

Managed Long-Term Care (MLTC) Medicaid



Please complete the form in its entirety. If a field/section does not apply, write "N/A". Attach additional information on separate sheets as needed.

The completed form can be submitted:

- Online: <https://nascentiahealth.org/managed-long-term-care-plan/provider-information/recredentialing-form/>
- Email: providerrelations@477home.org
- Fax: 315.671.5129
- Mail: Nascentia Health Options
Attn: Provider Relations Department
1050 West Genesee Street
Syracuse, NY 13204-2215

Questions: Call 315.477.9820

Recredentialing Form

General Information

Name:			
Street Address:			
City:	State:	Zip Code:	
County:			
Phone:	()	Fax (for authorizations):	()
Billing Address:			
City:	State:	Zip Code:	
County:			
Phone:	()	Fax (for authorizations):	()
Tax ID (EIN) #:			
Medicaid Provider Number:			
Medicare Certification:	Yes	No	N/A
Medicare Provider Number:		NPI #:	
Electronic Visit Verification Software (required for FI and Home Care providers):			

If your facility has more than one NPI #, please list the NPI # and the facility name below:

NPI #:

Facility Name:

NPI #:

Facility Name:

NPI #:

Facility Name:

License/Facility Operating Certificate#:

Parent Company Information (if applicable):

Parent Company:

Street Address:

City:

State:

Zip Code:

Primary Contact
Person:

Contact Person
Title:

Contact Person
Phone:

()

Contact Person
Email:

Location Information

Please indicate counties serviced by main address location:

Address and Phone Number of Branch or Satellite Offices (with counties serviced):

1.

2.

3.

4.

5.

Operating Hours: Please list hours (a.m. and p.m.)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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Hours:							
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Contact Information (include name, title, phone and email):

Compliance:

Contracts:

Credentialing:

Scheduling:

Billing:

If your facility uses a third-party billing agency, please provide the legal name and address below:

[Empty text box for legal name and address]

Billing Format and Forms Used:

(i.e. UB-92, HCFA-1500)

[Empty text box for billing format and forms used]

Select all items applicable to your location:

<input type="checkbox"/>	Public Transportation Accessibility		
<input type="checkbox"/>	Wheelchair Accessible		
<input type="checkbox"/>	Foreign Languages Spoken	If selected, list languages:	<input type="text"/>
<input type="checkbox"/>	American Sign Language		
<input type="checkbox"/>	Network Hearing System (TDD)		
<input type="checkbox"/>	Elevator		
<input type="checkbox"/>	Vision Accessible		
<input type="checkbox"/>	Other	If selected, list "Other Services" offered:	<input type="text"/>

******THE FULLY EXECUTED CONTRACT WILL BE MAILED BACK TO THE PERSON WHO SIGNED IT. IF YOU WISH FOR IT TO BE MAILED TO A DIFFERENT PERSON/ADDRESS PLEASE LIST BELOW******

Name:

Street Address:

City: <input type="text"/>	State: <input type="text"/>	Zip Code: <input type="text"/>
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Recredentialing:

Please select what type of service provider(s) you are recredentialing for:

<input type="checkbox"/>	Adult Day Care (page 6)
<input type="checkbox"/>	Certified Home Care Agency (CHHA) / Licensed Home Care Services Agency (LHCSA) (page 7-8)
<input type="checkbox"/>	Consumer-Directed Personal Aid (FI) (page 9)
<input type="checkbox"/>	Durable Medical Equipment / Personal Emergency Response System (page 10)
<input type="checkbox"/>	Home and Safety Modification (page 11)
<input type="checkbox"/>	Licensed/ Certified Professional Services (pages 12-13)
<input type="checkbox"/>	Meals Provider (page 14)
<input type="checkbox"/>	Skilled Nursing Facility (SNF) (pages 15-16)
<input type="checkbox"/>	Transportation Provider (page 17)

Complete the required additional sections for each form you are recredentialing for.

The page number of the required section for each service provider application is listed in the table above.

After completing pages 1-4 and the necessary Recredentialing forms REMEMBER TO COMPLETE the Attestation, Recredentialing Attestation and Release Form and Certification / Affirmation of Accuracy and Completeness on pages 18-20.

Adult Day Care:

Please attach the following document:

- Provider Compliance Certification (provide information on page 18) – *applicable only to adult medical day care providers*
 - Certification of a Provider Compliance Program is **required**. By signing the [Certification Statement for Provider Billing Medicaid](#), you (or the entity) certify that you (or the entity) have adopted and implemented an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations Part 521. For more information on the Provider compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>.
 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

Note:

- Provider Compliance Certification *not applicable* to Adult Social Day Care providers

Adult Day Care Services offered (Check all that apply):

<input type="checkbox"/>	Adult Medical Day Care – Full Day
<input type="checkbox"/>	Adult Medical Day Care – Half Day
<input type="checkbox"/>	Adult Social Day Care – Full Day
<input type="checkbox"/>	Adult Social Day Care – Half Day
<input type="checkbox"/>	Meals Included
<input type="checkbox"/>	Day Care Transportation – Taxi
<input type="checkbox"/>	Day Care Transportation – Wheelchair

Certified Home Care Agency (CHHA) / Licensed Home Care Services Agency (LHCSA):

Please attach the following document:

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 - Certification of a Provider Compliance Program is **required**. By signing the [Certification Statement for Provider Billing Medicaid](#), you (or the entity) certify that you (or the entity) have adopted and implemented an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations Part 521. For more information on the Provider compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>.
 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

JCAHO Accreditation:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A
CARF Accreditation:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A

Home Health Care Agency Services offered (Check all that apply):

Certified	Licensed			
		Home Health Aide		
		Housekeeping (Personal Care Aide, Level I)		
		Personal Care Aide, Level II		
		Medical Social Work		
		Medication Dispensing Services		
		Nutritional Counseling		
		Nursing, in home (LPN, RN)		
		Occupational Therapy		
		Physical Therapy		
		Speech Therapy		
		Personal Emergency Response Systems (PERS) – Landline		
		Personal Emergency Response Systems (PERS) – Cellular		
		Personal Emergency Response Systems (PERS) – GPS		
		Personal Emergency Response Systems (PERS) – Fall Detection		
		PRI & Screen Assessment Services		
		Private Duty Nursing, LPN		
		Private Duty Nursing, RN		
		Respiratory Therapy		
		Telehealth Services		
		UAS Assessment Services		
		Wound Care		
		Other Certified Home Health Services	If selected, list "Other Home Health Services":	
		Other Licensed Home Health Services	If selected, list "Other Licensed Home Health Services":	

Consumer-Directed Personal Aid (FI):

Please attach the following document:

- Provider Compliance Certification (provide information on page 18) – *applicable only to adult medical day care providers*
 - Certification of a Provider Compliance Program is **required**. By signing the [Certification Statement for Provider Billing Medicaid](#), you (or the entity) certify that you (or the entity) have adopted and implemented an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations Part 521. For more information on the Provider compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>.
 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

Durable Medical Equipment / Personal Emergency Response System:

Please attach the following document:

- Provider Compliance Certification (provide information on page 18)
 - Certification of a Provider Compliance Program **may be required**. By signing the [Certification Statement for Provider Billing Medicaid](#), you (or the entity) certify that you (or the entity) have adopted and implemented an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations Part 521. For more information on the Provider compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>.
 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

Durable Medical Equipment/Personal Emergency Response System Services offered (Check all that apply):

<input type="checkbox"/>	Durable Medical Equipment and Supplies
<input type="checkbox"/>	Incontinence Supplies
<input type="checkbox"/>	Medicare-Authorized DME provider (Lift Chairs, Wheelchairs, Walkers, etc.)
<input type="checkbox"/>	Medication Dispensing Systems
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – Basic / Landline
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – Cellular
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – GPS
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – Fall Detection
<input type="checkbox"/>	Other
	If selected, list "Other Services" offered:

Home and Safety Modification:

Environmental Modifications and Support Services offered (Check all that apply):			
<input type="checkbox"/>	Installation of Ramps (Portable, Threshold, Modular)		
<input type="checkbox"/>	Installation of Wheelchair Lifts (Platform, Incline)		
<input type="checkbox"/>	Installation of Stair Lifts (Straight, Curved)		
<input type="checkbox"/>	Installation of DME Supplies (Grab Bars, Handheld Shower, etc.)		
<input type="checkbox"/>	Other Services	If selected, list "Other Services offered:"	<input type="text"/>
<input type="checkbox"/>	Other Home and Safety Modifications	If selected, list "Other Home and Safety Modifications" offered:	<input type="text"/>

Licensed / Certified Professional Services:

Please attach the following document:

- Provider Compliance Certification (provide information on page 18)
 - Certification of a Provider Compliance Program **may be required**. By signing the [Certification Statement for Provider Billing Medicaid](#), you (or the entity) certify that you (or the entity) have adopted and implemented an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations Part 521. For more information on the Provider compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>.
 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

Services offered (Check all that apply):

<input type="checkbox"/>	Audiology (exam only)
<input type="checkbox"/>	Audiology (hearing aid services available)
<input type="checkbox"/>	Nutritional Counseling
<input type="checkbox"/>	Outpatient Occupational Therapy
<input type="checkbox"/>	Outpatient Physical Therapy
<input type="checkbox"/>	Outpatient Speech Therapy
<input type="checkbox"/>	Podiatry, in Home
<input type="checkbox"/>	Podiatry, in Outpatient Setting
<input type="checkbox"/>	Podiatry, in Skilled Nursing Facility
<input type="checkbox"/>	Prosthetics and Orthotics
<input type="checkbox"/>	Respiratory Therapy
<input type="checkbox"/>	Other
	If selected, list "Other Services" offered:

Please list License/Certification information for all professionals employed at your facility. Applicable to all licensed staff, including but not limited to: Audiologists, Dieticians, Nutritionists, Optometrists, Opticians, Outpatient Therapists (PT, OT, ST, Respiratory), and Podiatrists. Copy this page if you need more space.

1. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
2. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
3. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
4. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
5. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

Meals Provider:

Meal Services offered (Check all that apply):

<input type="checkbox"/>	Congregate Meals
<input type="checkbox"/>	Home Delivered Meals

Skilled Nursing Facility (SNF):

Please attach the following document:

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 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

Permanent Facility Identifier:					
JCAHO Accreditation:		Yes		No	N/A
CARF Accreditation:		Yes		No	N/A
Covered Services offered:					
	Adult Medical Day Care (ADHC)				
	Adult Social Day Care (SADC)				
	Audiology (hearing aid dispensing)				
	Audiology (hearing exam services)				
	Dentistry (on-site)				
	Outpatient Occupational Therapy				
	Outpatient Physical Therapy				
	Outpatient Speech Therapy				
	Podiatry (on-site)				
	Transportation (Day Care)				
	Transportation (to member appointments)				
	Vision Care (on-site)				
Skilled Nursing Facility Services:					
	Daily Room and Board				
	Specialty Beds (Behavioral, Neurological, Ventilation)				
	Respite Care				

For SNFs providing OUTPATIENT THERAPY: Please list License/Certification information for all OT/PT/ST professionals employed at your outpatient facility. Copy this page if you need more space.

1. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
2. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
3. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
4. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

Transportation Provider:

Please attach the following document:

- Provider Compliance Certification (provide information on page 18)
 - Certification of a Provider Compliance Program **may be required**. By signing the [Certification Statement for Provider Billing Medicaid](#), you (or the entity) certify that you (or the entity) have adopted and implemented an effective compliance program pursuant to New York State Social Services Law section 363-d, and have satisfied the requirements of Title 18 of the New York Code, Rules and Regulations Part 521. For more information on the Provider compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>.
 - If a 2021 certification is not yet due, please provide a copy of 2019 SSL Certification.

DOT Certificate # (Required for wheelchair transportation):

Transportation Services offered (Check all that apply):

<input type="checkbox"/>	After Hours Transportation
<input type="checkbox"/>	Door to Door Assist
<input type="checkbox"/>	Non-Emergent Ambulance
<input type="checkbox"/>	Stretcher
<input type="checkbox"/>	Wheelchair
<input type="checkbox"/>	Bariatric Wheelchair
<input type="checkbox"/>	Taxi

After filling out the necessary Recredentialing forms **REMEMBER TO COMPLETE** the Attestation, Recredentialing Attestation and Release Form and Certification / Affirmation of Accuracy and Completeness on pages 18-20.

Provider Compliance Certification

I agree to submit to Nascentia annually a copy of the [Certification Statement for Provider Billing Medicaid](#) pursuant to NYS Social Services Law (SOS) § 363-d and Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) Part 521. For more information on the Provider Compliance Program, please go to the program website at <https://omig.ny.gov/compliance/compliance>

Please initial:

I confirm that I have submitted a certification statement to Medicaid as required (please provide a copy)

I confirm that I am not required to submit a certification statement to Medicaid pursuant to NYS Social Services Law (SOS) § 363-d and Title 18 of the New York Codes, Rules and Regulations (18 NYCRR) Part 521

Attestation

I agree to use best efforts to inform Nascentia Health Options in writing within 15 business days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to signing this application.

I agree that a photocopy or facsimile of this document with my signature may be accepted with the same authority as the original.

Recredentialing Attestation and Release Form

In the past 3 years or presently, has your company or any of its representatives:			
Had disciplinary actions, criminal proceedings, or other adverse actions initiated against them (this includes license or certification limitations, revocations, suspensions, terminations, or voluntary relinquishment)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been subject of an investigation, or ever been suspended, sanctioned or otherwise excluded from participating in any private, state, or federal health insurance program (examples – Medicare, Medicaid, other Managed Care Organization)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been subject to (in whole or in part) professional liability or malpractice claims, suits, settlements, arbitration proceedings, or complaints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been subjected to any investigation, claim, or disciplinary action due to unethical conduct?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Been denied liability insurance (in whole or in part) or had your insurance canceled, involuntarily restricted, denied renewal, or rated up because of the nature volume of claims against your company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If you answered “yes” to any of the above questions, please explain below.			
Please initial:			
	I confirm that there is a process in place to monitor and screen employees, volunteers, governing body members, and downstream entities for Healthcare related criminal convictions.		
	I confirm that there is a process in place to monitor and screen employees, volunteers, governing body members, and downstream entities against the List of Excluded Individuals (LEIE) – https://exclusions.oig.hhs.gov/ , Excluded Parties List System (EPLS) https://sam.gov/SAM/ , and the New York Exclusions Database – https://www.omig.ny.gov/search-exclusions prior to hiring and monthly thereafter.		

Certification / Affirmation of Accuracy and Completeness

I hereby affirm that all information provided in or attached to this application for credentialing/recredentialing is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that any misrepresentation or omission of any fact requested, whether intentional or not, is cause for automatic and immediate rejection and/or termination of the credentialing/recredentialing process.

I hereby agree to immediately notify Nascentia Health Options if such representation ever ceases to be accurate and true. I understand that this credentialing/recredentialing review process will occur prior to approval of participation. I hereby authorize Nascentia Health to consult with any third party who may have information bearing on any services that my company provides. I hereby release any person, institution or other party from any liability in connection with the provision of such information or documentation.

Name of Organization:

Authorized Representative
Signature:

Authorized Representative
Printed Name:

Authorized Representative
Title:

Date: