ Yes ☐ No

Agency Name	Acronym	Issue Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Osteopathic Hospital Association	AOHA		
Commission on Accreditation for Rehab Facilities	CARF		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
Others (please list):			

*Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective date of accreditation or certification, deficiencies and approved plan for corrective action.

Licensure and Certification Information

	Issuing Entity	Type of Lic or Certificate	License Number	Expiration Date
1.				
2.				
3.				
4.				

Does the organizational provider state licensure/certification include a site visit by the state? Yes ☐ No ☐

If "yes", please attach a copy of the audit, the site visit letter including the date of site visit, and any corrective action plan issued.

buckeye health plan

Facility Practice Locations

Locations	Age Category	Mental Health: Inpatient	Partial	IOP	Residential	Observation	Other:	Substance Abuse: I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other:
Location #1 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
City,State Zip:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fax:		ECT	I/P		O/P		☐ Methadone				☐ Suboxone			
NPI: _____ _____ _____ _____		_____ # of I/P Beds (MH)			_____ # of Beds Medicare					_____ # of Beds (SA)				
		☐ ACT			☐ IHBT Services									
If Detoxification is offered, on which unit are services offered:		☐ Located on Medical Floor/Unit					Taxonomy:							
		☐ Located on Behavioral Health Floor/Unit												
Hours of Operation:		☐ 24 Hours			☐ M-F 8-5		☐ M-F 8:30-5				☐ M-F 9- 5			
Monday	Tuesday	Wednesday			Thursday		Friday			Saturday			Sunday	
_____ to _____	_____ to _____	_____ to _____			_____ to _____		_____ to _____			_____ to _____			_____ to _____	
Language(s) spoken at this facility:		☐ English	☐ Spanish		☐ French		☐ Russian			☐ Polish				
		Other: _____												
Wheelchair Accessible?		☐ Yes	☐ No		Genders Treated:		☐ M			☐ F				
Location #2 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
City,State Zip:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fax:		ECT	I/P		O/P		☐ Methadone				☐ Suboxone			
NPI: _____ _____ _____ _____		_____ # of I/P Beds (MH)			_____ # of Beds Medicare					_____ # of Beds (SA)				
		☐ ACT			☐ IHBT Services									
If Detoxification is offered, on which unit are services offered:		☐ Located on Medical Floor/Unit					Taxonomy:							
		☐ Located on Behavioral Health Floor/Unit												
Hours of Operation:		☐ 24 Hours			☐ M-F 8-5		☐ M-F 8:30-5				☐ M-F 9- 5			
Monday	Tuesday	Wednesday			Thursday		Friday			Saturday			Sunday	
_____ to _____	_____ to _____	_____ to _____			_____ to _____		_____ to _____			_____ to _____			_____ to _____	
Language(s) spoken at this facility:		☐ English	☐ Spanish		☐ French		☐ Russian			☐ Polish				
		Other: _____												
Wheelchair Accessible?		☐ Yes	☐ No		Genders Treated:		☐ M			☐ F				
Location #3 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
City,State Zip:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Phone:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fax:		ECT	I/P		O/P		☐ Methadone				☐ Suboxone			
NPI: _____ _____ _____ _____		_____ # of I/P Beds (MH)			_____ # of Beds Medicare					_____ # of Beds (SA)				

Location #3 (cont)

If Detoxification is offered, on which unit are services offered:	☐ ACT ☐ IHBT Services ☐ Located on Medical Floor/Unit Taxonomy: ☐ Located on Behavioral Health Floor/Unit						
Hours of Operation:	☐ 24 Hours ☐ M-F 8-5 ☐ M-F 8:30-5 ☐ M-F 9- 5						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	
Language(s) spoken at this facility:	☐ English ☐ Spanish ☐ French ☐ Russian ☐ Polish Other:						
Wheelchair Accessible?	☐ Yes ☐ No	Genders Treated:	☐ M ☐ F				

Location #4 Name:															
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
City,State Zip:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Phone:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Fax:		ECT	I/P	O/P	☐ Methadone						☐ Suboxone				
NPI: _____ _____ _____ _____		____ # of I/P Beds (MH)			____ # of Beds Medicare						____ # of Beds (SA)				
	☐ ACT ☐ IHBT Services														
If Detoxification is offered, on which unit are services offered:	☐ Located on Medical Floor/Unit Taxonomy: ☐ Located on Behavioral Health Floor/Unit														
Hours of Operation:	☐ 24 Hours ☐ M-F 8-5 ☐ M-F 8:30-5 ☐ M-F 9- 5														
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday									
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	____ to ____									
Language(s) spoken at this facility:	☐ English ☐ Spanish ☐ French ☐ Russian ☐ Polish Other:														
Wheelchair Accessible?	☐ Yes ☐ No	Genders Treated:	☐ M ☐ F												

Location #5 Name:															
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
City,State Zip:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Phone:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Fax:		ECT	I/P	O/P	☐ Methadone						☐ Suboxone				
NPI: _____ _____ _____ _____		____ # of I/P Beds (M/H)			____ # of Beds Medicare						____ # of Beds (SA)				
	☐ ACT ☐ IHBT Services														
If Detoxification is offered, on which unit are services offered:	☐ Located on Medical Floor/Unit Taxonomy: ☐ Located on Behavioral Health Floor/Unit														
Hours of Operation:	☐ 24 Hours ☐ M-F 8-5 ☐ M-F 8:30-5 ☐ M-F 9- 5														
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday									
____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	____ to ____	____ to ____									
Language(s) spoken at this facility:	☐ English ☐ Spanish ☐ French ☐ Russian ☐ Polish Other:														
Wheelchair Accessible?	☐ Yes ☐ No	Genders Treated:	☐ M ☐ F												

***If additional locations are needed, please make a copy of this page**

Administrative Information

Administrative/Mailing Address:		
City, State, Zip:	County:	
Administrative phone:	Fax:	Email:
Billing Address:		
City, State, Zip:		
Federal Tax ID #:		
Medicare Provider #:	Issue Date:	Expiration Date:
Medicaid Provider #:	Issue Date:	Expiration Date:

Are all of your HIPAA transactions conducted from a centralized location? Yes ☐ No ☐
*If "no", please ensure you indicate a separate NPI number per location on page 3 above

Contact Information

	Name	Phone	Email
Managed Care Contact			
Credentialing Contact			
Billing Contact			
Clinical Director			

Insurance Coverage – *(Attach copy of declaration pages)*

Current Professional Carrier:	
Amount per Occurrence:	Amount per Aggregate:
Coverage Start Date:	End date:
Current Worker's Compensation Carrier:	
Coverage Start Date:	End date:

***If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts.*

Sanctions & Disclosure questions

If any question below is responded to with a "yes", please provide an explanation on a separate sheet, and attach to this Application.

☐ YES ☐ NO	In the last 5 years, have there been any professional liability suits, or are there currently any pending or threatened suits against the Facility, 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 Facility?
☐ YES ☐ NO	Has the facility 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 governmental health care plans or programs?
☐ YES ☐ 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 professional conduct?
☐ YES ☐ 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.)
☐ YES ☐ NO	Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?
☐ YES ☐ NO	Have criminal proceedings ever been initiated against the Provider or its authorized representatives?
☐ YES ☐ NO	Has the Facility 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 Facility ever been notified that the information pertaining to anyone in the Facilities staff has been reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data bank or professional state licensing boards or Registries?

Facility Responsibility Form

I hereby understand that as a prospective/current **Buckeye 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, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Buckeye 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 Buckeye Health Plan credentialing/recredentialing requirements for all such individuals associated with my practice.

By applying for participation with Buckeye Health Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Buckeye Health 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 Buckeye Health Plan.
- Authorize Buckeye Health 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, or other State or Federal regulatory agencies.
- Consent to an inspection by Buckeye Health 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 Buckeye Health 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.

In order to evaluate this application for participation in and/or continued participation with Buckeye Health Plan, the Facility hereby grants permission to Buckeye Health 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 Buckeye Health 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 Buckeye Health 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 is selected or retained, after such selection or retention, the Facility agrees to inform Buckeye Health Plan in writing within 10 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 Buckeye Health Plan on its own behalf and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Buckeye Health Plan programs or any program until such time as this Facility receives notice of participation.

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. A photo copy shall have the same force and effect as the signed original.

Signature of Facility CEO (or authorized designee) | **Title**

Name (Print) | **Date**

Clear Form | CMHC_SUD Roster | Disclosure of Ownership Form | **Submit**