OUTPATIENT CLINIC / GROUP PRACTICE APPLICATION AND RELEASE FORM - TEXAS

Provider identification	
Outpatient clinic/group name:	
Doing business as (DBA): (if applicable)	
Administrator/credentialing contact person:	
Email:	Web address:
Medicaid #1:	Medicare #1:
Medicaid #2:	Medicare #2:
Provider type medical clinic	**Provider type behavioral health clinic**
☐Ambulatory health clinic ☐Community health center (CHC) ☐Diagnostic treatment center (DTC) ☐Federally qualified health center (FQHC) (S293) ☐Health Department ☐Outpatient group practice (Traditional) ☐Outpatient rehabilitation facilities (CORF) ☐Public health clinic ☐Urgent care center (UCC) (S202) ☐Rural health clinic (RHC) (S325) ☐Walk-in (Convenient care clinic)(CCC) (S209)	☐Community mental health center (CMHC) (S292) ☐Outpatient mental health clinic ☐Outpatient methadone maintenance clinic ☐Outpatient substance abuse clinic
Number of physicians and other practitioners in group: Group consists of: ☐PCPs____ ☐Specialists____ ☐Both____	

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			

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

Amerivantage is an HMO plan with a Medicare contract and a contract with the Texas Medicaid program. Enrollment in Amerivantage depends on contract renewal.

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Billing information (Please enclose a copy of your claim form.)			
Billing name:			
Address line 1:			
Address line 2:			
City:	State:	ZIP code:	County:
Phone:	Fax:	Primary contact:	
Tax ID#:			
Administrator (full name):			

National provider identifier	
Name:	
Service address:	
Tax ID/EIN:	NPI#:
Taxonomy code(s):	TPI#: (if applicable)

Sub-groups	
Group name:	
Tax ID/EIN:	NPI#:
Taxonomy code(s):	TPI#: (if applicable)
Group name:	
Tax ID/EIN:	NPI#:
Taxonomy code(s):	TPI#: (if applicable)

If there are additional groups, please attach a separate sheet indicating name and tax ID#.

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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#:			

For Outpatient Clinics Only!

Accreditation/certification **(Attach a copy of current accreditation certificate or survey.)**

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

Date of initial accreditation: Date of last survey:

Note: Non-accredited organizational providers must submit an on-site review, including a medical record review audit. Or substitute a current CMS or state review in lieu of conducting a site visit. (The CMS or state review may not be aged beyond three years.)

Has provider had an on-site survey by a state agency? ☐Yes ☐No Date of last state survey:

Is provider participating in the Medicare program? ☐Yes ☐No Date of last CMS survey:

Insurance **(Attach a copy of liability insurance face sheet indicating general and professional coverage.)**

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 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**.

Physician Incentive Program

1. Are any of your providers paid capitation (CAP) by the group? ☐Yes ☐No

2. Does the group reimbursement arrangement with their providers include bonuses and withholds? ☐Yes ☐No
   *If you answered **No** to both questions 1 and 2, please skip to question 6 below. If you answered **Yes** to either question, please copy this form and complete the following questions for each category of providers with similar reimbursement methodologies. If your providers have similar reimbursement methodologies, complete just this form.*

3. If CAP is paid by the group or if there are bonuses or withholds, does the Physician Incentive Plan cover services not furnished by the physicians? ☐Yes ☐No
   *If you answered **No** to question 3, please skip to question 6 below.*

4. If the group's Physician Incentive Plan covers services not furnished by the physician, is it a:
   Withhold? ☐ Bonus? ☐

5. What percentage of the provider's total compensation from the group is from these withholds and bonuses? %

6. Do you sub-contract with other provider groups and if so, how many? ☐Yes ☐No
   # of groups _____

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 as an Amerigroup participating provider, I authorize the plan, its medical director and appropriate representatives to consult with administrators and members of other institutions, including past and present malpractice carriers. 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 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 hereby release Amerigroup and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating this provider's 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 competence 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.

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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.

1. A copy of your state facility license(s).
2. A copy of your CLIA Certificate for each location to receive claims reimbursement for lab services.
3. A copy of your Liability Insurance Policy face sheet with effective and expiration dates, including the coverage amounts for each location. Professional liability limits as outlined in the Participating Provider Agreement; General Liability with limits of at least $1M/$3M.
4. For clinics only: a copy of your accreditation for each location **or** recent (within the last 36 months) CMS or state review for each location, if not accredited.
5. A copy of your W-9 Form(s).

Form completed by:

Printed name of authorized representative	Signature of authorized representative
Authorized representative's title	Date signed

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 (SSNs) 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, 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**, 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.

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	% Owner-ship	Title

Name	Address	City	ST	ZIP	DOB	SSN for individuals or tax ID for business entities	% Owner-ship	Title

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 excluded by the federal Office of the Inspector General(OIG)

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:**

Date of Debarment	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:**

Name of Individual	State of practice when terminated	Reason for 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 health care 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

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 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 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 Individual	Name of original **owner**	SSN or TAX ID of original **owner**	Place of transfer	Date of transfer

8a) List any **subcontractor** with which this **provider entity** has a direct or indirect **ownership** or an interest of at least a 5%. **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	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 Owner-ship	Title

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 of subcontractor	Address	City	State	ZIP	Tax I.D.

8c) Is anyone from the list in 8b 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 entity's** 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 entity's** business functions, i.e., billing agent, or to provide medical services, i.e., a medical lab.

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, 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

Application Addendum – Mental health and/or substance abuse outpatient clinic questionnaire

Provider name: _____ **TIN:** _____

Taxonomy: _____ **NPI:** _____

Address: _____

1) Does the organization have a governing body and an organized professional staff?

_____

_____

2) Does the clinic have a multidisciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one licensed masters or doctoral level mental health clinician staff?

_____

_____

3) Does the clinic have criteria for admissions, screenings and referrals?

_____

_____

4) Does the clinic provide comprehensive individualized treatment plans?

_____

_____

5) Does the clinic provide 24 hours/7 days per week coverage for crisis assessment/intervention? If no, what are the clinic's procedures for emergencies?

_____

_____

6) All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services. Does this follow the clinic's protocol?

_____

_____

Application addendum – Mental health and/or substance abuse outpatient clinic questionnaire

7) Does the clinic have a written quality improvement program?

_____

_____

8) Do the licensed and non-licensed clinicians receive oversight from a medical director? If not, what oversight Is currently in place?

_____

_____

9) Is the billing submitted under the clinic's name and tax identification number?

_____

_____

10) Does the clinic have centralized intake and billing? Are all claims submitted on the CMS 1500 form?

_____

_____

11) All practitioners providing outpatient services must be included in an Amerigroup-approved provider roster. Is the clinic able to provide the level of detail outlined in the Amerigroup provider roster?

_____

_____

12) Is the clinic currently licensed or accredited by a nationally recognized accreditation review body? If yes, please identify the applicable licensing agency and/or the accrediting entity, or provide a copy of the CMS or state agency survey.

_____

_____