Provider/facility and long-term services and supports (LTSS) provider application

Provider identification

Legal business name:	
Doing business as (if applicable):	
Contact person:	Email:
Tax ID number 1:	Tax ID number 2:
Medicaid number 1:	Medicare number 1:
Medicaid number 2:	Medicare number 2:
Long-term care vendor number:	

Provider type

Facility/ancillary:

- ☐ Ambulance (8)
- ☐ Ambulatory surgery center (8)
- ☐ Audiology services (12)
- ☐ Birthing center (13)
- ☐ Dialysis (31)
- ☐ Dietician/nutritional services (33)
- ☐ Durable medical equipment (DME) and supplies (36)
- ☐ Early childhood intervention (37)
- ☐ Family planning services (41)
- ☐ Federally Qualified Health Center (FQHC) (293)
- ☐ Fetal monitoring services (45)
- ☐ Genetic services (50)
- ☐ Hemophilia center (62)
- ☐ Home health agency (64)
- ☐ Home infusion therapy (65)
- ☐ Hospice care – outpatient (67)
- ☐ Hospice facility (68)
- ☐ Hospital (69)
- ☐ Imaging facility (71)
- ☐ Inpatient mental health/ substance abuse facility (74)
- ☐ Inpatient rehab hospital (75)
- ☐ Intensive family intervention (819)
- ☐ Interpreter service (77)
- ☐ Laboratory (78)
- ☐ Methadone maintenance clinic (84)
- ☐ Nursing home (98)
- ☐ Occupational therapy (OT) services (105)
- ☐ Organ transplant facility (111)
- ☐ Orthotics and prosthetics (112)
- ☐ Outpatient mental health/substance abuse facility (115)
- ☐ Outpatient rehab center (116)
- ☐ Physical therapy (PT) services (148)
- ☐ Psychiatric hospital (153)
- ☐ Radiology – mobile unit (163)
- ☐ Radiology facility (165)
- ☐ Residential treatment center (mental health/substance abuse) (212)
- ☐ Respite care (169)
- ☐ Rural health clinic (172)
- ☐ Skilled nursing facility (173)
- ☐ Sleep disorder clinic (175)
- ☐ Speech therapy (ST) services (177)
- ☐ Sub acute/intermediate care facility (180)
- ☐ Trauma center (201)
- ☐ Urgent care center (202)
- ☐ Walk-in clinic (CCCs) (206)

Long-term care/home- and community-based services (HCBS)/waiver programs:

- ☐ Adult companion services (214)
- ☐ Adult foster home (4)
- ☐ Adult day activity/health services (27)
- ☐ Area agency on aging
- ☐ Assistive services/technology (721/722)
- ☐ Attendant care (901)
- ☐ Centers for Independent Living (591)
- ☐ Chore services (21)
- ☐ Community-transitional services (945)
- ☐ Consumer-directed services (211)
- ☐ Core (911)
- ☐ Escort attendant (215)
- ☐ Financial assessment/risk reduction services (46)
- ☐ Habilitation (1067)
- ☐ Home-delivered meals (63)
- ☐ Home health agency
- ☐ Home health aide (235)
- ☐ Home infusion therapy (65)
- ☐ Homemaker (216)
- ☐ Home modification/repair (66)
- ☐ Hospice care – outpatient (67)
- ☐ Hospice facility (68)
- ☐ Intermediate care facility for individuals with disabilities (384)
- ☐ Music therapy (87)
- ☐ Nursing home (98)
- ☐ Nurse registry (213)
- ☐ Personal assistant services (143)
- ☐ Personal emergency response systems (457)
- ☐ Pest control (145)
- ☐ Prevocational services
- ☐ Residential care/assisted living facility (168)
- ☐ Respite care (169)
- ☐ Respite care – in home (462)
- ☐ Respite care – inpatient (456)
- ☐ Service facilitator/independent support broker(S825)
- ☐ Supportive employment (653)
- ☐ Supportive living services (629)
- ☐ Transitional living skill (682)
- ☐ Vehicle modification (713)

Primary office/service address

Practice location name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Primary contact person:	
Administrator (full name):			
Does provider bill from this address? ☐ Yes ☐ No			
Does this office meet American Disabilities Act (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 (if different from above)

Name (billing name):			
Address line 1:			
Address line 2:			
City:	State:	ZIP:	Phone:

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 person:	
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 (NPI)

Provider name:	
Service address:	
Tax ID/EIN:	NPI number:
Taxonomy code(s):	
Provider name:	
Service address:	
Tax ID/EIN:	NPI number:
Taxonomy code(s):	

Note: If you are a DME provider, please submit NPI and taxonomy code(s) for each location. If more space is needed, please attach a separate sheet of paper with name, service address, tax ID/EIN, NPI number and taxonomy code(s).

Licensure (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)

State:	Date of license:	License number:	Expiration date:
State:	Date of license:	License number:	Expiration date:

CLIA certificate number:

Accreditation/certification (attach a copy of current accreditation certificate or survey)

A.

☐ AASM ☐ AAAHC ☐ AAAASF ☐ ABC ☐ ACHC ☐ ACR ☐ BOC Int'l. ☐ CABC ☐ CAP ☐ CARF
☐ CCAC ☐ CHAP ☐ COA ☐ DNV ☐ 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 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 your corrective action plan (if deficiencies were cited), or attach the letter from the government agency stating facility is in substantial compliance with most recent survey standards.

Facilities that 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: $

Credentialing questions

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

1. Evidence of all subcontractors' 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 on a separate sheet for any questions 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 Iowa, Inc. of any changes thereto. I understand that this application does not entitle me to participation in the Amerigroup network. 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 nonmembers of Amerigroup 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: ____/____/____ Date of birth: ___/___/____

Enclosures

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

Amerigroup disclosure form for provider entities

Directions: Please answer all questions. For any "Yes" response, please provide an explanation or listing as required. If you do not believe a question is applicable to you or your organization/entity, you should answer the question "NA." If you need additional space to respond to a question, please add a separate sheet of paper: Include your entity name on each sheet and identify the question and header for the listing. One disclosure entity form is required per TIN. **No questions should be left blank.**

Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as outlined in 42 CFR 455.104 (b) (1) (ii).

I. Identifying information

Provider entity name:	Doing business as 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:

II. Ownership and control information

Directions: The entity/organization must list all controllers, owners, agents and managing employees on the **master list**. For the purposes of this form, these terms are defined as follows:

- **Controller:** includes all directors, trustees and officers of a corporation or partners in a partnership. If the entity is a non-profit or not-for-profit entity, please respond "N/A" to the percentage of ownership question below, but still list all controllers
- **Owner:** includes any person or business entity that owns 5 percent or more of the assets, stock or profits of the provider entity either directly or indirectly
- **Agent:** includes any person or entity that has the authority to obligate the provider to a contract, mortgage or loan that may or may not be secured by the entity's assets
- **Managing employee:** includes anyone who has the authority to make material business decisions on behalf of the provider entity

A. Master list (use additional pages if needed)

Full name	Address (street and/or P.O. Box)	City	State	ZIP	Date of birth	SSN for individuals or Tax ID for business entities	Percent owner-ship	Title

B. Specific questions

1) Is any person listed in 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. If **No**, go to the next question.

Full name of first related person:	Full name of second related person:	Type of relation:

2) Does any person or entity listed in the **master list** have an **ownership** or c**ontrol** interest in any other p**rovider 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. If **No**, go to the next question.

Name of other provider entity:	Address:	City:	State:	ZIP:	Tax ID:

3) Has any person or entity listed in the **master list** been convicted of a criminal offense related to that person or entity's involvement in any program under Medicare, Medicaid, TRICARE or the CHIP services program since the inception of those programs?
Yes ☐ No ☐ If **Yes**, please provide the following information. If **No**, go to the next question.

Name on court records:	SSN/ Date of birth:	Matter of the offense:	Date of the conviction:	Exclusion period of the offense, if excluded by the federal Office of the Inspector General (OIG):

4) Has any person or entity listed in the **master list** ever been debarred from participation in federal government contracts? Debarred means an individual is prohibited from participation in contracts paid for by the federal government, whether or not those contracts are in the health care area.
Yes ☐ No ☐ If **Yes**, please provide the following information. If **No**, go to the next question.

Date of debarment:	Length of debarment:	Reason for debarment:

5) Has any person or entity listed in the **master list** ever been excluded from participation in federal health care programs (Medicare, Medicaid, CHIP or TRICARE) in the past? Excluded means a provider or entity has been notified by the Department of Health and Human Services, Office of the Inspector General (HHS, OIG) that they are prohibited from participating as a provider in any federally funded health care program.

Yes ☐ No ☐ If **Yes**, please provide the following information. If **No**, go to the next question.

Full name of individual or entity	Beginning date of exclusion or termination	End date of exclusion or termination	Reason for exclusion or termination

6) Has any person or entity listed in the **master list** ever been terminated from a state's Medicaid or CHIP program for reasons having to do with program integrity (fraud or abuse)? Terminated means the provider lost the right to bill a state's Medicaid and/or CHIP programs for a cause related to fraud or abuse.

Yes ☐ No ☐ If **Yes**, please provide the following information. If **No**, go to the next question.

Full name of provider	State of practice when terminated	Reason for termination	Date of termination

7) Has any person or entity listed in the **master list** ever had civil monetary penalties (CMP) assessed against them? A CMP is a type of fine assessed against a provider by a governmental agency that manages a federal health care program.

Yes ☐ No ☐ If **Yes**, please provide the following information. If **No**, go to the next question.

Full name of individual or entity:	State of practice when CMP assessed:	Reason for CMP:	Amount of CMP:	Date of CMP:

8) Has any person listed in the **master list** obtained an ownership interest in a provider entity: (1) As a result of a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal health care program, or was, in fact excluded or terminated from participation in a federal health care program, (2), where the original owner is or was a member of the current owner's immediate family or member of the current owner's household 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. Member of household means, 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 renter or boarder is not considered a member of the household.)

Yes ☐ No ☐ If **Yes**, please provide the following information. If **No**, go to the next question.

Full name of original **owner**:	SSN or TAX ID of original **owner**:	Place of transfer:	Date of transfer:

9) Does any person or entity listed in the **master list** have a direct or indirect ownership interest of at least 5 percent in a subcontractor of the provider entity? A subcontractor is a person or company that the provider entity has contracted with to provide some of the provider entities' management functions (i.e., billing agent) or provide medical services (i.e., a medical lab).
Yes ☐ No ☐ If **Yes**, please list each subcontractor. If **No**, go to Section III.

Full name of subcontractor:	Address:	City:	State:	ZIP:	Tax ID:

a) For each subcontractor listed in 9 above, please provide the following information about the individuals with an ownership or control interest in the subcontractor. See the directions for Section II above for a definition of these terms. Attach a separate sheet, if necessary.

Full name:	Address (street and/or P.O. Box):	City:	State:	ZIP:	Date of birth:	SSN for individuals or Tax ID for business entities:	Percent of owner-ship:	Title:

b) Is anyone listed in 9a related to any person in the **master list**?
Yes ☐ **No** ☐ If **Yes**, please provide the following information about the related persons. If **No**, go to Section III.

Full name of first related person:	Full name of second related person:	Type of relation:

III. Business transactions

1) Has the provider entity entered into any financial transaction(s) with any subcontractor totaling more than $25,000 or any significant business transactions with any subcontractor?
Yes ☐ No ☐ If **Yes**, please provide the following information. If **No** go to next question.

List the ownership of any subcontractor with whom this provider has had one or more business transactions totaling more than $25,000 during the previous 12-month period and any significant business transactions between this provider and any wholly-owned supplier, or between the provider and any subcontractor during the past five-year period.

Full name:	Address:	City:	State:	ZIP:

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**, please provide the following information. If **No**, go to next question.

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. The signature below **MUST** be the written signature of an individual who can legally bind this provider.

In compliance with 42 CFR 455.104(c), provider shall complete this disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of recredentialing/reenrollment, and within 35 days after any change in ownership by the provider. In compliance with 42 CFR 455.105(b), provider certifies that it will submit within 35 days of the date on a request by the secretary or the Medicaid agency, full and complete subcontractor information as outlined in Section III, business transactions, above.

Name of person (printed):	Signature of person:	Title:	Date:

Name of person completing form:	Phone number of person completing form:
	( )