FACILITY/ ANCILLARY/ LONG-TERM CARE PROVIDER APPLICATION

Please check each applicable Health Plan:

☐**GA** ☐**KS** ☐**LA** ☐**MD** ☐**NJ** ☐**NV** ☐**NY** ☐**OH** ☐**TX** ☐**VA** ☐**WA**

PROVIDER IDENTIFICATION

Legal Business Name:	
Doing Business As: (if applicable)	
Contact Person:	Email:
Tax ID #1:	Tax ID #2:
Medicaid #1:	Medicare #1:
Medicaid #2:	Medicare #2:
Long-Term Care Vendor #:	

PROVIDER TYPE

FACILITY:

__Ambulatory Surgery Center (8)
__Birthing Center (13)
__Hospital (69
__Inpatient Mental Health/ Substance Abuse Facility (74)
__Inpatient Rehab Hospital (75)
__Nursing Home (98)
__Organ Transplant Facility (111)
__Psychiatric hospital (153)
__Skilled Nursing Facility (173)
__Sub acute/ Intermediate Care Facility (180)
__Trauma Center (201)

ANCILLARY:

__Ambulance (8)
__Audiology Services (12)
__Dialysis (31)**
__Dietician/ Nutritional Services (33)
__Durable Medical Equipment & Supplies (36)
__Early Childhood Intervention (37)
__Family Planning Services (41)
__Federally Qualified Health Center (293)**
__Fetal Monitoring Services (45)
__Genetic Services (50)
__Hearing Aids (59)
__Hemophilia Center (62)
__Home Health Agency (64)
__Home Infusion Therapy (65)**
__Hospice Care- Outpatient (67)
__Hospice Facility (68)**
__Imaging Facility (71)**
__Interpreter Service (77)
__Laboratory (78)
__Lithotripsy Services (82)
__Occupational Therapy Services (105)
__Orthotics & Prosthetics (112)
__Outpatient Rehab Center (116)**
__Personal Assistance Services (143)
__Physical Therapy Services (148)
__Radiology Facility (165)
__Radiology- Mobile Unit (163)**
__Respite Care (169)
__ Rural Health Clinic (172)**
__Sleep Disorder Clinic (175)
__Speech Therapy Services (177)
__ Urgent Care Center (202)
__ Walk-In Clinic (CCCs)(206)
__Residential Service Agency (467)

Behavioral Health Ancillaries:

__Meth. Maint. Clinic (84)
__Outpatient Mental Health/ Substance Abuse Facility (115)
__Residential Treatment Ctr (MH/SA) (212)

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LONG-TERM CARE/ HOME COMMUNITY BASED SERVICES:

__ Adult Companion Services (214)	__Home Delivered Meals (63)	__Hospice Facility (68)	__Personal Emergency Response Systems (457)
__Adult Foster Home (4)	__Home Health Agency (64)	__Music Therapy (87)	__Pest Control (145)
__Adult Day Activity/ Health Services (27)	__Home Infusion Therapy (65)	__Nursing Home (98)	__Residential Care/Assisted Living Facility (168)
__Chore Services (21)	__ Homemaker (216)	__Nurse Registry (213)	__Respite Care (169)
__Escort Attendant (215)	__Home Modification/ Repair (66)	__Personal Asst. Svcs. (143)	__Respite Care – In Home (462)
__Financial Assessment/ Risk Reduction Svcs. (46)	__Hospice Care- Outpatient (67)		__Respite Care – Inpatient(456)

PRIMARY OFFICE /SERVICE ADDRESS			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Contact:	
Administrator (Full Name):			
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			
BILLING INFORMATION			
Name (Billing Name)			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	Phone:

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SECONDARY OFFICE /SERVICE ADDRESS (Attach separate sheet of paper for additional practice locations)			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Contact:	
Administrator (Full Name):			
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐ American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			

BILLING INFORMATION			
Name (Billing Name)			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	Phone:

NATIONAL PROVIDER IDENTIFIER	
Name:	
Service Address:	
Tax ID/EIN:	NPI#:
Taxonomy Code(s):	
Name:	
Service Address:	
Tax ID/EIN:	NPI#:
Taxonomy Code(s):	

Note: If you are a DME provider, please submit NPI and Taxonomy for each location. If more space is needed, please attach a separate sheet with Name, Service Address, Tax ID/EIN, NPI# and Taxonomy Code(S).

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LICENSURE (Attach a copy of current licensure and CLIA certification, if applicable.)			
State:	Date of License:	License Number:	Expiration Date:
State:	Date of License:	License Number:	Expiration Date:
CLIA Certificate #:			

ACCREDITATION/CERTIFICATION **(Attach a copy of current Accreditation certificate or survey.)**

A.

☐ AASM ☐ AAAHC ☐ AAAASF ☐ ABC ☐ ACHC ☐ ACR ☐ AOA ☐ ASDA ☐ BOC Int'l. ☐ CABC ☐ CACH ☐ CAP
☐ CARF ☐ CCAC ☐ CHAP ☐ COA ☐ DNV ☐ HCU ☐ HFAP ☐ HQAA ☐ IAC ☐ NABP ☐ NBAOS ☐ TJC
☐ **NOT ACCREDITED (complete section B below)**

Date of initial accreditation: _____/_____/_____ Date of next survey_____

Date of last survey: _____/_____/_____

B.

Has provider had an on-site 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 Hea
schedule the visit.

Non accredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with your Corrective Action Plan (if deficiencies were cited), OR attach letter from government agency stating Facility is in substantial compliance with 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.

GENERAL AND PROFESSIONAL LIABILITY INSURANCE

General Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

Professional Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

FACILITY/ ANCILLARY/ LONG-TERM CARE PROVIDER APPLICATION

AMERIGROUP DISCLOSURE FORM FOR PROVIDER ENTITIES

Directions: Use this form if you are applying for network participation as a **Provider Entity**, or if you are re-credentialing or re-contracting the **Provider Entity**, or if there have been significant changes to the information required on this form, for example an ownership change, the addition of a new managing employee or the change of your business location. A **Provider Entity** is a business entity. i.e. a partnership or corporation, that provides covered services to Amerigroup members.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Please return the original to Amerigroup and retain a copy for your files. Completely answer the applicable questions. If a question is not applicable, please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***.

Social Security Numbers (SSN) must be provided for validation purposes.

I. Identifying Information

Provider Entity Name	Provider DBA Name (if different from Provider Entity name)	Provider Federal Tax Id number
Provider NPI number	Medicaid ID number	Provider telephone Number

Provider Address- Must include at least one street address. (attach a separate sheet if needed).List all Practice locations	City	State	Zip Code

II. OWNER OR CONTROL INFORMATION

Directions: An **"Owner"** is a person or business entity which owns 5% or more of the assets, stock or profits of the **Provider Entity**. This 5% may be **Direct** ownership or **Indirect** ownership i.e., an individual might own 50% of a company that owns the actual **Provider Entity** meaning the indirect ownership is 50%. In addition to ownership of stock, an **Owner** is also a person who owns a legal obligation like a mortgage or loan that is secured by the assets of the **Provider Entity**.

A person with **"Control**" is someone who directs the **Provider Entity** and includes Directors, Trustees and Officers of Corporations and Partners in a Partnership. If the **Provider Entity** is a non-profit entity, respond **N/A** in the column for % of ownership.

A **"Managing Employee"** is someone who makes the day-to-day decisions for the **Provider Entity**. These individuals include office or billing managers for smaller providers, and for larger **Provider Entities** the heads of the major operating groups of the provider like, Head of Accounting, or Director of same day services. In other words, the line of individuals typically listed below the corporate officers on an organizational chart.

An **"Agent"** is an individual who has the legal ability to bind the **Provider Entity,** i.e., the **Provider Entity** may use an **Agent** to obtain contracts for it.

Please provide the following information for **Owners**, persons with **Control** interests, **Agents** and **Managing Employees** of the **Provider Entity**. Attach a separate sheet if needed.

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A. Master List

Name	(For *individuals* use Home address. For *business entities* that might have ownership interest use all street addresses (if more than one location), and P.O. Box address if any.) Address	City	ST	ZIP	DOB	SSN for individuals or Tax ID for business entities	% own er-ship	Title
Name	Address	City	ST	ZIP	DOB	SSN for individuals or Tax ID for business entities	% own er-ship	Title

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B. Specific Questions

1) Is any person on the **Master List** related to another person on the **Master List** as a spouse, parent, child or sibling?
Yes ☐ No ☐. **If yes, please provide the following information about the related persons:**

Name of First related person	Name of Second related Person	Type of relation

2) Does any person or entity in the **Master List** have an **Ownership** or **Control** interest in any other **Provider Entity**?

Yes ☐ No ☐. If "yes", please provide the following information about the other **Provider Entity** the person on the **Master List** has an interest in.

Name of other Provider entity	Address	City	State	Zip	Tax I.D.

3) Have any of the individuals or entities on the **Master list** been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, TRICARE or the Title XX services program since the inception of those programs?
Yes ☐ No ☐. **If yes, please provide the information requested below:**

Name on Court records	SSN /TIN	Matter of the Offense	Date of the Conviction	Exclusion Period of the Offense if you were excluded by the Federal Office of the Inspector General(OIG)

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4) Have any of the individuals or entities on the **Master List** ever been **Debarred** from participation in Federal Government contracts? **"Debarred"** means an individual is not allowed to participate in Contracts paid for by the Federal government, whether or not those contracts are in the health care area.

Yes ☐ No☐ **If 'yes' is checked, provide the following information:**

When you were debarred	Length of Debarment	Reason for Debarment

5) Has any person or entity on the **Master List** ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past. "Excluded" means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

Yes ☐ No☐ **If "Yes" please supply the following information:**

Name of Individual	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

6) Has any person or entity on the **Master List** ever been **Terminated** from a State's Medicaid or SCHIP programs for reasons having to do with Program Integrity(fraud or abuse) ? **Terminated** means the Provider lost the right to bill a State's Medicaid or SCHIP programs for a cause related to fraud or abuse.

Yes ☐ No☐ **If "Yes", please supply the following information:**

State of practice when terminated	Reason for termination	Date of termination

7) Has any person or entity on the **Master List** ever had Civil Monetary Penalties (CMPs) assessed against them? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

Yes ☐ No☐ **If "Yes" please supply the following information:**

Name Of Individual	State of practice when CMP assessed	Reason for CMP	Amount of CMP	Date of CMP

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8) Did anyone on the **Master List** obtain **Ownership** interest 1)as a result of a transfer of ownership from someone who was about to be Excluded or Terminated from participation in a Federal healthcare program, or was in fact Excluded or terminated from participation in a federal healthcare Program.: And 2) where the original **Owner** is or was a member of the **current Owner's Immediate Family** or M**ember of** the current owner's H**ousehold**, at the time of the transfer of ownership? [**Immediate Family** is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. **Membe**r **of Household** is, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A roomer or boarder is not considered a member of household.

Yes ☐ No ☐ **If "Yes" please supply the following information:**

Name of original **Owner**	SSN or TAX ID of original **Owner**	Place of Transfer	Date of Transfer

8a) List any **Subcontractor** in which this **Provider Entity** has a direct or indirect **Ownership** interest of at least a 5%. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** management functions, i.e., billing agent, or provide medical services i.e. a medical lab.

Name of Subcontractor	Address	City	State	Zip	Tax I.D.

8b) For each **Subcontractor(s)** listed in 8a above please provide the following information for the individuals with an **Ownership** or **Control** interest in the **Subcontractor(s).** See the Introduction section above for a definition of those terms. Attach a separate sheet if necessary.

Name	Address (for individuals use Home address, for business entities that might have ownership interest use business street address, and P.O. Box address if any.)	City	State	Zip	DOB	SSN for individuals or Tax ID for business entities	% of own er-ship	Title

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Name	Address	City	State	Zip	DOB	SSN/TIN	%	Title

8c) Is anybody in the list in 8b list related to any person in the **Master List** above?

Yes ☐ No☐ **If yes, please supply the following information about the related persons:**

Name of First related person	Name of Second related Person	Type of relation

III. Business transactions

1) Please list the **Subcontractors** with whom you have done business over the last 5 years where the contract is worth at least 5% of your **Provider Entities'** total operating expenses *or* $25,000 *whichever is less*. Use a separate sheet if necessary. *Do not* include the Subcontractors listed in II.8a. in which you have an ownership interest. A **Subcontractor** is a person or company that this **Provider Entity** has contracted with to do some of the **Provider Entities'** business functions, i.e., billing agent, or to provide medical services, i.e., a medical lab.

Name	Address	City	State	Zip

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2) Does the **Provider Entity** *wholly own* a **Supplier**? **Supplier** means an individual, agency, or organization from which the **Provider Entity** *purchases goods and services* used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy.)

Yes ☐ No ☐. If yes, supply the following information about the **Supplier:**

Name	Address	City	State	Zip	NPI	TIN

IV Signature

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of an individual who can legally bind this **Provider Entity**;

Name of Person (Printed)	Signature of Person	Title	Date

Name of person Completing form	Phone number of person completing form

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CREDENTIALING QUESTIONS

Does the facility/ancillary/long-term care have:

1. Evidence of the subcontractor's professional liability claims history? Yes ☐ No ☐
2. Any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state? Yes ☐ No ☐
3. Any history of loss or limitation of privileges or disciplinary activity? Yes ☐ No ☐

Please include an explanation for any questions(s) answered YES.

ATTESTATION AND INFORMATION RELEASE AUTHORIZATION

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Amerigroup of any changes thereto. I understand that this application does not entitle me to participation in Amerigroup. By applying for appointment as an Amerigroup Participating Provider, I authorize the Plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by Amerigroup, its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Amerigroup's Plans, that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for Participating Provider status with Amerigroup. I consent and agree that Amerigroup will complete a criminal history background check to determine if I or any Subcontracted Providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my Subcontracted Providers to undergo such background checks. I hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to Amerigroup or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between me or my group and Amerigroup, as such terms may be applicable to me.

I understand that as an applicant for participation in Amerigroup, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Amerigroup, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

Owner/Registered/Authorized Agent Printed Name: _____ DATE:_____

Owner/Registered/Authorized Agent Signature: _____ Title:_____

SSN/DOB: SSN: ____/____/____ DOB: ___/___/____

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ATTACHMENTS

Please submit all applicable documents, from the list below, with your completed and signed application. Failure to provide this information will prohibit Amerigroup from completing your credentialing and/ or contracting process.

- ☐ Copy of all Federal, State and/or local licenses required to operate as a health care facility (by location)
- ☐ Copy of Accreditation certificate or letter
- ☐ Copy of most recent CMS or state survey including your corrective action plan if deficiencies were cited, OR cover letter from CMS/state agency stating facility is in substantial compliance
- ☐ Copy of CLIA Certificate for each location, as applicable

Addendum -Texas LTSS Applicants Only

PROVIDER TYPE			
Personal Assistance Service Direct: ____Consumer Direct - Block Grant Model ____Consumer Direct – CDS Model ____Consumer Delegated – Agency Model _____ Rate Enhancement Program (DAD's Participant Contract # _____ List Level:_____	Day Activity/Health Services: _____Rate Enhancement Program (DAD's Participant Contract # List Level:_____	Residential Care/Assisted Living Facility: _____Rate Enhancement Program (DAD's Participant Contract # List Level:_____	_____Transition/Relocation Services