Nascentia Health OPTIONS
TOMORROW'S HEALTHCARE TODAY

Managed Long Term Care (MLTC) Medicaid
Recredentialing Form

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.	**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, 1050 West Genesee Street Syracuse, NY 13204-2215** **Questions: (315) 477-9280**

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 7
☐	Audiologist/Hearing Aids — Page 8
☐	Consumer Personal Aid (FI) — Page 10
☐	Home and Safety Modification — Page 11
☐	Licensed Home Care Services Agency (LHCSA) — Pages 12-13
☐	Meals Provider — Page 14
☐	Personal Emergency Response System — Page 15

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 1-5 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 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**

Audiologist/Hearing Aids

Note:

- Provider Compliance Certification **may be required** for Audiologist/Hearing Aids providers (Attestation section to be completed on page 16).

Services offered (Check all that apply):			
☐	**Audiology (exam only)**		
☐	**Audiology (hearing aid services available)**		
☐	**Other Services**	**If selected, list "Other Services" offered:**	

Please list License/Certification information for all professionals employed at your 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):			
5. Name:		**License #:**	
Occupation:		**Individual NPI:**	
Practitioner Medicaid ID:		**Practitioner Medicare ID:**	
Practice Location(s):			

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).

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 Home Care Services Agency (LHCSA)

Note:

- Provider Compliance Certification **is required** for 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**

Licensed Home Care Services Agency services offered (Check all that apply):			
☐	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		
☐	PRI & Screen Assessment Services		
☐	Private Duty Nursing, LPN		
☐	Private Duty Nursing, RN		
☐	Respiratory Therapy		
☐	Other Licensed Home Health Services	If selected, list “Other Licensed Home Health Services”:	

Meals Provider

Meal Services offered (Check all that apply):	
☐	Congregate Meals
☐	Home Delivered Meals

Personal Emergency Response System

Note:

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

Personal Emergency Response System Services offered (Check all that apply):			
☐	**Medication Dispensing Systems**		
☐	**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**		
☐	**Other**	**If selected, list "Other Services" offered:**	

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.

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/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:	