Managed Long-Term Care (MLTC) Medicaid

Nascentia Health OPTIONS
TOMORROW'S HEALTHCARE TODAY

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@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) 477-9280

Recredentialing Form

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:	

Recredentialing:

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

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 16-18.

Adult Day Care:

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 16).

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):

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 16).

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 Home Health Services”:	
	☐	Other Licensed Home Health Services	If selected, list “Other Licensed Home Health Services”:	

Consumer-Directed Personal Aid (FI):

Note:

- Provider Compliance Certification **is required** for Consumer-Directed Personal Aid (FI) providers (Attestation section to be completed on page 16).

Durable Medical Equipment / Personal Emergency Response System:

Note:

- Provider Compliance Certification **may be required** for Durable Medical Equipment / Personal Emergency Response System providers (Attestation section to be completed on page 16).

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:

Home and Safety Modification:

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:

Note:

- Provider Compliance Certification **may be required** for Licensed / Certified Professional Service providers (Attestation section to be completed on page 16).

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	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):	
☐	Congregate Meals
☐	Home Delivered Meals

Skilled Nursing Facility (SNF):

Note:

- Provider Compliance Certification **is required** for Skilled Nursing Facility providers (Attestation section to be completed on page 16).

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 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 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.

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)?	☐	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/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:	