magnolia health

HOSPITAL-ANCILLARY-CLINIC PROVIDER CREDENTIALING APPLICATION

INSTRUCTIONS: In order to be considered complete:

1. **All information must be legible. Please print or type all information**
2. **Application must be completed in its entirety**
3. **Must be signed and dated**
4. **If necessary, use a separate sheet of paper to provide additional information**
5. **The original application with attachments should be attached to your provider agreement**

Please attach a copy of the following with this COMPLETED application:

- ❑ State Operational License
- ❑ Other applicable State/Federal Licensures (i.e. CLIA, DEA, Pharmacy, or Department of Health)
- ❑ Accreditation/certification (by a nationally-recognized accrediting body, i.e. TJC/JCAHO)
- ❑ If not accredited by a nationally-recognized accrediting body, Site Evaluation Results by a governmental agency
- ❑ Current General Liability coverage (document showing the amounts and dates of coverage)
- ❑ Medicaid/Medicare Certification (if not certified, provide proof of participation)
- ❑ W-9
- ❑ Ownership and Disclosure Form

☐ Initial Credentialing ☐ Re-Credentialing ☐ Addition of a new site to current contract

Facility credentialing is required for the following facility types: Choose all that apply and complete an addendum page for each additional NPI.

☐ **Hospital; NPI:**	☐ **Skilled Nursing Facility; NPI:**
☐ **Rehabilitation Center; NPI:**	☐ **Adult Living Facility; NPI:**
☐ **Surgical Center; NPI:**	☐ **Home Health Agency; NPI:**
☐ **Clinic- FQHC, RHC, Other; NPI:**	☐ **Durable Medical Equipment (DME) ; NPI:**
☐ **Diagnostic Imaging Center; NPI:**	☐ **Other; NPI:**
☐ **Assisted Long-Term Care Facility; NPI:**	

CONTACT INFORMATION

Credentialing Contact:	**Phone:**

LEGAL/BILLING INFORMATION

Entity Legal Name:	**Fed. Tax ID Numbers:**	**Medicaid Numbers:**
State License No.	**National Provider ID# (NPI):**	**Medicare Numbers:**
Pay To:		
Pay to Address:	**City/State/Zip**	**Phone:**
Billing Contact Person:	**Fax:**	**E-Mail:**

FACILITY/SITE INFORMATION

Group or d/b/a Name		
Location Telephone	**Title/Name of Group Signatory:**	**Location Fax**
Physical Address	**City/State/Zip**	**County**

Office Hours:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Is this facility open at least 5 days per week? ☐Yes ☐ No	Handicap Access? ☐Yes ☐ No
Please list any Foreign Languages Spoken at this location:	
Does your practice have a gender restriction? ☐Yes ☐ No If Yes, Please explain:	
Is your practice limited to certain ages? ☐Yes ☐ No	**ADA Compliant? ☐Yes ☐ No**

If Yes, specify age restrictions. Please Check One.

☐ None	**☐ 0-2 years**	**☐ 0-12 years**	**☐ 0-17 years**	**☐ 0-20 years**	**☐ 13+ years**
☐ 13-17 years	**☐ 13-20 years**	**☐ 21+ years**	**☐ 3+ years**	**☐ 17+ years**	

INSURANCE COVERAGE

Please attach copy of declaration pages			
Current Professional Carrier:			
Amount per Occurrence: $		**Amount per Aggregate: $**	
Dates of Coverage	**From:**	**To:**	
Current Liability Carrier:			
Amount per Occurrence: $		**Amount per Aggregate: $**	
Dates of Coverage	**From:**	**To:**	
Current Worker's Compensation Carrier:			

ACCREDITATION / CERTIFICATION TYPE

Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective date of accreditation or certification, deficiencies and approved plan for corrective action.

Agency Name	Acronym	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Board for Certification in Orthotics & Prosthetics, Inc	ABCOP		
American College of Radiology	ACR		
American Osteopathic Hospital Association	AOHA		
Board of Orthotist / Prosthetist Certification	BOCUSA		
Clinical Laboratory Improvement Act	CLIA		
Commission on Accreditation for Rehab Facilities	CARF		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
The Joint Commission	TJC (aka JCAHO)		
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations	DNV/NIAHO		
National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
State Facility Operating License	N/A		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
Others (please list)			

SANCTIONS

If yes to any question below, please explain on a separate sheet	
Have there been any settled malpractice claims, suits, settlements or proceedings involving your Organization within the past 5 years?	**☐ Yes ☐ No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	**☐ Yes ☐ No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse or a sexual offense?	**☐ Yes ☐ No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Magnolia Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Magnolia Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Magnolia Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Magnolia Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Magnolia Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Magnolia Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.
By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.
The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.
The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.
All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ **Date:** _____
Print or type name

_____
Signature of Provider or Authorizing Representative **Title**
A stamp signature is not acceptable

ADDENDUM PAGE for each additional NPI:

Specialty:	Fed. Tax ID Numbers:	Medicaid Numbers:
State License No.	National Provider ID# (NPI):	Medicare Numbers:

Pay To:		
Pay to Address:	City/State/Zip	Phone:
Billing Contact Person:	Fax:	E-Mail:

FACILITY INFORMATION

Group or d/b/a Name		
Location Telephone	Title/Name of Group Signatory:	Location Fax
Physical Address	City/State/Zip	County

Office Hours:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Is this facility open at least 5 days per week? ☐Yes ☐ No	Handicap Access? ☐Yes ☐ No
Are PAs, CNMs and/or Nurse Practitioners used? ☐Yes ☐ No	Will you be accepting new patients? ☐Yes ☐ No
Please list any Foreign Languages Spoken at this location:	
Does your practice have a gender restriction? ☐Yes ☐ No	If Yes, Please explain:
Is your practice limited to certain ages? ☐Yes ☐ No	ADA Compliant? ☐Yes ☐ No

If Yes, specify age restrictions. Please Check One.

☐ None	☐ 0-2 years	☐ 0-12 years	☐ 0-17 years	☐ 0-20 years	☐ 13+ years
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Clinical Laboratory Improvement Act	CLIA		
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National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
State Facility Operating License	N/A		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
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Others (please list)			

SANCTIONS

If yes to any question below, please explain on a separate sheet	
Have there been any settled malpractice claims, suits, settlements or proceedings involving your Organization within the past 5 years?	☐ **Yes** ☐ **No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐ **Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse or a sexual offense?	☐ **Yes** ☐ **No**

MAGNOLIA HEALTH PLAN
Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of *5%* or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to (*Health Plan/Entity Name*) within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary.(42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: 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

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve 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 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____