Amerigroup

Provider update

Foundational Community Supports Provider Application

To apply to become a contracted Foundational Community Supports (FCS) provider, complete this form and return to us by email at FCSTPA@amerigroup.com or by fax to **844-470-8859**. Include a copy of your Federal Tax ID *W-9* form with this application. All fields with an asterisk (*) are required fields.

Agency name: *		
Washington Medicaid Provider ID number: *	Tax ID #: *	
Date: *		
NPI #: *	Primary taxonomy: *	
Primary address: *		
City:*	State:	ZIP:
Phone: *	Fax:	
Counties served at this location: *		
ADA accessible? * ☐Yes ☐ No		
Secondary address:		
City:	State:	ZIP:
Phone: *	Fax:	
Counties served at this location: *		
ADA accessible? * ☐Yes ☐ No		
(Attach a separate sheet of paper for additional agency locations.)		
Remit address: *		
City:	State:	ZIP:
Phone: *	Fax:	
Washington facility license or business license number:		
License effective date: *	License expiration date: *	

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 Washington, Inc. 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 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: