AmeriHealth Caritas VIP Care Plus | MI HEALTH LINK Linking Medicare & Medicaid for you

Application Checklist for Facilities

Please use the following checklist to complete the credentialing process. Current copies of all items listed below are required for the facility to participate with AmeriHealth Caritas VIP Care Plus. Please use this Application Checklist for Facilities as a fax cover sheet. Fax all applicable items on the checklist to Provider Network Management at **1-855-306-9762**, or signed documents may be scanned and submitted by secure email to **michiganprovidernetwork@amerihealthcaritas.com**. Please ensure this checklist is included with the documents.

Please provide AmeriHealth Caritas VIP Care Plus with the following:

Facility information	
Legal business name:	
Practice name to appear in directory (DBA):	
Products: ☐ Medicaid ☐ Medicare ☐ Both	
Practice tax ID number (TIN):	
Group NPI number (Please list all NPI numbers. Attach additional sheet if needed.):	
Medicaid ID number:	
Is the provider enrolled in the Community Health Automated Medicaid Processing System (CHAMPS*)?: ☐ Yes ☐ No If yes, effective date: End date: *Per state requirements, effective January 1, 2018, providers must be enrolled in CHAMPS, the Michigan Department of Health and Human Services enrollment system, before enrolling in our network.	
Medicare number (The provider must have a Medicare number to participate with the Medicare plan.):	
Credentialing contact name:	
Contact email address:	Contact phone number:

Please provide the following:

☐ Facility Credentialing Application (completed, signed, and dated)
(Application for new credentialing only. For recredentialing, please complete this checklist and include all below applicable documents.)

☐ State license (applicable to state requirements)

- Current state license.
- Current business permit.
- Current occupational license.
- Current medical gases permit.

☐ Accreditation, certification, or Centers for Medicare & Medicaid Services (CMS) state survey

- **Note:** Any hospital or ancillary facility that is not accredited or does not have a CMS state survey requires a plan site evaluation.

Application Checklist for Facilities

☐ Drug Enforcement Administration (DEA) registration certificate (if applicable)

- DEA must have the state in which the provider is rendering services to our members. DEA registration certificate is not transferable by location.

☐ Controlled dangerous substance (CDS) license (if applicable)

☐ Malpractice insurance policy face sheet showing expiration dates and limits of liability

☐ Clinical Laboratory Improvement Amendments (CLIA) (if applicable)

☐ Proof you have submitted an application for a Medicaid number if one is not listed above. For applications in process, please submit a copy of the first page and signature page of the application you submitted. (If not certified, provide proof of participation.)

☐ W-9 form

☐ Facility office hours, which must be completed on the application

☐ Dual eligible demonstration compliance attestation or ownership disclosure

To check the status of your application, or if you have any questions or concerns regarding this process, please contact the AmeriHealth Caritas VIP Care Plus Credentialing department at **1-855-350-2005**.

If you are new to AmeriHealth Caritas VIP Care Plus and you or your group does not have a provider contract, you must first call your Provider Network Management Account Executive or Provider Services at **1-888-667-0318** to discuss obtaining an AmeriHealth Caritas VIP Care Plus provider agreement.

AmeriHealth Caritas
VIP Care Plus

Facility Credentialing Application

Facility identification	
Legal business name (as reported to the Internal Revenue Service [IRS]):	Medicaid number:
Doing business as (DBA) name (if applicable):	Medicare number:
Health system affiliation (if applicable):	Tax identification number (TIN):
Length of time in business with this name and tax ID: _____ years _____months	National Provider Identifier (NPI):

Is the provider enrolled in the Community Health Automated Medicaid Processing System (CHAMPS*)? ☐ Yes ☐ No

If yes, effective date: _____ End date:_____ CHAMPS number: _____

* Per state requirements, effective January 1, 2018, providers must be enrolled in CHAMPS, the Michigan Department of Health and Human Services enrollment system, before enrolling in our network.

Facility information (Please refer to Attachment A for services provided at this location and additional locations.)	
Facility name:	
Address line 1:	
Address line 2:	
City:	State:
ZIP:	County:
Phone:	Fax:
Website: www.	
Credentialing contact name:	
Phone:	Fax:
Email:	
Facility administrator name:	
Phone:	Fax:
Email:	

Office hours (use HH:MM format)									
Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday									
Thursday									
Friday									

Services at this location:	
☐ Americans with Disabilities Act (ADA) accessibility requirements	☐ 24/7 phone coverage
☐ Handicap accessibility	☐ Answering service

Mailing address

☐ Check here if all correspondence can be directed to the facility location above. If not, complete the section below.

Name:	
Address line 1:	
Address line 2:	
City:	State:
ZIP:	County:
Phone:	Fax:
Email:	

Remittance/Billing address

Name:	
Address line 1:	
Address line 2:	
City:	State:
ZIP:	County:
Phone:	Fax:
Email:	

Facility Credentialing Application

Facility type

- ☐ Ambulatory surgical center — freestanding only
- ☐ Behavioral health care and social services provider
- ☐ Behavioral rehabilitation services provider
- ☐ Comprehensive outpatient rehabilitation facility (CORF)
- ☐ Community mental health center
- ☐ Durable medical equipment supplier
- ☐ Diabetic education program
- ☐ Dialysis center
- ☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinic
- ☐ Federally qualified health center (FQHC)
- ☐ FQHC (behavioral health only)
- ☐ Freestanding radiology center
- ☐ Freestanding sleep center or sleep lab
- ☐ Home health care agency providing skilled services only and no personal care assistant (PCA) services
- ☐ Home health care agency providing both skilled services and PCA services
- ☐ Home health hospice
- ☐ Home infusion services provider
- ☐ Hospital (acute care and acute rehabilitation)
- ☐ Hospital (psychiatric and geriatric)
- ☐ Intermediate care facility — mental health
- ☐ Mental health clinic
- ☐ Nursing home
- ☐ Portable X-ray supplier
- ☐ Rural health clinic (RHC)
- ☐ Skilled nursing facility or nursing home
- ☐ Skilled nursing facility providing sub-acute services
- ☐ Other (please indicate): _____

Health care licensure

Attach a copy of each facility license. Do not submit provider licenses.

License number	State or city	Licensing agency	Initial issue date	Renewal date	Expiration date

Medicare status

1. Is this facility participating in the Medicare program? ☐ Yes ☐ No ☐ Pending

If yes, provide Medicare number:

2. Is this facility certified by the Centers for Medicare & Medicaid Services (CMS)?
☐ Yes ☐ No ☐ Pending

If yes, provide date of initial CMS certification (_____) and Medicare certification number: _____

☐ Check here if facility is **not eligible** for CMS certification

Accreditation	Select accrediting agency from the list below and attach a copy of current accreditation certificate. If not accredited, skip checklist and go to the site visit requirements section.

☐ American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF)
☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ American Academy of Sleep Medicine (AASM)
☐ Accreditation Commission for Health Care (ACHC)
☐ American College of Radiology (ACR)
☐ American Osteopathic Association (AOA)
☐ Board of Certification (BOC)
☐ The Commission on Accreditation of Birth Centers (CABC)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)
☐ Continuing Care Accreditation Commission (CCAC)
☐ Community Health Accreditation Program (CHAP)
☐ Council on Accreditation (COA)
☐ Det Norske Veritas Healthcare, Inc. (DNVHC)
☐ National Integrated Accreditation for Healthcare Organizations (NIAHO)
☐ The Joint Commision, previously known as JCAHO

Date of initial accreditation: _____

Date of last full survey: _____

Site visit requirement	Attach a copy of most recent on-site survey for each location (with Corrective Action Plan [CAP], if citations were issued) or attach cover letter from government agency stating facility is in substantial compliance.

1. Has facility had a post-licensing on-site visit by a government agency such as the Department of Health or CMS within the past 36 months?

☐ Yes — Date of most recent standard survey: _____

☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A — no recent survey

If yes, have all deficiencies been corrected?

☐ Yes — Provide evidence of state acceptance of your CAP

☐ No — Provide explanation and your plan to correct all deficiencies

If no deficiencies were cited during the last full survey, **submit verification of no deficiencies.**

Provider credentialing

Does the facility validate, for each licensed provider employed or contracted at the facility, the credentials necessary to perform health care services? ☐ Yes ☐ No

If yes, indicate how the facility conducts the credentialing process for each provider:

☐ Credentialing procedures are performed internally.

☐ Credentialing procedures are outsourced or delegated to: _____

☐ Other, specify:_____

If no, please explain:

Insurance	Both facility general and professional liability insurance is required. Minimum coverage requirement is $1 million per occurrence and $3 million aggregate.
General liability coverage	**Attach certificate showing policy number, coverage amounts, effective and expiration dates.**
Current carrier name:	Policy number:
Street/P.O. box:	City:
State:	ZIP:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence based ☐ Claims based	

Facility Credentialing Application

Professional liability coverage	Attach certificate showing policy number, coverage amounts, and effective and expiration dates.
Current carrier name:	Policy number:
Street or P.O. box:	City:
State:	ZIP:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence based ☐ Claims based	

Attachments	Indicate which documents are included with this completed application.
☐ Copy of all federal, state, and/or local licenses required to operate as a health care facility	
☐ Copy of facility's general liability insurance certificate	
☐ Copy of professional liability insurance certificate covering all facility employees	
☐ Copy of accreditation certificates	
☐ Copy of CMS letter certifying or recertifying facility can provide partial hospitalization services	
☐ Copy of most recent Department of Health or CMS survey including your CAP, if deficiencies were cited, or cover letter from the Department of Health or CMS stating you are in compliance	

Disclosure questions Answer every question yes or no. Provide a detailed explanation on a separate sheet for any questions answered yes.	
1. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been convicted of any health care-related criminal offense, had adjudication withheld on any health care-related criminal offense, pleaded no contest to any health care-related criminal offense, or entered into a pre-trial agreement for any health care-related criminal offense?	☐ Yes ☐ No
2. Has any entity, agent, owner, or managing employee of 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?	☐ Yes ☐ No
3. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	☐ Yes ☐ No
4. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had his or her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a consent order issued by a licensing, certifying, or professional standards board or agency?	☐ Yes ☐ No
5. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	☐ Yes ☐ No
6. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any federal executive branch procurement or non-procurement program?	☐ Yes ☐ No
7. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	☐ Yes ☐ No
8. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fines have been paid in full?	☐ Yes ☐ No
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the facility, under any current or former name or business identity?	☐ Yes ☐ No
10. Does the facility or any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	☐ Yes ☐ No
11. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care item or service?	☐ Yes ☐ No

12. Has any entity, agent, owner, or managing employee of 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 the delivery of an item or service under Medicare or state health care program?	☐ Yes ☐ No
13. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
14. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been found to have violated federal or state laws, rules or regulations in any program established under Medicare, any other state's Medicaid program, Title XX, or any other publicly funded federal or state health care or health insurance program?	☐ Yes ☐ No

Attestation

I certify that the information contained in this application is correct and complete to the best of my knowledge. I hereby authorize AmeriHealth Caritas VIP Care Plus to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to facility status, licensure, accreditation, or operations to AmeriHealth Caritas VIP Care Plus. I authorize and agree that AmeriHealth Caritas VIP Care Plus and its agents, employees, and representatives may provide AmeriHealth Caritas VIP Care Plus' subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing, or peer review. I release AmeriHealth Caritas VIP Care Plus and its affiliates, agents, employees, and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize AmeriHealth Caritas VIP Care Plus and its applicable subsidiaries and affiliates to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as appropriate.

Authorized signature

Print name

Title

Date

ATTACHMENT A: ADDITIONAL LOCATION ADDENDUM

COPY PAGE FOR ADDITIONAL LOCATIONS

(Complete section C only if you are an accredited or deemed behavioral health care provider organization.)

List services by location.

Section A — Demographics (If primary location, please skip to section C.)

Location name: _____

Service site address (no P.O. box):

_____

_____

Billing NPI or atypical number: _____ Medicaid number (if applicable): _____

Remittance address (if different from primary location):

_____

_____

Office hours (use HH:MM format)									
Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday									
Thursday									
Friday									
Services at this location:									
☐ ADA accessibility requirements					☐ 24/7 phone coverage				
☐ Handicap accessibility					☐ Answering service				

Section B — Site visit requirement (Attach a copy of the most recent on-site survey for each location with CAP.)

1. Has the facility had a post-licensing on-site visit by a government agency such as the Department of Health or CMS within the past 36 months?

   ☐ Yes — Date of most recent standard survey: _____

   ☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A — no recent survey

   If yes, have all deficiencies been corrected?

   ☐ Yes — Provide evidence of state acceptance of your CAP

   ☐ No — Provide explanation and your plan to correct all deficiencies

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies.**

Section C — Services available at this location (Check all that apply.)

Behavioral health (BH) service type and description (Please indicate service type: mental health [MH], substance use [SU], or both.)							
☐ MH	☐ SU	☐ Both	BH day treatment	☐ MH	☐ SU	☐ Both	Integrated health home
☐ MH	☐ SU	☐ Both	Behavioral therapy under EPSDT	☐ MH	☐ SU	☐ Both	Intensive community treatment
☐ MH	☐ SU	☐ Both	Case management	☐ MH	☐ SU	☐ Both	Intensive in-home services
☐ MH	☐ SU	☐ Both	Community-based Residential Level A	☐ MH	☐ SU	☐ Both	Medication management by psychiatrist
☐ MH	☐ SU	☐ Both	Community-based Residential Level B	☐ MH	☐ SU	☐ Both	Multi-systemic therapies
☐ MH	☐ SU	☐ Both	Crisis intervention				Neuropsychological testing
☐ MH	☐ SU	☐ Both	Crisis residential	☐ MH	☐ SU	☐ Both	Opioid treatment
☐ MH	☐ SU	☐ Both	Crisis stabilization	☐ MH	☐ SU	☐ Both	Outpatient psychiatric services
☐ MH	☐ SU	☐ Both	Day treatment or partial hospitalization services for adults	☐ MH	☐ SU	☐ Both	Partial hospitalization
				☐ MH	☐ SU	☐ Both	Psychosocial rehabilitation
☐ MH	☐ SU	☐ Both	Developmental disability (DD) case management	☐ MH	☐ SU	☐ Both	Peer support
				☐ MH	☐ SU	☐ Both	Psychological testing
☐ MH	☐ SU	☐ Both	Electroconvulsive therapy (ECT)	☐ MH	☐ SU	☐ Both	Telepsychiatry
☐ MH	☐ SU	☐ Both	Health skill-building services	☐ MH	☐ SU	☐ Both	Therapeutic day treatment for children and adolescents
			Individual, group, and family therapy	☐ MH	☐ SU	☐ Both	Treatment foster care case management
☐ MH	☐ SU	☐ Both	In-home behavioral therapies (including, but not limited to, applied behavioral analysis [ABA])	☐ MH	☐ SU	☐ Both	
☐ MH	☐ SU	☐ Both	Inpatient psychiatric hospital services — freestanding psychiatric hospital				

Substance use disorder services
☐ Outpatient substance use disorder services
☐ Residential substance use disorder treatment for pregnant and postpartum women
☐ Substance use disorder day treatment
☐ Substance use disorder day treatment for pregnant and postpartum women
☐ Substance use disorder intensive outpatient treatment

Waiver services (please list waiver type and all services)	
Mental health	**Substance use disorder**

Other services	
Mental health	**Substance use disorder**