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/provider-information/service-provider-application/
- Email: providerrelations@nascentiahealth.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

Service Provider Application

General Information

Legal Provider Name:					
Street Address:					
City:		State:		Zip Code:	
Phone:	( )	Fax (for authorizations):	( )		
Billing Address:					
City:		State:		Zip Code:	
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
Hours:							

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:

Billing Format and Forms Used: (i.e. UB-92, HCFA-1500)	

Select all items applicable to your location:

	Public Transportation Accessibility		
	Wheelchair Accessible		
	Foreign Languages Spoken	If selected, list languages:	
	American Sign Language		
	Network Hearing System (TDD)		
	Elevator		
	Vision Accessible		
	Other	If selected, list "Other Services" offered:	

******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:		State:		Zip Code:	

Service Provider Applications:

Please select what type of service provider(s) you are applying for:	
	Adult Day Care (page 6)
	Certified Home Care Agency (CHHA) / Licensed Home Care Services Agency (LHCSA) (pages 7-8)
	Consumer-Directed Personal Aid (FI) (pages 9)
	Durable Medical Equipment / Personal Emergency Response System (pages 10-11)
	Home and Safety Modification (page 12)
	Licensed / Certified Professional Services (e.g. Audiologist, Dieticians, Nutritionists, Outpatient Therapists (OT, PT, ST), and Podiatrists) (page 13 -14)
	Meals Provider (page 15)
	Skilled Nursing Facility (SNF) (pages 16-17)

Complete the required sections for each service provider you are applying for.

The page number for the required sections for each service provider is listed in the table above.

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

Adult Day Care:

Please attach the following documents:

- Business Associates Agreement (Social adult day only)
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form; Medicaid Provider Number and NPI *not* required for Adult Social Day Care)
- W-9 with legal name and remit address
- Proof of OMIG Certification (Social adult day only)
- Proof of adequate insurance coverage
  - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204 listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Adult Medical Day Care Providers, but is **not applicable** to Adult Social Day Care providers (Attestation section to be completed on page 18).
- BE ADVISED: Before contract may be executed with an Adult Social Day Care an in-person site inspection visit must be completed. Your regional Provider Relations Representative will request to schedule one upon receipt of all necessary credentialing documentation listed above.

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

	Adult Medical Day Care – Full Day
	Adult Medical Day Care – Half Day
	Adult Social Day Care – Full Day
	Adult Social Day Care – Half Day
	Meals Included
	Day Care Transportation – Taxi
	Day Care Transportation – Wheelchair

Certified Home Care Agency (CHHA) /

Licensed Home Care Services Agency (LHCSA):

Please attach the following documents:

- Valid state license(s) or operating certificate(s)
- JCAHO accreditation report (if applicable)
- Most recent NYSDOH State Survey & Plan of Correction
- EIN, Medicaid Provider Number, NPI number and Electronic Visit Verification (EVV) Software (provide information on page 1 of this form)
- W-9 with legal name and remit address
- Copy of patient satisfaction survey
- Proof of adequate insurance coverage
  - Commercial General Liability, Professional Liability and Transportation (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Certified Home Health Agency (CHHA) / Licensed Home Care Services Agency (LHSCA) providers (Attestation section to be completed on page 18).

JCAHO Accreditation:		Yes		No		N/A
CARF Accreditation:		Yes		No		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 Certified 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 documents:

- EIN, Medicaid Provider Number, NPI number and Electronic Visit Verification (EVV) Software (provide information on page 1 of this form)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Consumer-Directed Personal Aid (FI) providers (Attestation section to be completed on page 18).

Durable Medical Equipment / Personal Emergency Response System:

Please attach the following documents:

- Business Associates Agreement
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Incontinence Products Verification (only applicable to DME providers who offer incontinence supplies)
- Proof of adequate insurance coverage
  - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **may be required** for Durable Medical Equipment / Personal Emergency Response System providers (Attestation section to be completed on page 18).

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

	CPAP Supplies		
	Diabetic Supplies		
	Durable Medical Equipment and Supplies		
	Enteral Therapy		
	Incontinence Supplies		
	Medicare-Authorized DME Provider (Lift Chairs, Wheelchairs, Walkers, etc.)		
	Medication Dispensing Systems		
	Orthotics/Prescription Footwear		
	Oxygen Related Equipment		
	Personal Emergency Response Systems (PERS) – Basic / Landline		
	Personal Emergency Response Systems (PERS) – Cellular		
	Personal Emergency Response Systems (PERS) – GPS		
	Personal Emergency Response Systems (PERS) – Fall Detection		
	Prosthetics		
	Other	If selected, list “Other Services” offered:	

For Durable Medical Equipment (DME) vendors who supply incontinence products:

The Department of Health (DOH) issued an incontinence supply initiative effective September 1st, 2016. DME companies must now ensure that incontinence products that they dispense to Medicaid members meet minimum quality standards put in place by the DOH.

The minimum standards include:

- No plastic (non-breathable) backed products
- Rewet rate of <2.0g
- Rate of Acquisition (ROA) of <60 seconds
- Retention Capacity >250g
- Presence of breathable zones with a minimum value of >100 cubic feet per minute (cfm)
- Presence of closure system which allows for multiple fastening and unfastening occurrences

Verification that your incontinence products meet minimum standards must be on file with Provider Relations at VNA Options. Verification must be in the form of test results obtained from an independent testing laboratory.

IF your company purchases incontinence products from Twin Med, LLC, the State's new preferred supplier, you do not have to verify incontinence product quality standards. Proof that your products are being purchased from Twin Med, LLC will suffice.

Further, most First Quality and Covidien brands meet minimum quality standards, however, verification for these brands must also be on file.

	Twin Med verification		or Minimum quality standards verification

Home and Safety Modification:

Please attach the following documents:

- Business Associates Agreement
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form; Medicaid Provider Number and NPI *not* required)
- W-9 with legal name and remit address
- Copy of contractor's license
- Proof of adequate insurance coverage
  - Commercial General Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Environmental Modifications and Support Services offered (Check all that apply):

	Installation of Ramps (Portable, Threshold, Modular)		
	Installation of Wheelchair Lifts (Platform, Incline)		
	Installation of Stair Lifts (Straight, Curved)		
	Installation of DME Supplies (Grab Bars, Handheld Shower, etc.)		
	Other Services	If selected, list "Other Services offered:"	
	Other Home and Safety Modifications	If selected, list "Other Home and Safety Modifications" offered:	

Licensed / Certified Professional Services:

Please attach the following documents:

- Valid state licensure information (provide Licensure/Certification information on page 17)
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
  - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **may be required** for Licensed / Certified Professional Service providers (Attestation section to be completed on page 18).

Services offered (Check all that apply):

	Audiology (exam only)		
	Audiology (hearing aid services available)		
	Nutritional Counseling		
	Outpatient Occupational Therapy		
	Outpatient Physical Therapy		
	Outpatient Speech Therapy		
	Orthotics/Prescription Footwear (provide copy of current Certification for each practitioner)		
	Podiatry, in Home		
	Podiatry, in Outpatient Setting		
	Podiatry, in Skilled Nursing Facility		
	Prosthetics (provide copy of current Certification for each practitioner)		
	Respiratory Therapy		
	Other Services	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:

Please attach the following documents:

- Business Associates Agreement
  - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form; Medicaid Provider Number and NPI *not* required)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
  - Commercial General Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 2 million aggregate, or umbrella coverage)

Meal Services offered (Check all that apply):

	Congregate Meals
	Home Delivered Meals

Skilled Nursing Facility (SNF):

Please attach the following documents:

- Valid state license(s) or operating certificate(s)
- JCAHO accreditation report (if applicable)
- Most recent NYSDOH State Survey & Plan of Correction
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Copy of patient satisfaction survey
- Proof of adequate insurance coverage
    - Commercial General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note:

- Provider Compliance Certification **is required** for Skilled Nursing Facility providers (Attestation section to be completed on page 18).

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):			

Provider Compliance Certification

As required, I agree to submit 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 the appropriate box (CHOOSE ONE):

	I confirm that I have submitted a certification statement to Medicaid as required
	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.

Credentialing 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)?		Yes		No
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)?		Yes		No
Been subject to (in whole or in part) professional liability or malpractice claims, suits, settlements, arbitration proceedings, or complaints?		Yes		No
Been subjected to any investigation, claim, or disciplinary action due to unethical conduct?		Yes		No
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?		Yes		No
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/re-credentialing 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/re-credentialing 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/re-credentialing 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:	