Nascentia Health
TOMORROW'S HEALTHCARE TODAY

Dual Special Needs Plan (DSNP) Managed Long Term Care (MLTC) Combined Credentialing Application

For Certified Home Health Agency (CHHA), Durable Medical Equipment (DME), Prosthetic and Orthotics, Skilled Nursing Facility (SNF), and Licensed Professional Services (Audiology; Podiatry; Outpatient Occupational, Physical and Speech Therapy)

Please include the following documentation with your DSNP and MLTC Credentialing Application. Submission of all applicable items is required for the application to be considered complete.

Requirements to Participate:

☐ Business Associate Agreement (required for **DME** providers)
☐ Current signed and dated Services Agreement
☐ Current Medicaid ID (Pending Medicaid is not acceptable)
  ☐ Medicaid Approval Letter including Medicaid Number (TPI) and effective date (if applicable)
☐ Current Medicare Number (Pending Medicare is not acceptable; *not required for Supplemental benefit provider*)
☐ Current State Operating License/Business License/Certificate of Need for applicable locations
☐ Current Accreditation Letter and/or Certificate (JCAHO, NCQA, URAC, DNV, or CHAP – if applicable)
  ☐ *If *not* accredited, the most recent NYS Department of Health (NYSDOH) State Survey and Plan of Correction (**CHHA** and **SNF**)
☐ Copy of Patient Satisfaction Survey (**CHHA**)
☐ *Incontinence Products Verification (required only for **DME** providers offering incontinence supplies)
☐ *Current General Liability & Professional Liability Insurance with limits of $1M / $3M or State Law Requirement
  ACORD Form (Certificate Holder: Nascentia Health, 1050 West Genesee Street, Syracuse, NY 13204)
☐ Completed IRS Form W-9 including legal name and remit-to address
☐ Signed and dated Attestation for each service location
☐ *Current Provider Roster including Medicaid ID and CAQH identifiers (required for **Licensed/Certified Professionals**)

**Submit updated documentation for any changes, renewals, or new inspections as they occur.*

Provider Compliance Certification

Provider Compliance Certification **is required** for Certified Home Health Agencies (**CHHA**). Provider Compliance Certification **may be** required for Durable Medical Equipment (**DME**) providers and **Licensed or Certified Professional Service providers**, as applicable. Refer to page 8 for more information.

Note: Applications will not be considered complete until all applicable documentation has been received and reviewed.

Complete all applicable fields and enter N/A where a field does not apply.

1. General Organization Information

Legal provider name (as reported to the IRS)		**DBA name**	
Tax ID (EIN)		**Organization NPI**	
Medicaid provider #		**Medicare provider #**	
License / operating certificate #		**Permanent facility identifier (if SNF)**	
Health system / parent company		**Length of time in business**	_____ Years _____ Months

2. Primary Service Location

Street address		**Suite / floor**	
City		**State / ZIP**	
Main phone		**Fax**	
Contact Person:		**Contact Phone**	
Contact Email		**Website**	

Counties serviced by main location: _____

Branch or satellite offices (including NPI, address, phone, hours of operation, and counties serviced):

1. _____

2. _____

3. _____

4. _____

5. _____

Attach additional location information, if necessary

3. Pay to Name & Billing Address (should match w-9)

Name			
Street Address		**Suite / floor**	
City		**State / ZIP**	

4. Mailing Address (if different than previously listed)

Street Address		**Suite / floor**	
City		**State / ZIP**	
Main phone		**Fax**	

5. Key Contacts and Operations

Primary contact (Name / title / phone / email):	
Credentialing (Name / title / phone / email):	
Contracts (Name / title / phone / email):	
Compliance (Name / title / phone / email):	
Scheduling (Name / title / phone / email):	
Billing (Name / title / phone / email):	

6. Billing and Claims

Billing format / forms used **(i.e. UB-92, HCFA-1500)**	
Third-party billing agency	
Electronic Visit Verification Software (required for CHHA providers)	

7. Accessibility and Communication

☐ Public transportation accessible	☐ Wheelchair accessible
☐ American Sign Language available	☐ Network hearing system (TDD) available
☐ Restroom Handicap Accessible	☐ Parking Handicap Accessible
☐ Elevator available (if services are not on first floor)	☐ Vision accessible
☐ Foreign languages spoken:	☐ Other accessibility / support services:

8. Service Lines

☐ CHHA – page 4	☐ Durable Medical Equipment (DME) – page 4
☐ Skilled Nursing Facility (SNF) – page 5	☐ Licensed/Certified Professional Services (Audiology, Podiatry, Outpatient Occupational, Physical and/or Speech Therapy) – page 5-6

8. CHHA Services

☐ Home health aide	☐ Housekeeping / PCA Level I
☐ PCA Level II	☐ Medical social work
☐ Medication dispensing services	☐ Nutritional counseling
☐ Nursing in home (LPN / RN)	☐ Occupational therapy
☐ Physical therapy	☐ Speech therapy
☐ Telehealth services	☐ UAS assessment services
☐ Wound care	☐ Other CHHA services: _____
☐ Other CHHA services: _____	☐ Other CHHA services: _____

JCAHO accreditation: ☐ Yes ☐ No ☐ N/A

Most recent site visit survey date (if not accredited; attach copy of results and corrective action plan): _____

Operating Hours: Please list hours (a.m. and p.m.)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

9. DME Services

☐ CPAP supplies	☐ Diabetic supplies
☐ Durable medical equipment and supplies	☐ Enteral therapy
☐ Incontinence supplies (MLTC only)	☐ Medicare-authorized DME provider
☐ Medication dispensing systems (MLTC only)	☐ Orthotics / prescription footwear
☐ Oxygen related equipment	☐ Prosthetics
☐ Other DME services: _____	

Operating Hours: Please list hours (a.m. and p.m.)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

10. SNF Services

☐ Adult Medical Day Care (ADHC; MLTC only)	☐ Daily room and board (MLTC only)
☐ Outpatient occupational therapy*	☐ Outpatient physical therapy*
☐ Outpatient speech therapy*	☐ Short term rehabilitation
☐ Specialty beds (behavioral / neurological / ventilation)	

JCAHO accreditation: ☐ Yes ☐ No ☐ N/A

Most recent site visit survey date (if not accredited; attach copy of results and corrective action plan)

**Attach roster, or provide practitioner information on page 6*

Operating Hours: Please list hours (a.m. and p.m.)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

11. Licensed / Certified Professional Services

☐ Audiology* - hearing aid exam and dispensing	☐ Outpatient occupational therapy*
☐ Outpatient physical therapy*	☐ Outpatient speech therapy*
☐ Orthotics / prescription footwear	☐ Podiatry*
☐ Prosthetics	☐ Other professional services: _____

**Attach roster, or provide practitioner information on page 6*

Operating Hours: Please list hours (a.m. and p.m.)						
Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

12. Licensure (attach a copy of each facility/ancillary license), Certificates, and Accreditation

State	Licensing agency	License / certificate #	Initial issue date	Renewal date	Expiration date

14. Practitioner Roster *(Licensed/Certified Professional Services - Audiology; Podiatry; Outpatient Occupational, Physical and Speech Therapy)*

Facility / Ancillary Staff with CAQH (if applicable)

NPI	First Name	Last Name	CAQH	Degree	Medicaid ID	Service Address

16. CMS Facility Attestation Questions

Please answer every question "Yes" or "No" and provide a detailed explanation on a separate sheet for any yes answers.	**Yes**	**No**
1. Has this facility under any current or former name or business identity ever had any felony or misdemeanor convictions under federal or state law related to either of the following: (a) The delivery of an item or service under Medicare or a State Health Care Program? (b) The abuse or neglect of a patient in connection with the delivery of a health care item or service?	☐	☐
2. Has this facility 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?	☐	☐
3. Has this facility under any current or former name or business identity ever had any felony or misdemeanor convictions, under federal or state law relating to the unlawful manufacture distribution prescription or dispensing of a controlled substance?	☐	☐
4. Has this facility under any current or former name or business identity ever been suspended or excluded from participation in or any sanction imposed by a federal or state health care program or any disbarment from participation in any federal executive branch procurement or non-procurement program?	☐	☐
5. Is this facility under any current or former name or business identity, currently suspended from Medicare or Medicaid payment under any Medicare or Medicaid billing number?	☐	☐

17. NYS Medicaid Attestation Questions

Please answer every question "Yes" or "No" and provide a detailed explanation on a separate sheet for any yes answers. **In the past 3 years or presently, has your company or any of its representatives:**	**Yes**	**No**
Had disciplinary actions, criminal proceedings, or other adverse actions initiated against them (this includes license or certification limitations, revocations, suspensions, terminations, or voluntary relinquishment)??	☐	☐
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)?	☐	☐
Been subject to (in whole or in part) professional liability or malpractice claims, suits, settlements, arbitration proceedings, or complaints?	☐	☐
Been subjected to any investigation, claim, or disciplinary action due to unethical conduct?	☐	☐
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?	☐	☐

Initial: ____ We monitor and screen employees, volunteers, governing body members, and downstream entities for healthcare-related criminal convictions.

Initial: ____ We screen employees, volunteers, governing body members, and downstream entities against LEIE, SAM, and the New York exclusions database prior to hiring and monthly thereafter.

18. Provider Compliance Certification (NYS Medicaid requirement)

For more information on the Provider Compliance Program, please go to the program website at https://omig.ny.gov/compliance/compliance

Initial **one:**

____ I have submitted a Certification Statement for Provider Billing Medicaid to Medicaid as required.

____ I am not required to submit a certification statement to Medicaid pursuant to NYS Social Services Law § 363-d and 18 NYCRR Part 521.

19. Certification and Signature

I present the information included in this application as part of the credentialing/re-credentialing process with the understanding that its confidentiality will be maintained to the extent permitted by law, and that such information may be used and disclosed for current and future credentialing, peer review, and quality assurance activities, or as otherwise required by law, court, or administrative agency, or as authorized by the provider.

I hereby affirm that all information provided in or attached to this application is current, true, accurate, complete, and submitted in good faith to the best of my knowledge and belief. I understand that any misrepresentation, misstatement, or omission, whether intentional or not, may result in the automatic and immediate rejection, denial, or termination of the credentialing/re-credentialing process.

I agree to notify Nascentia Health in writing within fifteen (15) business days of any material change to the information provided in this application or any response contained herein. I further agree to use best efforts to provide all required and requested documentation in a timely manner to facilitate completion of the credentialing process.

I understand that credentialing/re-credentialing review must be completed prior to approval of participation. I authorize Nascentia Health to consult with any third party that may have information relevant to this application and the services provided by my organization, and I release any such person or entity from liability related to the provision of such information.

I acknowledge that a photocopy or facsimile of this document, including my signature, shall be considered as valid as the original. I represent that I am duly authorized to execute this application on behalf of the organization.

Authorized representative signature		**Printed name**	
Title		**Organization**	
Date		**Email / phone**	