California Plus Care Network

PROVIDER APPLICATION

INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed to write on, than attach additional sheets and reference the question being answered. Please copy and complete page 4 and a Provider Profile for each additional facility providing services and include the applicable licenses, certification and accreditations.

Current copies of the following documents must be attached with the application:

- State License
- Certification letter from Medicaid
- CMS Site visit HCFA 2567 (if applicable)
- Staff Physician Roster
- Facility Accreditation Certificate (s)
- Liability Coverage Face Sheet

PROVIDER DEMOGRAPHIC INFORMATION:

(If provider has multiple facilities, please complete a Provider Profile for each facility.)

Legal Business Name:_____
DBA Name (if applicable):_____
Federal Tax ID Number:_____National Provider Identifier (NPI):_____
Address:_____
City:_____County_____State_____Zip_____
Telephone number:_____Fax Number:_____
Contact name:_____Fax Number:_____
Contact email:_____Provider email:_____

Mailing address: (if different from above address):
City:_____County: _____State:_____Zip:_____

Services Information

Please check the services which you are licensed to provide:

☐ Ambulance	☐ Diagnostic Imaging	☐ Hospice	☐ Prosthetics/Orthotics
☐ Ambulatory Surgery Center	☐ DME	☐ In-Patient Rehab	☐ Radiology Center
☐ Audiology	☐ Family Planning	☐ Mental Health	☐ Skilled Nursing Facility
☐ Birthing Center	☐ Hemodialysis	☐ Midwife	☐ Therapist (PT/OT/ST)
☐ Chiropractic	☐ Home Health Agency	☐ Pathology	☐ Urgent Care
☐ Clinical Laboratory	☐ Home Infusion Therapy	☐ Pharmacy (drugs)	☐ Other_____

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Billing Information (if applicable):

Billing Co Name:_____ Billing address (if different from above address):_____

City:_____ County:_____ State:_____ Zip:_____

Billing Co phone:_____ Billing Co fax:_____

Billing Contact:_____ Email:_____

Website:_____

Check/EOB address (if applicable):

Check/EOBb address:_____ City:_____

County:_____ State:_____ Zip:_____

Business Structure/Ownership:

Is the provider a unit of a larger entity/agency/corporation/network?: ☐ Yes ☐ No

If yes, name of larger entity/agency/corporation/network:_____

Address:_____ County:_____ Zip:_____

Are any of the provider employees/entities in a position to make professional referrals to the provider?: ☐ Yes ☐ No

If yes, please describe:_____

_____

Licensure:

State License Number:_____ Issue Date:_____ Expiration Date:_____

Medicare Number:_____ ☐ N/A Issue Date:_____ Expiration Date:_____

Medical Number:_____ ☐ N/A Issue Date:_____ Expiration Date:_____

Date of last survey:_____ Medicare Number:_____ Medicaid Number:_____

Accreditation:

Is facility accredited?: ☐ Yes ☐ No

If yes, type of accreditation obtained:

☐ AAASF ☐ AAAHC ☐ AAPSF ☐ AOA ☐ CARF ☐ CCAC ☐ CHAP ☐ CLIA ☐ HFAP ☐ IMQ ☐ JCAHO

☐ Other: _____

Expiration Date:_____

Professional Liability:

Liability Carrier:_____Coverage Limits:_____

Policy Number:_____Expiration Date:_____

If self-insured, please provide self-insurance program documentation.

_____

_____

Professional Liability:

Complete page 4 of the application and Provider Profile for each facility providing services and include copies of the applicable licenses, certification and accreditations.

For each type of medical of technical professional employed by Provider (i.e. physicians, registered nurses, respiratory therapists, prosthetists, pharmacist, audiologists, etc.) please provide the information below regarding employment qualifications:

Professional Type	Registration/Certification Requirements	No. of Employees
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Skilled Nursing Facility:

1. Please indicate the number of licensed beds, staffed beds and occupancy rate during the most recent fiscal year for the following services:

☐ N/A

Specify time: From _____ to _____
Month and Year Month and Year

Service	Licensed Bed Total	Staffed Bed Total	Licensed Bed Occupancy Rate
Skilled Nursing Facility	_____	_____	_____
Rehabilitation	_____	_____	_____
In-Patient Hospice	_____	_____	_____
Total	_____	_____	_____

2. Please indicate overall occupancy rate for the fiscal year indicated above. Occupancy Rate_____%
_____N/A
3. Do you have a Quality Assurance Program? ☐ Yes ☐ No

Sanctions:

Has the facility been sanctioned, placed on probation or lost accreditation, licensure or certification status during the last five (5) years by any of the following accrediting/licensing bodies:

JCAHO/AAAHC/IMQ/CLIA/CARF/AOA/CCAC:	☐ Yes	☐ No	☐ N/A
Medicare:	☐ Yes	☐ No	☐ N/A
Medicaid:	☐ Yes	☐ No	☐ N/A
State License:	☐ Yes	☐ No	☐ N/A
Professional Review Organization (PRO):	☐ Yes	☐ No	☐ N/A
CLIA:	☐ Yes	☐ No	☐ N/A

Other, please specify:_____

_____

_____

If you answered yes to any of the above, please describe the nature of the sanction, reason for sanction and date of the sanction on a separate sheet of paper and attach to application.

Insurance:

Please provide evidence of professional liability and comprehensive general liability insurance or funded self insurance information.

General Liability:	Professional (Malpractice):
$1,000,000 per occurrence	$1,000,000 per occurrence
$3,000,000 in aggregate	$3,000,000 in aggregate

Compliance:

I attest that this facility complies with State, Federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disability Act. ☐ Yes ☐ No

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Attestation Questions:

Please answer the following questions "yes" or "no." If you answer "yes" please provide full details on a separate sheet.

A. Has your malpractice insurance ever been terminated or revoked except with your consent or request?
☐ Yes ☐ No

B. Are you currently under investigation by any government agency?
☐ Yes ☐ No

C. Have you been expelled or suspended from receiving payment under Medicare or Medicaid?
☐ Yes ☐ No

D. Has your accreditation status ever been reduced, terminated, suspended or revoked?
☐ Yes ☐ No

E. Is your malpractice insurance provided through a self-insurance trust or program?
☐ Yes ☐ No

If yes, an officer of the company (i.e. President, Vice-President, Chief Financial Officer or Chief Operating Officer) must sign the following attestation. On behalf of the applicant, I represent and warrant the following with respect to the self-insurance program maintained by the applicant, or which provides professional liability insurance for the applicant:

1. The self insurance program is adequately funded to provide the minimum required limits of liability as required by Plan, and;
2. The self insurance program has an actuarially validated reserve adequate for incurred claims, for incurred but not reported claims, and future claims based on past experience, and;
3. The self insurance program has a designated third party administrator or other appropriately licensed claims professional or attorney serving the program, and;
4. The self insurance program has a designated medical malpractice defense firm, or more than one designated medical malpractice defense firm, and;
5. The self insurance maintains excess insurance/reinsurance above the self funded level, if the self-insured level alone is insufficient to meet Plan's required limits, and;
6. The self insurance program maintains evidence of a surety bond or letter of credit as collateral to the self-insured limit, or a captive, self management of a large retention through a trust, and;
7. The self insurance program maintains a total value of the program that at a minimum meets the required limit of liability as set forth b Plan?
8. I have confirmed the foregoing with my auditor or the actuary for the self insurance fund.

Attest:_____

Name:_____

Title:_____

I hereby affirm that the information submitted in this application is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment or participating practitioner agreement.

A photocopy of this document shall be as effective as the original.

_____ _____

Preparer's Name Title

_____ _____

Signature (not a stamped signature) Date

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Provider Profile

Provider Demographic Information:
(Please attach facility list with address, phone, fax, TIN and Medicare ID)

Legal Business Name:_____

DBA Name (if applicable):_____

Federal Tax ID No:_____ Medicare ID #:_____ Corporation Status:____
(LLC, Inc, Partnership, etc.)

Address:_____ NPI:_____

City:_____ County:_____ State_____ Zip_____

Telephone #:_____ Fax #:_____

Contact name:_____ Fax Number:_____

Contact email:_____ Provider email:_____

Billing Information (if applicable):

Billing Co Name:_____ Billing address (if different from above address):_____

City:_____ County:_____ State:_____ Zip:_____

Billing Co phone:_____ Billing Co fax:_____

Billing Contact:_____ Email:_____

Website:_____

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☐ Audiology	☐ Family Planning	☐ Mental Health	☐ Skilled Nursing Facility
☐ Birthing Center	☐ Hemodialysis	☐ Midwife	☐ Therapist (PT/OT/ST)
☐ Chiropractic	☐ Home Health Agency	☐ Pathology	☐ Urgent Care
☐ Clinical Laboratory	☐ Home Infusion Therapy	☐ Pharmacy (drugs)	☐ Other:_____

Documentation:

Please attach copies of the following for each Provider Facility Profile:

☐ W9 ☐ State License/Business License ☐ Organizational Structure/Contact List
☐ Medicare Certification Letter with effective date of the provider number
☐ JCAHO/AAAHC/AAAASF/AOACHA/AAPSF Accreditation showing the effective date
☐ Other program certification. Proof/Letter of Ownership (physician-owned including name and title of physician)

Current copies of the following documents must be submitted with the application

1. Copy of Current license
   Expiration date: _____
2. Copy of JCAHO, CLIA, AOA, AAAHC, CCAC, CARF or copy of most recent DHS site survey with corrective action plan and acceptance letter
   Expiration date: _____
3. Liability Insurance ($1Million General/$3Million Aggregate required)
4. Medicare Certification
5. Medical Certification
6. Sanctions information (if applicable)
7. W-9
8. Completed application-signed and dated