KANSAS ORGANIZATIONAL PROVIDER CREDENTIALING/RECREDENTIALING APPLICATION

ATTACHMENTS NEEDED. Please include with your completed application the following items for each location.

- Form W-9 completed, signed, and dated
- Copy of current State License/Approval, as applicable
- Copy of Medicare Participation Certification, as applicable
- Copy of Certifications and/or Accreditation Certificates (e.g. TJC, Medicare)
- Copy of CLIA certification, as applicable
- Copy of all CDDO Affiliate Agreements (I/DD providers)
- Copy of State certification for HCBS services, as applicable (e.g. atypical, non BCBA autism providers, and letter of documentation for 1,000 hours oftreatment)
- Copy of Declaration Sheet and/or Certificate of Insurance
    - **For I/DD-TCM and PBS and HCBS providers** who are not providing medical or behavioral health services: **General** Liability Insurance Policies
    - **All other provider types: BOTH** current **Professional** Malpractice and comprehensive **General** Liability Insurance Policies
- Copy of completed HCBS Supplemental Form (HCBS providers)

Note:

- ☐ All applicants must complete all questions (unless otherwise noted).
- ☐ Please check the N/A box if not applicable.
- ☐ Applications that do not include all requested documents and responses to questions will not be able to be processed.

Return all documents via the method below:

- **Sunflower**: Contracting Department, Four Pine Ridge Plaza, 8325 Lenexa Drive, Lenexa, KS 66214
  Cenpatico (Behavioral Health): Attn: Credentialing, 12515-8 Research Blvd., Ste. 400, Austin, TX 78759
- **UnitedHealthcare**: Return this application along with your contract to the address provided on your cover letter or directly to your assigned UnitedHealthcare or Optum Behavioral Health contractor.
- **Aetna Better Health**: Return requested documents to the address provided on your cover letter or directly to your assigned Aetna Provider Experience liaison.

1. Facility/Provider Name & Address

***Note*: Legal name and DBA name must match Form W-9.**

Legal Name: _____

DBA Name: _____

Corporate Name (if different): _____

Federal Tax ID Number: _____ Is this Tax ID used for all locations? Yes ☐ No ☐

* If NO, list on a separate sheet of paper all Tax ID numbers and the Legal Name for each. Name for each.

Primary Address: _____

City: _____ County: _____

State: _____ ZIP code: _____

Phone: _____ Ext: _____ Fax: _____

Handicap accessible: ☐ YES ☐ NO

ADA compliant: ☐ YES ☐ NO

Credentialing Contact/Office Manager: _____

Phone: _____ Ext: _____ Fax: _____

Email Address: _____

PANEL/CAPACITY Status:

For individual providers or clinics, answer the following questions:

1. **How many Medicaid members are you currently seeing?** _____
2. **Is your panel Open or Closed to additional Medicaid Members?** ☐ **OPEN** ☐ **CLOSED**
3. **How many additional Medicaid members do you have the capacity to see, in each county, by specialty?**

2. Type of Component (as listed on License or Accreditation)
Check all that apply.

MEDICAL/LONG-TERM SUPPORT SERVICES (LTSS)

☐ Adult Care Home Nursing Facility (SNF/NF)	☐ Federally Qualified Health Center (FQHC)	☐ Positive Behavioral Supports
☐ Adult Care Home Nursing Facility Mental Health (NFMH)*	☐ HCBS*	☐ Public Health or Welfare Agency and Clinic
☐ Adult Care Home Assisted Living Facility*	☐ Head Injury Rehabilitation	☐ Rehabilitation Facility
☐ Adult Care Home Home Plus*	☐ Hearing Aid Dealer	☐ Renal Dialysis Center
☐ Adult Care Home Residential Health Care Facility (RHCF)*	☐ Home Health Agency	☐ Rural Health Clinic (RHC)
☐ Adult Care Home Adult Day Care*	☐ Hospice	☐ Specialized Home Nursing Services
☐ Ambulance	☐ Hospital/Psychiatric	☐ Targeted Case Management
☐ Ambulatory Surgical Center	☐ Hospital/Long-Term Acute Care Hospital (LTACH)	☐ Tribe/Tribal Organization/Urban Indian Organization/Indian Health Services (IHS)
☐ Autism –Interpersonal Communication Therapy	☐ Intermediate Care Facility/ Intellectually Developmentally Disabled (ICF/IDD)	☐ Vaccine Administration
☐ Diagnostic Imaging Center	☐ Laboratory	☐ WORK Program Independent Living Counseling
☐ DME/Medical Supply Dealer	☐ Money Follows the Person Transition Coordination Services – HCBS	☐ WORK Program Assistive Services
☐ Family Planning Clinic	☐ Money Follows the Person Transition Coordination Services – Home Health	

* **Please also complete HCBS Supplemental Form, if providing HCBS services.**

BEHAVIORAL HEALTH SERVICES

Identify what best describes the organization (check).

MH	SA		MH	SA	
☐	☐	Community Mental Health Center (CMHC)	☐	☐	Outpatient Clinic
☐	☐	Day Treatment (free standing)	☐	☐	Peer Support
☐	☐	Detox Facility	☐	☐	Psychiatric Residential Treatment Facility (PRTF)
☐	☐	Intensive Outpatient (IOP) (freestanding)	☐	☐	Residential Treatment Facility/Center
☐	☐	Methadone Maintenance	☐	☐	Substance Use Disorder (SUD)
☐	☐	Consultative Clinical & Therapeutic Service (CCTS)	☐	☐	Intensive Individual Support Services (IIS)

Age Range Served		
Geriatric (65 years or more)	YES ☐	NO ☐
Adult (18 – 64 years)	YES ☐	NO ☐
Adolescent (13 – 17 years)	YES ☐	NO ☐
Child (12 years or less)	YES ☐	NO ☐

Are in-home services offered? ☐ YES ☐ NO

Number of total Nursing Facility Beds: _____

Number of total Assisted Living Facility Beds: _____

Office Hours
Open 24 hours? ☐ YES ☐ NO
If NO, complete hours of operation below.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing Address:	**Same as Primary** ☐ YES ☐ NO	**If Yes, donot complete this section.**
Indicate all billing addresses used and include ZIP plus four if used.		
Address		
City	State	ZIP
Phone	Ext	Fax

Mailing Address:	**Same as Primary** ☐ YES ☐ NO	**If Yes, donot complete this section.**
Indicate all billing addresses used and include ZIP plus four if used.		
Address		
City	State	ZIP
Phone	Ext	Fax

3. CORPORATE/SYSTEM OWNER (as provided on Form W-9) ☐ **N/A**

Name: _____

DBA Name: _____

Address: _____

City: _____ State: _____ ZIP code: _____

Phone: _____ Ext: _____ Fax: _____

4. ADDITIONAL PRACTICE/OFFICE LOCATIONS

Do you have additional practice/office locations? ☐ YES ☐ NO

If YES, list other practice/office addresses. If additional space is needed, attach a separate page.

1	Address					
	City	County	State	ZIP		
	Phone		Fax			
	Handicap accessible ☐ YES ☐ NO ☐ N/A		ADA compliant ☐ YES ☐ NO ☐ N/A			

Office Hours **Open 24 hours?** ☐ **YES** ☐ **NO** **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

2	Address					
	City	County	State	ZIP		
	Phone		Fax			
	Handicap accessible ☐ YES ☐ NO ☐ N/A		ADA compliant ☐ YES ☐ NO ☐ N/A			

Office Hours **Open 24 hours?** ☐ **YES** ☐ **NO** **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

3	Address					
	City	County	State	ZIP		
	Phone		Fax			
	Handicap accessible ☐ YES ☐ NO ☐ N/A		ADA compliant ☐ YES ☐ NO ☐ N/A			

Office Hours **Open 24 hours?** ☐ **YES** ☐ **NO** **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

5. LICENSURE/CERTIFICATIONS

Medicare Certified: ☐ YES ☐ NO
If YES, attach a copy of the CMS letter indicating the Medicare number(s) and effective date(s).

Medicare numbers: _____

Number of Medicare Beds: _____

Medicaid Certified: ☐ YES ☐ NO
If YES, list active KMAP ID number(s).

Active KMAP ID numbers: _____

Number of Medicaid Beds: _____

LICENSE TYPE	STATE	LICENSE NUMBER	EXPIRATION DATE
CLIA NUMBER			**EXPIRATION DATE**
OTHER LICENSE/CERTIFICATE – TYPE		**NUMBER**	**EXPIRATION DATE**

6. INSURANCE

Complete Section A, B, or both as applicable.

Professional Liability/Malpractice Liability ☐ **No Coverage**

Malpractice not required for HCBS providers who are not providing medical or behavioral health services.

Name of Corporate Entity on Declaration Sheet and/or Certificate of Insurance:

_____

Name of Carrier	Effective Date	Expiration Date	Coverage Amount per Occurrence	Coverage Amount Aggregate	Policy Number

Comprehensive General Liability ☐ **No Coverage**

Name of Carrier	Effective Date	Expiration Date	Coverage Amount per Occurrence	Coverage Amount Aggregate	Policy Number

QUESTIONAIRE

Please answer all questions and provide an explanation for affirmative answers.

Applications that do not include all requested responses and explanations will not be processed.

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed? ☐ YES ☐ NO
2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? ☐ YES ☐ NO
3. Has the business ever had its professional liability coverage cancelled but not renewed? ☐ YES ☐ NO
4. Has the business been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ☐ YES ☐ NO ☐ N/A

ACCREDITATION/CERTIFICATION

SECTION A

Section to be completed by non-HCBS providers only. Attach a copy of current Accreditation certificate or survey.

AASM ☐	AAAHC ☐	AAAASF ☐	ABC ☐	ACHC ☐	ACR ☐	AOA ☐	ASDA ☐	BOC Intl ☐
CABC ☐	CACH ☐	CAP ☐	CARF ☐	CCAC ☐	CHAP ☐	COA ☐	COLA ☐	CORF ☐
ABPCO ☐	DNVHCU ☐	HFAP ☐	HQAA ☐	IAC ☐	NABP ☐	NBAOS ☐	TJC ☐	NCQA ☐
URAC ☐	OTHER Not Accredited*							

*Complete Section B below.

Date of initial accreditation: _____ Date of next survey: _____

Date of last survey: _____

SECTION B

Has the provider had an onsite survey by CMS or State agency? ☐ YES ☐ NO

Date of last State survey: _____

If No, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.

Nonaccredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with their Corrective Action Plan (if deficiencies were cited), OR attach a letter from a government agency stating the Facility is in substantial compliance with the most recent survey standards. Facilities who don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

Component Attestation/Consent& Release Form

☐ **Accept Sunflower State Health Plan** ☐ **Decline Sunflower State Health Plan**

☐ **Accept United HealthCare** ☐ **Decline United HealthCare**

☐ **Accept Aetna for Better Health** ☐ **Decline Aetna for Better Health**

Section 12 Attestation / Consent and Release Form I hereby give permission to Plan/Network, directly and/or through its designee to request information regarding my professional credentials and qualifications from educational facilities, the hospital(s) in which I currently have or formerly privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers. The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless Plan/Network and its designee, and their respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering or good faith use of the information gathered during the credentialing process. I hereby authorize the education facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by Plan/Network, directly and/or through its designee, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. If applicable, I hereby authorize the Physician Recovery Network or applicable recovery program to release to Plan/Network information regarding my health status and participation status in any treatment program(s). I hereby further release and agree to hold harmless all such entities referenced in the previous sentence, their representatives, employees, and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice. I agree that the photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individuals who may provide information based upon this authorized request. I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection of this application by Plan/Network and may result in denial of my application or termination of my participation in Plan/Network. I further understand that any representation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of those privileges. I agree to use my best efforts to inform Plan/Network in writing within 15 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 my signing this application. I warrant that I have the authority to sign this application, on my behalf, and on behalf of any entity or organization for which I am signing

in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating provider. If I am accepted for participation, I consent to the inspection of my patient records for Plan Members as necessary for peer review and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual. I understand that I have the right to review and correct erroneous information obtained by the Plan/Network to evaluate my credentialing application. This includes information obtained from primary source (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require Plan/Network to allow a provider to review references or recommendations or other information that is peer-review protected. I understand that if my application is rejected for reasons relating to my professional conduct or competence, Plan/Network may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank and /or the Health Care Integrity and Protection Data Bank. I represent the information provided in or attached to this application is accurate and complete. I attest to either having adequate current malpractice insurance or I have attached a statement regarding arrangements for meeting state financial responsibility requirements. I certify that I hold a full, unrestricted license to practice in the state in which I reside or I have indicated on this application the limitations and/or restrictions imposed. I agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to the Plan/Network through its designee. I attest that I will continue to maintain active admitting and staff privileges at a Plan/Network participating hospital or I have otherwise indicated on this application. This health care organization, and its designee, does not discriminate on the basis of race, color, national origin, sex, religion, age, or disability. Your signature is required to complete this application. Stamped signatures are not acceptable.

Please remember to complete the below information, including signature and date (print or type).

Business Name: _____

Authorized Representative Name: _____

Title: _____

Signature: _____

Date: _____

NPI Information (as applicable)

If you have multiple NPI numbers, please list all that apply:

NPI Number	Organization/ Sub-Part Name	Address	Taxonomy Code	Level Information	NPI Issue Date	NPI Cancelled*

*Please explain.

Authenticare Information

Organization	Tax ID	NPI	Medicaid ID Number