EmblemHealth | ConnectiCare

Organizational Provider Credentialing Application

Name of Entity:	
Name (please print)**:**	**Date:**
Title:	

Note: After we receive your completed application, we will credential or recredential your facility in our networks, as applicable. Please complete and submit this form with attachments as outlined below or send directly to your contracting representative. Contracts will not be completed until credentialing is completed. Credentialing approval, however, **DOES NOT** constitute finalization or approval of your contract and network participation. **Please remember to sign and date your application**.

INCLUDE THE FOLLOWING DOCUMENTS IN ADDITION TO YOUR APPLICATION:

- Current operating certificate/license
- Evidence of Joint Commission or other applicable accreditation
- If the entity is not accredited by Joint Commission or other accreditation agency, please send a statement of deficiencies, along with a plan of correction, from the facility's most recent State Survey (i.e., DOH, CMS, NSOFA [New York State Office of the Aging])
- General and Professional liability insurance face sheets
- Malpractice claims history details
- Form W-9 (for billing)
- CLIA Certificate (if applicable)
- Drug Enforcement AG/Controlled Dangerous Substance (DEA/CDS) certificate (if applicable)
- Letter verifying approval of CMS participation

TRANSPORTATION SERVICE (also include the following):

- General liability and vehicle insurance coverage
- Safe Vehicle Maintenance Protocol Tracking Program

MEAL (HOME AND CONGREGATE) PROVIDERS (also include the following):

- Food Handling Certification for Individuals Employed

A ROSTER OF ALL EMPLOYEES (FIRST, MIDDLE, LAST NAME) FOR THE FOLLOWING SERVICE TYPES:

- Urgent Care
- Transportation
- DME
- Outpatient Physical Therapy

DRUG POLICY FOR EMPLOYEES FOR THE FOLLOWING TYPES:

- Adult Day Care
- AIDS Adult Day Care
- DME
- Transportation
- Social Day Care
- Personal Care Services
- Personal Emergency Response Services
- Social and Environmental Supports
- Assisted Living
- Outpatient Physical Therapy

I. PROVIDER IDENTIFICATION

A. Corporate Identification Information

Furnish the provider's legal business name (as reported to the IRS), the "doing business as" name (name provider is generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

1. Legal Business Name as Reported to the IRS (claims will be paid to this name):		
2. "Doing Business As" (DBA) Name for Directory Listing (if applicable):	County Where DBA Name Is Registered (if applicable):	
3. Address:		4. Tax Identification Number:

B. Primary Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

RESET PRINT

C. First Additional Practice Location			
Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

D. Second Additional Practice Location			
Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

E. If you have additional locations, please provide the same information for each on a separate sheet as an attachment.		
Hours of Operation: Mon.:_____ to_____ Tues.: _____ to _____ Wed.: _____ to _____ Thurs.: _____ to _____Fri.: _____ to _____Sat.: _____ to _____ Sun.: _____ to _____		
Phone:	Fax:	Email:
Administrator (Full Name):		

F. Mailing/Correspondence Address			
This must be an address where the provider can be contacted directly. Check here ☐ if all correspondence can be directed to the practice location in Section B.			
Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	ZIP:	County:

II. WHAT TYPE OF ENTITY IS YOUR ORGANIZATION?

- ☐ Adult day health care
- ☐ AIDS adult day care
- ☐ Ambulatory surgery center
- ☐ Assisted living
- ☐ Birthing center
- ☐ Certified home health agency
- ☐ Clinical laboratory
- ☐ Comprehensive outpatient rehabilitation center
- ☐ Dialysis center
- ☐ DME
- ☐ Early intervention agency
- ☐ Federally qualified health center
- ☐ Free-standing imaging center
- ☐ Home infusion therapy
- ☐ Hospice
- ☐ Hospital
- ☐ Licensed home health agency
- ☐ Meals (home and congregate)
- ☐ Outpatient diabetes self-management center (NDPP)
- ☐ Outpatient physical therapy, occupational and speech language
- ☐ Pathology center
- ☐ Personal care services (chore and housekeeping)
- ☐ Personal emergency response services
- ☐ Portable x-ray supplier
- ☐ Rural health clinic
- ☐ School-based clinic/diagnostic & treatment center
- ☐ Skilled nursing facility
- ☐ Social and environmental services
- ☐ Social day care
- ☐ Transportation
- ☐ Urgent care center
- ☐ Voluntary foster care agency (29-I facility)
- ☐ Urgent care (retail convenience health clinic)
- ☐ Urgent care (walk-in medical office)

Identification Numbers:		
NPI #:	PFI #:	Operating Cert/License #:
Medicare #:	Medicaid #:	

RESET PRINT

III. ACCREDITATION AND CERTIFICATION

Attach a copy of verification for each accreditation and certification that your facility has. If your facility received less than full accreditation, please attach a copy of a recommendation.

CLIA (Clinical Laboratory) #:	Expiration (if applicable):
CARF, Expiration Date:	CHAP, Expiration Date:
DNV, Expiration Date:	JCAHO, Expiration Date:
Other:	Expiration Date:

IV. STATEMENT OF DEFICIENCIES SURVEY

Indicate any current statements of deficiencies your facility has received from any federal, state or local regulatory agency or accreditation body. Include a copy of each statement, along with the approved plans of correction. (If your entity has more than one current deficiency issued by the same regulator, please list them on a separate sheet of paper.)

Medicare Audit or Survey Date:	Medicaid Audit or Survey Date:
DOH Audit or Survey Date:	Other Audit or Survey Date:

V. GENERAL AND PROFESSIONAL LIABILITY INSURANCE

Attach a copy of your facility's general and professional liability insurance policy face sheets and malpractice claims history details.

My facility does not have a general liability insurance policy. ☐

Present general liability insurance carrier: _____

Address:	City:	State:	ZIP:
Policy #:	Initial Date:		
Limits of Liability:	Expiration Date:		

My facility does not have a professional liability insurance policy. ☐

Present general liability insurance carrier: _____

Address:	City:	State:	ZIP:
Policy #:	Initial Date:		
Limits of Liability:	Expiration Date:		

VI. HEALTH SERVICE DELIVERY AND QUALITY MANAGEMENT INFORMATION

Do you subcontract for medical services with other organizations or individuals? ☐ Yes ☐ No

If yes, please provide their names and addresses and describe your relationship(s):

_____

_____

Do you have a quality improvement process in place? ☐ Yes ☐ No If yes, please include a brief summary as an attachment.

Do you have a process in place to measure and collect patient satisfaction? ☐ Yes ☐ No

If yes, please describe your most recent patient satisfaction measure and instrument used:

_____

_____

RESET PRINT

VII. PRIMARY OFFICER/CONTACT PERSON

Name:		Title:
Telephone #:	Fax #:	Email:

I attest that the information given or attached to this application is accurate. As a condition to making this application, any misrepresentation or misstatement in or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial or nonrenewal of a contract. In the event that a contractual arrangement is in effect prior to this discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such contract.

Sign Here:

Name (please print):	Title:	Date:

VIII. AMERICANS WITH DISABILITIES ACT (ADA) ATTESTATION

If your practice has more than one location, please complete a form for each location. Once submitted, please notify EmblemHealth within 10 business days of any change to your answers below. Additional forms can be downloaded from the "Join Our Networks" page at **emblemhealth.com**.

Note: If you do not see patients at the address on the credentialing application (e.g., you're an inpatient provider only or administrative only), please answer N/A here and sign the form. ☐ N/A

1. Does the office have at least one wheelchair-accessible path from an entrance to an exam room?	☐ Yes	☐ No	☐ N/A
2. Are examination tables and all equipment accessible to people with disabilities?	☐ Yes	☐ No	☐ N/A
3. If parking is provided, are spaces reserved for people with disabilities and pedestrian ramps at sidewalks and drop-offs?	☐ Yes	☐ No	☐ N/A
4. If parking is provided, are there an adequate number (see below) of accessible parking spaces (8 feet wide for a car and 5-foot access aisle)?	☐ Yes	☐ No	☐ N/A

Total spaces	Accessible spaces
1-25	1
26-50	2
51-75	3
76-100	4

5. a. For a provider with a disability-accessible parking space, is there a path of travel from the disability-accessible parking space to the facility entrance that doesn't require stair use?	☐ Yes	☐ No	☐ N/A
b. Is the path of travel stable, firm, and slip-resistant?	☐ Yes	☐ No	☐ N/A
c. Except for curb cuts, is the path at least 36 inches wide?	☐ Yes	☐ No	☐ N/A
6. a. Is there a method for persons using wheelchairs or requiring other mobility assistance to enter as freely as everyone else?	☐ Yes	☐ No	☐ N/A
b. Is that route of travel safe and accessible for everyone, including people with disabilities?	☐ Yes	☐ No	☐ N/A
7. Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following:			
a. 32 inches clear opening.	☐ Yes	☐ No	☐ N/A
b. 18 inches of clear wall space on the pull side of the door, next to the handle.	☐ Yes	☐ No	☐ N/A
c. The threshold edge is no greater than ¼-inch high; or if beveled, no greater than ¾-inches high.	☐ Yes	☐ No	☐ N/A
d. The door handle is no higher than 48 inches and can be operated with a closed fist.	☐ Yes	☐ No	☐ N/A
8. a. Are there ramps to permit wheelchair access? If yes, complete the following four questions:	☐ Yes	☐ No	☐ N/A
b. Are the slopes of the ramp accessible for wheelchairs?	☐ Yes	☐ No	☐ N/A
c. Are the railings sturdy and high enough for wheelchair access?	☐ Yes	☐ No	☐ N/A
d. Is the width between railings enough to accommodate a wheelchair?	☐ Yes	☐ No	☐ N/A
e. Are the ramps nonslip and free from any obstruction (cracks)?	☐ Yes	☐ No	☐ N/A
9. If there are stairs at the main entrance, is there also a ramp or lift or is there an alternative accessible entrance?	☐ Yes	☐ No	☐ N/A
10. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance?	☐ Yes	☐ No	☐ N/A
11. Can the accessible entrance be used independently and without assistance?	☐ Yes	☐ No	☐ N/A

RESET PRINT

Organizational Provider Credentialing Application (Continued)

12. Are doormats ½-inch high or less with beveled or secured edges?	☐ Yes	☐ No	☐ N/A
13. Are waiting rooms and exam rooms accessible to people with disabilities?	☐ Yes	☐ No	☐ N/A
14. Does the layout of the interior of the building allow people with disabilities to obtain materials and services without assistance?	☐ Yes	☐ No	☐ N/A
15. Do the interior doors comply with the criteria set forth for exterior doors (see question 7)?	☐ Yes	☐ No	☐ N/A
16. Are the accessible routes to all public spaces in the facility 31 inches wide?	☐ Yes	☐ No	☐ N/A
17. Is there a 5-foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered?	☐ Yes	☐ No	☐ N/A
18. Are all buttons or other controls in the hallway no higher than 42 inches?	☐ Yes	☐ No	☐ N/A
19. Do elevators in the facility meet the following standards:	☐ Yes	☐ No	☐ N/A
a. There are raised and Braille signs on both door jambs on every floor.	☐ Yes	☐ No	☐ N/A
b. The controls inside the cab have raised and Braille lettering.	☐ Yes	☐ No	☐ N/A
c. The call buttons in the hallway are not higher than 42 inches.	☐ Yes	☐ No	☐ N/A
20. Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances?	☐ Yes	☐ No	☐ N/A
21. Is the public lavatory wheelchair-accessible?	☐ Yes	☐ No	☐ N/A
22. With respect to the public restroom, do the accessible route, the exterior door, and the interior stall doors comply with standards set forth for exterior doors (see question 7)?	☐ Yes	☐ No	☐ N/A
23. Is there at least one wheelchair-accessible stall in the public restroom that has an area of at least 5 feet by 5 feet clear of the door swing, or is there at least one stall that is less accessible but provides greater access than a typical stall (either 36 by 69 inches or 48 by 69 inches)?	☐ Yes	☐ No	☐ N/A
24. In the accessible stall of the public restroom, are there grab bars behind and on the side wall nearest the toilet?	☐ Yes	☐ No	☐ N/A
25. Is there one lavatory in the public restroom that meets the following standards:			
a. 30 inches wide by 48 inches; deep bar space in front.	☐ Yes	☐ No	☐ N/A
b. A maximum of 19 inches of the required depth may be under the lavatory.	☐ Yes	☐ No	☐ N/A
c. The lavatory rim is no higher than 34 inches.	☐ Yes	☐ No	☐ N/A
d. There are at least 29 inches from the floor to the bottom of the lavatory apron.	☐ Yes	☐ No	☐ N/A
e. The faucet can be operated with a closed fist.	☐ Yes	☐ No	☐ N/A
f. The soap dispenser and hand dryers are within reach and usable with one closed fist.	☐ Yes	☐ No	☐ N/A
g. The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower.	☐ Yes	☐ No	☐ N/A

I hereby attest that I am a provider that occupies a physical site at which participants might possibly be physically present and that the answers provided are true and accurate and that I hold the authority to make these attestations.

Name:	Date:
Signature:	

RESET PRINT

IX. MEDICAID PROVIDER DISCLOSURE OF OWNERSHIP AND CONTROL

Section 1: Disclosing Provider

Name of Provider:	
Address of Provider:	
NPI #:	FEIN #:
Type of Entity (sole proprietorship, individual, business corporation, nonprofit corporation, nonprofit membership corporation, unincorporated association, limited liability corporation, partnership, professional limited liability corporation, governmental entity, other):	

Section 2: Ownership of Provider (per 42 CFR Part 455.104(b) (1) (i) (entities and/or individuals)

Copy this page to report additional owners.

Name of Individual or Entity:		Title (if individual):	Date of Birth (if individual) (MM/DD/YYYY):
Address – Street (home address if individual):			
City, State and ZIP Code:			
Primary Address (if corporation):			
SSN (if individual):	FEIN (if entity):	% of Ownership (if none, put 0%):	NPI or NY Medicaid ID (if none, write None):

For Individuals Only: If you are related to another person with an ownership or control interest in the Provider, complete the following:

Name of Other Owner:	**Relationship to Other Owner (parent, child, sibling, spouse):**

For Corporations Only (business and nonprofits): Use the space below to report other business addresses (per 42 CFR Part 455.104(b)(1)(i). For nonprofit membership corporations, use the space below to identify the members and their addresses.

Section 3: Ownership in Other Disclosing Entities (ODE) (per 42 CFR Part 455.104(b)(3))

Complete the following if any identified in Sections 1 and 2 have an ownership or control interest in any Other Disclosing Entity, as defined in 42 CFR 455.101 (any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (Title XVIII); Medicare intermediary or carrier; and any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for the furnishing of health-related services for which it claims payment under any plan or program established under Title V or Title XX). Copy this page to report additional ownerships in Other Disclosing Entities.

Name (from Section 1):	Name of Other Disclosing Entity:	NPI or Medicaid ID of ODE:
Name (from Section 1):	Name of Other Disclosing Entity:	NPI or Medicaid ID of ODE:
Name (from Section 1):	Name of Other Disclosing Entity:	NPI or Medicaid ID of ODE:

RESET PRINT

Section 4: Ownership in Subcontractors

If the provider has an ownership or control interest of five percent or more in a subcontractor and an owner of the provider also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in Section 3 have a familial relationship (parent, child, sibling, or spouse) with a person with ownership or control interest in one of these subcontractors, complete Section 5. Copy this page to report additional ownership in subcontractors.

Owner's Name (from Section 1):	Subcontractor's Name:	Tax ID or SSN:
Owner's Name (from Section 1):	Subcontractor's Name:	Tax ID or SSN:

Section 5: Familial Relationship in Subcontractors

Complete if those identified in Section 4 have a familial relationship (parent, child, sibling, or spouse) with a person with ownership or control interest in one of the subcontractors identified in Section 3. Copy this page to report additional familial relationship to the subcontractors.

Owner's Name (from Section 1):	Subcontractor's Name:	Name and Familial Relationship:
Owner's Name (from Section 1):	Subcontractor's Name:	Name and Familial Relationship:

Section 6: Managing Employees and Those With a Control Interest

Including, but not limited to, the following: Facility Administrator, all Members of the Board of Directors, Managing Employees, Compliance Officer, Laboratory Director, and Supervising Pharmacist. Include familial relationship to the Provider (spouse, parent, child, or sibling), if any. Copy this page to report additional managing employees and those with a control interest.

Name:	Association Type:	Familial Relationship:
Home Address:		
City, State and ZIP Code:		
Social Security Number:	Date of Birth:	
Name:	Association Type:	Familial Relationship:
Home Address:		
City, State and ZIP Code:		
Social Security Number:	Date of Birth:	

Section 7:

Respond to the following questions on behalf of: (i) the Provider, (ii) all individuals and entities identified in Sections 1, 2 and 6, and (iii) any entity in which the Provider has a five percent or more ownership. For any "yes" responses, please provide an explanation on a separate sheet of paper.

1. Have any of the individuals or organizations noted above ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned under any of the programs established by Title XVIII (Medicare), XIX (Medicaid), XX (Social Services), or any other governmental or private medical insurance program in any State? ☐ Yes ☐ No
2. Have any of the individuals or organizations noted above ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State? ☐ Yes ☐ No
3. Have any of the individuals or organizations noted above ever had their business or professional license, registration or certification, or the license of an entity in which they had an ownership interest over five percent been revoked, suspended, surrendered or, in any way, restricted by probation or agreement by a licensing authority in any State? ☐ Yes ☐ No
4. Are there currently any pending proceedings that could result in any of the above-stated sanctions for the individuals or organizations noted above? ☐ Yes ☐ No

RESET PRINT

Organizational Provider Credentialing Application (Continued)

5. Has there been a change of ownership or control within the last year? ☐ Yes ☐ No

If yes, give date of change of control: _____

If yes, did you advise EmblemHealth? ☐ Yes ☐ No

If yes, give date you advised EmblemHealth: _____

6. Do you anticipate a change of ownership within the year? ☐ Yes ☐ No

If yes, when: _____

7. Is this entity operated by a management company or leased in whole or in part by another organization? ☐ Yes ☐ No

If yes, give date of change of operations: _____

I certify that the information contained herein is true and accurate to the best of my knowledge and belief.	
Name of Authorized Representative (please type):	Title:
Signature:	Date:

RESET PRINT