Organizational/Facility Credentialing Application

AmeriHealth Caritas Pennsylvania

Submit this application, the organizations/facilities application checklist, and all other accompanying documents to **provider.credentialinghbg@amerihealthcaritaspa.com** or fax to **1-717-651-1673**. For more information, go to **www.amerihealthcaritaspa.com → Providers → Join our network**.

Organizational provider identification	
Legal business name (as reported to the IRS):	Medicaid number:
Doing Business As (DBA) name (if applicable):	Medicare number:
Health system affiliation (if applicable):	Taxpayer Identification Number (TIN):
Length of time in business with this name and TIN: _____ years _____ months	National Provider Identifier (NPI) number:

Organizational provider information **(please refer to attachment A for services provided at this location/site and additional locations).**	
Organizational provider name:	
Address line 1:	
Address line 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Website:	
Credentialing contact name:	
Phone:	Fax:
Email:	
Organizational provider administrator name:	
Phone:	Fax:
Email:	
Products: ☐ AmeriHealth Caritas Pennsylvania (Medical Assistance) ☐ AmeriHealth Caritas VIP Care (Medicare Advantage dual eligible special needs plan [D-SNP]) ☐ AmeriHealth Caritas Pennsylvania Community HealthChoices (long-term services and supports [LTSS]) ☐ All three	

Office hours (use HH:MM format)									
Day	**Start**	**A.M./P.M.**	**End**	**A.M./P.M.**	**Day**	**Start**	**A.M./P.M.**	**End**	**A.M./P.M.**
Monday					Saturday				
Tuesday					Sunday				
Wednesday									
Thursday									
Friday									

Services at this location:

☐ Americans with Disabilities Act (ADA) accessibility requirements
☐ Handicap accessibility
☐ 24/7 phone coverage
☐ Answering service

Mailing/correspondence address	
☐ Check here if all correspondence can be directed to the organizational provider address indicated on page 1. If not, complete the section below:	
Name:	
Mailing address 1:	
Mailing address 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Email:	

Remit/billing address	
Name:	
Mailing address 1:	
Mailing address 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Email:	

Facility type	
☐	Ambulatory surgical center — free-standing only
☐	Behavioral health and social services
☐	Behavioral rehabilitation
☐	Community mental health
☐	Comprehensive outpatient rehabilitation facilities (CORFs)
☐	Diabetic education program
☐	Dialysis center
☐	Durable medical equipment supplier
☐	Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinic
☐	Federally qualified health center (FQHC)
☐	Federally qualified health center (FQHC): Behavioral health only
☐	Free-standing radiology center
☐	Free-standing sleep center/sleep lab
☐	Home health care agency providing both skilled services and personal care assistance (PCA) services
☐	Home health care agency providing skilled services only and no PCA services
☐	Home health hospice
☐	Home infusion
☐	Hospital (acute care and acute rehabilitation)
☐	Hospital (psychiatric geriatric)
☐	Intermediate care facility — mental health
☐	Mental health clinic
☐	Nursing home
☐	Portable X-ray suppliers
☐	Rural health clinic (RHC)
☐	Skilled nursing facility/nursing home
☐	Skilled nursing facility providing sub-acute services
☐	Other (please indicate)

Health care licensure

Attach a copy of each facility licensure(s). Do not submit practitioner licensure(s).

License number	State or city	Licensing agency	Initial issue date	Renewal date	Expiration date

Medicare status

1. Is this organizational provider participating in the Medicare program?
   ☐ Yes ☐ No ☐ Pending

If yes, provide Medicare number:_____

2. Is this organizational provider Medicare (Centers for Medicare & Medicaid Services [CMS]) certified?
   ☐ Yes ☐ No ☐ Pending

If yes, provide date of initial CMS certification: _____ and Medicare certification number:_____

☐ Check here if organizational provider is **not eligible** for CMS certification.

Accreditation

Select accrediting agency from the list below. Attach a copy of current accreditation certificate.

If not accredited, skip checklist and go to the **Site visit requirement** section.

☐	**AAAAPSF** – American Association for Accreditation of Ambulatory Plastic Surgery Facilities
☐	**AAAASF** – American Association for Accreditation of Ambulatory Surgery Facilities
☐	**AAAHC** – Accreditation Association for Ambulatory Health Care
☐	**AASM** – American Academy of Sleep Medicine
☐	**ACHC** – Accreditation Commission for Health Care
☐	**AOA** – American Osteopathic Association
☐	**CARF** – Commission on Accreditation of Rehabilitation Facilities
☐	**CCAC** – Continuing Care Accreditation Commission
☐	**CHAP** – Community Health Accreditation Partner
☐	**NIAHO** – National Integrated Accreditation for Healthcare Organizations
☐	**The Joint Commission** – previously known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Date of initial accreditation:

Date of last full survey:

Site visit requirement

Attach a copy of most recent onsite survey for each location (with Corrective Action Plan (CAP), if citations were issued); OR attach cover letter from government agency stating organizational provider is in substantial compliance.

1. Has organizational provider had a post-licensing onsite visit by a government agency such as the Department of Health (DOH) or CMS within the past 36 months?

☐ Yes Date of most recent standard survey: _____

☐ No **Successful completion of a health plan onsite visit will be required to complete credentialing**.

2. Were any deficiencies cited during the last full survey?
☐ Yes ☐ No ☐ N/A; no recent survey

If yes, have all deficiencies been corrected?
☐ Yes **Provide evidence of state acceptance of your CAP**.
☐ No **Provide explanation and your plan to correct all deficiencies**.

If no deficiencies were cited during the last full survey, **submit verification of no deficiencies**.

Practitioner credentialing

Does the organizational provider validate, for each licensed practitioner employed or contracted at the facility, the credentials necessary to perform health care services? ☐ Yes ☐ No

If yes, indicate how the organizational provider conducts the credentialing process for each practitioner:

☐ Credentialing procedures are performed internally.

☐ Credentialing procedures are outsourced/delegated to: _____

☐ Other, specify:_____

If no, please explain:_____

Insurance

Both facility general and professional liability are required. Minimum coverage requirement is $1 million per occurrence and $3 million aggregate.

General liability coverage

Attach certificate showing policy number, coverage amounts, effective date, and expiration date.

Current carrier name:	Policy number:
Street/P.O. box:	City:
State:	ZIP code:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence-based ☐ Claims-based	

Professional liability coverage	
Attach certificate showing policy number, coverage amounts, effective date, and expiration date.	
Current carrier name:	Policy number:
Street/P.O. box:	City:
State:	ZIP code:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence-based ☐ Claims-based	

Attachments	
Indicate which documents are being included with this completed application.	
☐	Copy of all federal, state, and/or local licenses required to operate as a health care organizational provider
☐	Copy of organizational provider's General Liability Insurance certificate
☐	Copy of Professional Liability Insurance certificate covering all organizational provider employees
☐	Copy of accreditation certificate(s), if applicable
☐	Copy of CMS letter certifying/recertifying organizational provider to provide partial hospitalization services, if applicable
☐	Copy of most recent CMS or DOH survey including your CAP, if deficiencies were cited, or cover letter from CMS/DOH stating organizational provider is in compliance

Disclosure questions

Answer every question Yes or No.
Provide a detailed explanation on a separate sheet for any question(s) answered Yes.

1. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been convicted of any health-care-related criminal offense, had adjudication withheld on any health-care-related criminal offense, pleaded no contest to any health-care-related criminal offense, or entered into a pre-trial agreement for any criminal offense?	☐ Yes ☐ No
2. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	☐ Yes ☐ No
4. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had his or her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?	☐ Yes ☐ No
5. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	☐ Yes ☐ No
6. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any Federal Executive Branch procurement or non-procurement program?	☐ Yes ☐ No
7. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	☐ Yes ☐ No
8. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fine(s) have been paid in full?	☐ Yes ☐ No
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the organizational provider, under any current or former name or business identity?	☐ Yes ☐ No
10. Does the organizational provider or any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	☐ Yes ☐ No
11. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care item or services?	☐ Yes ☐ No

Disclosure questions	
12. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to the delivery of an item or service under Medicare or state health care program?	☐ Yes ☐ No
13. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
14. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been found to have violated federal or state laws, rules or regulations in any program established under Medicare, any other state's Medicaid program, or Title XX, any other publicly funded federal or state health care, or health insurance program?	☐ Yes ☐ No

Attestation

I certify that the information contained in this application is correct and complete to the best of my knowledge. I hereby authorize AmeriHealth Caritas to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation, or operations to AmeriHealth Caritas. I authorize and agree that AmeriHealth Caritas, its agents, employees, and representatives may provide AmeriHealth Caritas' subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing, or peer review. I release AmeriHealth Caritas, its affiliates, agents, employees, and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize AmeriHealth Caritas and its applicable subsidiaries and affiliates to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as appropriate.

Authorized signature	Print name
Title	Date

Attachment A: Additional Site/Location Addendum

Please copy this page for additional sites.
Complete Section C only if you are an accredited or deemed behavioral health provider organization.
List services by site.

Attention: Please list additional locations that are branches or sub-units of the primary location and are covered under the same license. A letter from CMS stating that this location is a branch or sub-unit of the primary location must be included. Any other locations not covered under this license should be submitted on a separate application.

Section A: Demographics (if primary location, please skip to Section C)	
Location/site name:	
Service site address (no P.O. box):	
Billing National Provider Identifier (NPI) or atypical number:	Medicaid number (if applicable):
Remittance address (if different from primary location/site):	

Office hours (use HH:MM format)

Day	Start	A.M./P.M.	End	A.M./P.M.	Day	Start	A.M./P.M.	End	A.M./P.M.
Monday					Saturday				
Tuesday					Sunday				
Wednesday									
Thursday									
Friday									

Services at this location:

☐ Americans with Disabilities Act (ADA) accessibility requirements
☐ Handicap accessibility
☐ 24/7 phone coverage
☐ Answering service

Section B: Site visit requirement
(attach a copy of most recent onsite survey for each location with Corrective Action Plan [CAP])

1. Has facility had a post-licensing onsite visit by a government agency such as the DOH or CMS within the past 36 months?

☐ Yes Date of most recent standard survey: _____

☐ No **Successful completion of a health plan onsite visit will be required to complete credentialing**.

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A; no recent survey

If yes, have all deficiencies been corrected?

☐ Yes Provide evidence of state acceptance of your CAP.

☐ No Provide explanation and your plan to correct all deficiencies.

If no deficiencies were cited during the last full survey, **submit verification of no deficiencies**.

Section C: Services available at this location/site (check all that apply)			
Behavioral health type and description (please indicate service type). MH = mental health SA = substance abuse			
☐ MH	☐ SA	☐ Both	Behavioral health day treatment
☐ MH	☐ SA	☐ Both	Behavioral therapy under Early, Periodic, Screening, Diagnostic, and Treatment (EPSDT)
☐ MH	☐ SA	☐ Both	Case management
☐ MH	☐ SA	☐ Both	Community-based residential level A
☐ MH	☐ SA	☐ Both	Community-based residential level B
☐ MH	☐ SA	☐ Both	Crisis intervention
☐ MH	☐ SA	☐ Both	Crisis residential
☐ MH	☐ SA	☐ Both	Crisis stabilization
☐ MH	☐ SA	☐ Both	Day treatment/partial hospitalization services for adults
☐ MH	☐ SA	☐ Both	Developmental disabilities (DD) case management
☐ MH	☐ SA	☐ Both	Electroconvulsive therapy (ECT)
☐ MH	☐ SA	☐ Both	Health skill-building services
☐ MH	☐ SA	☐ Both	Individual, group, and family therapy
☐ MH	☐ SA	☐ Both	Inpatient psychiatric hospital services — free-standing psychiatric hospital
☐ MH	☐ SA	☐ Both	Integrated health home
☐ MH	☐ SA	☐ Both	Intensive community treatment
☐ MH	☐ SA	☐ Both	Intensive in-home services
☐ MH	☐ SA	☐ Both	Medication management by psychiatrist
☐ MH	☐ SA	☐ Both	Multi-systemic therapies in-home behavioral therapies (includes but not limited to applied behavioral analysis [ABA])
☐ MH	☐ SA	☐ Both	Neuropsychological testing
☐ MH	☐ SA	☐ Both	Opioid treatment
☐ MH	☐ SA	☐ Both	Outpatient psychiatric services
☐ MH	☐ SA	☐ Both	Partial hospitalization
☐ MH	☐ SA	☐ Both	Peer support
☐ MH	☐ SA	☐ Both	Psychosocial rehabilitation
☐ MH	☐ SA	☐ Both	Psychological testing
☐ MH	☐ SA	☐ Both	Telepsychiatry
☐ MH	☐ SA	☐ Both	Therapeutic day treatment for children and adolescents
☐ MH	☐ SA	☐ Both	Treatment foster care case management

Substance abuse services:	
☐	Outpatient substance abuse services
☐	Residential substance abuse treatment for pregnant and postpartum women
☐	Substance abuse day treatment
☐	Substance abuse day treatment for pregnant and postpartum women
☐	Substance abuse intensive outpatient treatment

Waiver services (please list waiver type and all services):	
Mental health	**Substance abuse**

Other services:	
Mental health	**Substance abuse**

AmeriHealth Caritas Pennsylvania

Coverage by AmeriHealth First.

ACPA_211094240-6

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