Amerigroup RealSolutions in healthcare

https://providers.amerigroup.com

Facility/ancillary/long-term care 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:

__Ambulatory surgery center (8)
__Inpatient mental health/substance abuse facility (74)
__Organ transplant facility (111)
__Subacute/intermediate care facility (180)
__Birthing center (13)
__Inpatient rehabilitation hospital (75)
__Psychiatric hospital (153)
__Trauma center (201)
__Hospital (69)
__Nursing home (98)
__Skilled nursing facility (173)
__Intensive family intervention (819)

Ancillary:

__Ambulance (8)
__Genetic services (50)
__Laboratory (78)
__Respite care (169)
__Audiology services (12)
__Hearing aids (59)
__Lithotripsy services (82)
__Rural health clinic (172)
__Dialysis (31)
__Hemophilia center (62)
__Occupational therapy (OT) services (105)
__Sleep disorder clinic (175)
__Dietician/nutritional services (33)
__Home health agency (64)
__Orthotics and prosthetics (112)
__Speech therapy (ST) services (177)
__Durable medical equipment (DME) and supplies (36)
__Home infusion therapy (65)
__Outpatient rehabilitation center (116)
__Urgent care center (202)
__Early childhood intervention (37)
__Hospice care – outpatient (67)
__Personal assistance services (143)
__Walk-in clinic (CCCs) (206)
__Family planning services (41)
__Hospice facility (68)
__Physical therapy (PT) services (148)
__Residential service agency (467)
__Federally Qualified Health Center (FQHC) (293)
__Imaging facility (71)
__Radiology facility (165)
__Fetal monitoring services (45)
__Interpreter service (77)
__Radiology – mobile unit (163)

Behavioral health (BH) ancillaries:

__Methadone maintenance clinic (84)

__Outpatient mental health/substance abuse facility (115)

__Residential treatment center (mental health/substance abuse) (212)

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

__Adult companion services (214)

__Adult foster home (4)

__Adult day activity/health services (27)

__Agency adult foster care (988)

__Chore services (21)

__Core (911)

__Employment assistance (953)

__Escort attendant (215)

__Habilitation (1067)

__Home-delivered meals (63)

__Home health agency (64)

__Home infusion therapy (65)

__Homemaker (216)

__Home modification/repair (66)

__Hospice care – outpatient (67)

__Hospice facility (68)

__Music therapy (87)

__Nursing home (98)

__Nurse registry (213)

__Personal assistant services (143)

__Personal care attendant services (144)

__Private duty nursing (151)

__Personal emergency response systems (457)

__Residential care/assisted living facility (168)

__Respite care (169)

__Respite care – in home (462)

__Respite care – inpatient (456)

__Supported employment service (374)

Primary office/service address			
Practice location name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP code:	County:
Phone:	Fax:	Primary contact:	
Administrator (full name):			
Does provider bill from this address? ☐ Yes ☐ No			
Does this office meet American Disabilities Act (ADA) accessibility requirements? ☐ Yes ☐ No			

Hours of service

Primary office

Monday:		
Tuesday:		
Wednesday:		
Thursday:		
Friday:		
Saturday:		
Sunday:		

Age of patients served:
- ☐ Preschool children (birth to 5 years)
- ☐ Children (6-12 years)
- ☐ Adolescents (13-18 years)
- ☐ Geriactrics (65+ years)

Patient program/population served:
- ☐ Serves intellectual or developmental disability (IDD) population
- ☐ Services pediatric population
- ☐ Medical Dependent Children Program (MDCP) - Texas STAR Kids

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 code:	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 code:	County:

Phone:	Fax:	Primary contact:

Administrator (full name):

Does provider bill from this address? ☐ Yes ☐ No

Does this office meet American Disabilities Act (ADA) accessibility requirements? ☐ Yes ☐ No

Hours of service

Secondary office

Monday:		
Tuesday:		
Wednesday:		
Thursday:		
Friday:		
Saturday:		
Sunday:		

Age of patients served:	Patient program/population served:
☐ Preschool children (Birth to 5 years) ☐ Children (6-12 years) ☐ Adolescents (13-18 years) ☐ Geriatrics (65+ years)	☐ Serves intellectual or developmental disability (IDD) population ☐ Services pediatric population ☐ Medical Dependent Children Program (MDCP) - Texas STAR Kids

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 code:	Phone:

Provider identifier information

Name:	
Service address:	
Tax ID/EIN:	National Provider Identifier (NPI) number:
Taxonomy code(s):	

Name:	
Service address:	
Tax ID/EIN:	NPI number:
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 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:
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 ☐ AOA ☐ ASDA ☐ BOC Int. ☐ 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 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 question(s) answered Yes.

Knowledge of state requirements: The rendering service practitioner must be knowledgeable of the following:	
a. Acts that constitute abuse, neglect or exploitation of a member, as defined in 40 TAC Chapter 705, Subchapter A	a. ☐ Yes ☐No
b. Reports suspected abuse, neglect or exploitation, as instructed	b. ☐ Yes ☐No
c. Adheres to applicable state laws when providing transportation	c. ☐ Yes ☐No
d. May not be a spouse, legally responsible for person or employment supervisor of the member who receives the service	d. ☐ Yes ☐No

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

**Amerigroup members in the Medicaid Rural Service Area are served by Amerigroup Insurance Company; all other Amerigroup members in Texas are served by Amerigroup Texas, Inc.*

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

Addendum - Texas long-term services and supports applicants only

Provider type			
Personal assistance service direct: ____Consumer-directed - block grant model ____Consumer-directed service (CDS) model ____Consumer delegated – agency model • Financial management/CDS ____Rate enhancement program Department of Aging and Disability Services (DADS) participant contract number: ______________________ List level:___________	Day activity/health services: ____Rate enhancement program DADs participant contract number: ______________________ List level:___________	Residential care/assisted living facility: ____Rate enhancement program DADs participant contract number: ______________________ List level:______	____Transition/relocation services

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 recredentialing or recontracting as a **provider entity**, or if there have been significant changes to the information required on this form. For example, if you have an ownership change, the addition of a new managing employee or the change of your business location. A **provider entity** is a business entity, 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***.

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:
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 five percent or more of the assets, stock, or profits of the **provider entity**. This five percent may be **direct** ownership or **indirect** ownership (for example, an individual might own 50 percent of a company that owns the actual **provider entity**, meaning the indirect ownership is 50 percent). 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 nonprofit entity, respond **N/A** in the column for percent 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, such as 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**. For example, 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.

1) Master list

Full name	Address*	City	State	ZIP code	Date of birth	SSN for individuals or Tax ID number for business entities	Percent of owner-ship	Title

*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.

2) Specific Questions

a. 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**, provide the following information about the related persons:

Name of first related person:	Name of second related person:	Type of relation:

b. Does any person or entity on the **master list** have an **ownership** or **control** interest in any other **provider entity**?

Yes ☐ No ☐ If **Yes**, 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 code:	Tax ID number:

c. 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**, 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):

d. 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**, provide the following information:

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

e. 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 health care program.
Yes ☐ No ☐ If **Yes**, provide the following information:

Name of individual:	Beginning date of exclusion or termination:	End date of exclusion or termination:	Reason for exclusion or termination:

f. 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**, provide the following information:

Name of person terminated:	State of practice when terminated:	Reason for termination:	Date of termination:

g. 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 health care program.
Yes ☐ No ☐ If **Yes,** provide the following information:

Name of individual:	State of practice when CMP assessed:	Reason for CMP:	Amount of CMP:	Date of CMP:

h. 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 health care program, or was, in fact, excluded or terminated from participation in a federal health care program and 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** is, with respect to 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**, provide the following information:

Name of original **owner**:	SSN or Tax ID number of original **owner**:	Place of transfer:	Date of transfer:

1. List any **subcontractor** in which this **provider entity** has a direct or indirect **ownership** interest of at least a five percent. 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., medical lab).

Name of subcontractor:	Address:	City:	State:	ZIP code:	Tax ID number:

2. For each **subcontractor(s)** listed in h1 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*:	City:	State:	ZIP code:	Date of birth:	SSN for individuals or Tax ID number for business entities:	Percent of owner-ship:	Title:

*For individuals, use home address. For business entities that might have ownership interest, use business street address and P.O. Box address, if any.

3. Is anybody on the list in h2 related to any person in the **master list** above?
Yes ☐ No ☐ If **Yes**, provide the following information about the related persons:

Name of first related person:	Name of second related person:	Type of relation:

III. Business transactions

1) Has the disclosing entity had any financial transaction with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors?
Yes ☐ No ☐

2) If **Yes**, list the ownership of any subcontractor with whom this provider has had 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 of owner:	Address:	City:	State:	ZIP code:	Transaction details:

3) 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 (for example, a commercial laundry, a manufacturer of hospital beds or a pharmacy).
Yes ☐ No ☐ If **Yes**, provide the following information about the **supplier**:

Name:	Address:	City:	State:	ZIP code:	NPI number:	TIN number:

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**.

In compliance with 42 CFR 455.104(c), provider shall provide a 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 of the disclosing entity. In compliance with
42 CFR 455.105(b), a provider must submit, within 35 days of the date on a request by the secretary or the Medicaid agency, full and complete ownership information 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:
	( )