AmeriHealth Caritas
District of Columbia

Organizational Provider Credentialing Application

Organizational provider identification	
Legal business name (as reported to the IRS):	Medicaid ID number:
Doing business as (DBA) name (if applicable):	Medicare ID number:
Health system affiliation (if applicable):	Tax ID number (TIN):
Length of time in business with this name and tax ID: _____ years _____ months	National Provider Identifier (NPI):

Organizational provider information (Please refer to Attachment A for services provided at this location and additional locations.)		
Organizational provider name:		
Address line 1:		
Address line 2:		
City:	State:	ZIP:
County:		
Phone:	Fax:	
Website:		
Credentialing contact name:		
Phone:	Fax:	
Email:		

Organizational provider information (continued)

(Please refer to Attachment A for services provided at this location and additional locations.)

Organizational provider administrator name:	
Phone:	Fax:
Email:	

Office hours (use HH:MM format)

Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday					**Services at this location:**				
Thursday					☐ Americans with Disabilities Act (ADA) accessibility requirements			☐ 24/7 phone coverage	
Friday					☐ Handicap accessibility			☐ Answering service	

Mailing address

☐ **Check here if all correspondence can be directed to the organizational provider location above. If not, complete the section below.**

Name:		
Mailing address 1:		
Mailing address 2:		
City:	State:	ZIP:
County:		
Phone:	Fax:	
Email:		

Remittance address

Name:		
Mailing address 1:		
Mailing address 2:		
City:	State:	ZIP:
County:		
Phone:	Fax:	
Email:		

Organizational provider type

☐ Ambulatory surgical center — freestanding only

☐ Behavioral health and social services facility

☐ Behavioral rehabilitation facility

☐ Comprehensive outpatient rehabilitation facility (CORF)

☐ Community mental health center

☐ Durable medical equipment supplier

☐ Diabetic education program

☐ Dialysis center

☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinic

☐ Federally qualified health center (FQHC)

☐ FQHC (behavioral health only)

☐ Freestanding sleep center or sleep lab

☐ Freestanding radiology center

☐ Home health care agency providing skilled services only and no personal care assistant (PCA) services

☐ Home health care agency providing both skilled services and PCA services

☐ Home health hospice

☐ Home infusion service provider

☐ Hospital (acute care and acute rehabilitation)

☐ Hospital (psychiatric and geriatric)

☐ Intermediate care facility — behavioral health

☐ Mental health clinic

☐ Nursing home

☐ Portable X-ray supplier

☐ Psychiatric residential treatment facility (PRTF)

☐ Residential treatment facility

☐ Rural health clinic (RHC)

☐ Skilled nursing facility or nursing home

☐ Skilled nursing facility providing subacute care services

☐ Other (please indicate)

_____

Health care licensure			Attach a copy of each organizational provider licensure. Do not submit practitioner licensures.		
License number	**State or city**	**Licensing agency**	**Initial issue date**	**Renewal date**	**Expiration date**
			____ /____ /____	____ /____ /____	____ /____ /____
			____ /____ /____	____ /____ /____	____ /____ /____
			____ /____ /____	____ /____ /____	____ /____ /____

Medicare status

1. Is this organizational provider participating in the Medicare program? ☐ Yes ☐ No ☐ Pending
   If yes, provide Medicare ID number:_____

2. Is this organizational provider certified by the Centers for Medicare & Medicaid Services (CMS)? ☐ Yes ☐ No ☐ Pending
   If yes, provide date of initial CMS certification (____ /____ /____) and Medicare certification number:_____
   ☐ Check here if organizational provider is **not eligible** for CMS certification

Accreditation

Select accrediting agency from the list below and attach a copy of current accreditation certificate.
If not accredited, skip checklist and go to the site visit requirements section.

☐ American Association for Accreditation of Ambulatory Plastic Surgery Facilities (AAAAPSF)

☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ Accreditation Association for Ambulatory Health Care (AAAHC)

☐ American Academy of Sleep Medicine (AASM)

☐ Accreditation Commission for Health Care (ACHC)

☐ American College of Radiology (ACR)

☐ American Osteopathic Association (AOA)

☐ Board of Certification (BOC)

☐ Commission on Accreditation of Birth Centers (CABC)

☐ Commission on Accreditation of Rehabilitation Facilities (CARF)

☐ Continuing Care Accreditation Commission (CCAC)

☐ Community Health Accreditation Program (CHAP)

☐ Council on Accreditation (COA)

☐ Det Norske Veritas Healthcare Inc. (DNVHC)

☐ National Integrated Accreditation for Healthcare Organizations (NIAHO)

☐ The Joint Commission, previously known as JCAHO

Date of initial accreditation: ____ /____ /____

Date of last full survey: ____ /____ /____

Site visit requirement

Attach one of the following:

- A copy of most recent on-site survey for each location (with corrective action plan [CAP], if citations were issued).
- Cover letter from government agency stating organizational provider is in substantial compliance.

1. Has organizational provider had a post-licensing on-site visit by a government agency such as the Department of Health (DOH) or CMS within the past 36 months?

   ☐ Yes — Date of most recent standard survey: ____ /____ /____

   ☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A (no recent survey)
   If yes, have all deficiencies been corrected?

   ☐ Yes — **Provide evidence of state acceptance of your CAP**

   ☐ No — **Provide explanation and your plan to correct all deficiencies**

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies.**

Provider credentialing

Does the organizational provider validate, for each licensed provider employed or contracted at the organizational provider, the credentials necessary to perform health care services? ☐ Yes ☐ No

If yes, indicate how the organizational provider conducts the credentialing process for each provider:

☐ Credentialing procedures are performed internally.

☐ Credentialing procedures are outsourced or delegated to: _____

☐ Other, specify: _____

If no, please explain: _____

Insurance	Both organizational provider general and professional liability insurance is required. Minimum coverage requirement is $1 million per occurrence and $2 million aggregate.
General liability coverage	**Attach certificate showing policy number, coverage amounts, and effective and expiration dates.**
Current carrier name:	Policy number:
Street address or P.O. Box	City:
State:	ZIP code:
Effective date: _____ /_____ / _____	Expiration date: _____ /_____ / _____
Per incident: $_____	Aggregate: $_____
Coverage type: ☐ Occurrence based ☐ Claims based	

Professional liability coverage	Attach certificate showing policy number, coverage amounts, and effective and expiration dates.
Current carrier name:	Policy number:
Street address or P.O. Box	City:
State:	ZIP code:
Effective date: _____ /_____ / _____	Expiration date: _____ /_____ / _____
Per incident: $_____	Aggregate: $_____
Coverage type: ☐ Occurrence based ☐ Claims based	

Site visit requirement	Indicate which documents are being included with this completed application.
☐ Copy of all federal, state, and/or local licenses required to operate as a health care organizational provider	
☐ Copy of organizational provider's general liability insurance certificate	
☐ Copy of professional liability insurance certificate covering all organizational provider employees	
☐ Copy of accreditation certificates, if applicable	
☐ Copy of CMS letter certifying or recertifying organizational provider to provide partial hospitalization services, if applicable	
☐ Copy of most recent CMS or DOH survey including your CAP, if deficiencies were cited, or cover letter from CMS or DOH stating organizational provider is in compliance	

Disclosure questions Answer every question yes or no. Provide a detailed explanation on a separate sheet for any questions answered yes.	
1. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been convicted of any health care-related criminal offense, had adjudication withheld on any health care-related criminal offense, pleaded no contest to any health care-related criminal offense, or entered into a pre-trial agreement for any health care-related criminal offense?	☐ Yes ☐ No
2. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	☐ Yes ☐ No
4. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had his or her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a consent order issued by a licensing, certifying, or professional standards board or agency?	☐ Yes ☐ No
5. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been denied enrollment in or suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	☐ Yes ☐ No
6. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any federal executive branch procurement or non-procurement program?	☐ Yes ☐ No
7. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	☐ Yes ☐ No

Disclosure questions (continued) Answer every question yes or no. Provide a detailed explanation on a separate sheet for any questions answered yes.	
8. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fine(s) have been paid in full?	☐ Yes ☐ No
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the organizational provider, under any current or former name or business identity?	☐ Yes ☐ No
10. Does the organizational provider or any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	☐ Yes ☐ No
11. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care item or service?	☐ Yes ☐ No
12. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to the delivery of an item or service under Medicare or a state health care program?	☐ Yes ☐ No
13. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
14. Has any entity, agent, owner, or managing employee of this organizational provider, under any current or former name or business identity, ever been found to have violated federal or state laws, rules, or regulations in any program established under Medicare, any other state's Medicaid program, Title XX, or any other publicly funded federal or state health care or health insurance program?	☐ Yes ☐ No

Attestation

I certify that the information contained in this application is correct and complete to the best of my knowledge. I hereby authorize AmeriHealth Caritas District of Columbia (DC) to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation, or operations to AmeriHealth Caritas DC. I authorize and agree that AmeriHealth Caritas DC and its agents, employees, and representatives may provide AmeriHealth Caritas DC's subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing, or peer review. I release AmeriHealth Caritas DC and its affiliates, agents, employees, and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize AmeriHealth Caritas DC and its applicable subsidiaries and affiliates to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as appropriate.

Authorized signature

Print name

Title

Date

AmeriHealth Caritas
District of Columbia

Attachment A: Additional Location Addendum

Copy page for additional sites.
(Complete section C only if you are an accredited or deemed behavioral health care provider organization. List services by site.

Section A — Demographics (If this is the primary location, please skip to section C.):	
Location name:	
Service site address (no P.O. Box):	
Billing NPI or atypical number:	Medicaid ID number (if applicable)
Remittance address (if different from primary location):	

Office hours (use HH:MM format)									
Day	Start	a.m./p.m.	End	a.m./p.m.	Day	Start	a.m./p.m.	End	a.m./p.m.
Monday					Saturday				
Tuesday					Sunday				
Wednesday					**Services at this location:**				
Thursday					☐ Americans with Disabilities Act (ADA) accessibility requirements			☐ 24/7 phone coverage	
Friday					☐ Handicap accessibility			☐ Answering service	

Section B — Site visit requirement
(Attach a copy of the most recent on-site survey for each location with CAP.)

1. Has organizational provider had a post-licensing on-site visit by a government agency such as DOH or CMS within the past 36 months?

   ☐ Yes — Date of most recent standard survey: ____ /____ /____

   ☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A (no recent survey)
   If yes, have all deficiencies been corrected?

   ☐ Yes — **Provide evidence of state acceptance of your CAP**

   ☐ No — **Provide explanation and your plan to correct all deficiencies**

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies.**

Section C — Services available at this location (check all that apply)

Behavioral health care type and description (Please indicate service type: mental health [MH], substance use [SU], or both.)	
☐ MH ☐ SU ☐ Both	Behavioral health day treatment
☐ MH ☐ SU ☐ Both	Behavioral therapy under EPSDT
☐ MH ☐ SU ☐ Both	Case management
☐ MH ☐ SU ☐ Both	Community-based residential Level A
☐ MH ☐ SU ☐ Both	Community-based residential Level B
☐ MH ☐ SU ☐ Both	Crisis intervention
☐ MH ☐ SU ☐ Both	Crisis residential
☐ MH ☐ SU ☐ Both	Crisis stabilization
☐ MH ☐ SU ☐ Both	Day treatment or partial hospitalization services for adults
☐ MH ☐ SU ☐ Both	DD case management
☐ MH ☐ SU ☐ Both	Electroconvulsive therapy (ECT)
☐ MH ☐ SU ☐ Both	Health skill-building services
☐ Yes ☐ No ☐ Both	In-home behavioral therapies (including but not limited to ABA)
☐ MH ☐ SU ☐ Both	Individual, group, and family therapy
☐ MH ☐ SU ☐ Both	Inpatient psychiatric hospital services — freestanding psychiatric hospital
☐ MH ☐ SU ☐ Both	Integrated health home
☐ MH ☐ SU ☐ Both	Intensive community treatment
☐ MH ☐ SU ☐ Both	Intensive in-home services
☐ MH ☐ SU ☐ Both	Medication management by psychiatrist

Section C — Services available at this location (continued; check all that apply) Behavioral health care type and description (Please indicate service type: mental health [MH], substance use [SU], or both.)	
☐ MH ☐ SU ☐ Both	Multi-systemic therapies
☐ MH ☐ SU ☐ Both	Neuropsychological testing
☐ MH ☐ SU ☐ Both	Opioid treatment
☐ MH ☐ SU ☐ Both	Outpatient psychiatric services
☐ MH ☐ SU ☐ Both	Partial hospitalization
☐ MH ☐ SU ☐ Both	Psychosocial rehabilitation
☐ MH ☐ SU ☐ Both	Peer support
☐ MH ☐ SU ☐ Both	Psychological testing
☐ MH ☐ SU ☐ Both	Telepsychiatry
☐ MH ☐ SU ☐ Both	Therapeutic day treatment for children and adolescents
☐ MH ☐ SU ☐ Both	Treatment foster care case management

Substance use disorder services:

☐ Outpatient substance use disorder services

☐ Residential substance use disorder treatment for pregnant and postpartum women

☐ Substance use disorder day treatment

☐ Substance use disorder day treatment for pregnant and postpartum women

☐ Substance use disorder intensive outpatient treatment

Waiver services (please list waiver type and all services):

Mental health	Substance use disorder
_____	_____
_____	_____
_____	_____
_____	_____

Other services:

Mental health	Substance use disorder
_____	_____
_____	_____
_____	_____
_____	_____

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GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

www.amerihealthcaritasdc.com

AmeriHealth Caritas™
District of Columbia