HOSPITAL-ANCILLARY-CLINIC PROVIDER CREDENTIALING APPLICATION

For this application 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 Meridian provider agreement

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

- ❑ Copy of State Operational License
- ❑ Copy of other applicable State/Federal Licensures (i.e., CLIA, DEA, Pharmacy, or Department of Health)
- ❑ Copy of accreditation/certification (by a governmental accrediting body, i.e., CMS, JCAHO)
- ❑ Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- ❑ Copy of Medicaid Certification (if not certified, provide proof of participation)
- ❑ Copy of Site Evaluation Results by a governmental agency (If not accredited by a governmental agency)
- ❑ Copy of W-9
- ❑ Copy of 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 add NPI number for each:	
☐ 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:	☐ Local Education Agency (LEA); NPI:
☐ Assisted Long-Term Care Facility; NPI:	☐ Other; NPI:

OWNERSHIP/MANAGEMENT

President/CEO Name:	Phone:
Vice President Name:	Phone:
CFO Name:	Phone:
Medical Director:	Phone:
Medical Director License #:	Medical Director DEA #:

meridian

LEGAL INFORMATION

Entity Legal Name:		Fed. Tax ID Numbers:	Medicaid Numbers:
State License No.		National Provider ID# (NPI):	

FACILITY INFORMATION

Group or d/b/a Name		Group Fed. Tax ID No.
Location Telephone	Title/Name of Group Signatory:	Location Fax
Physical Address	City/State/Zip	County

BILLING ADDRESS

Pay to:		
Pay to address:	City/State/Zip	Phone:
Contact person:	Fax:	E-mail:

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 providers 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

__13-17 years __13-20 years __21+ years __3+ years __17+ years

AFFILIATIONS

Is your facility affiliated with any other health care organization(s) through corporate linkage or other formal arrangement? If so, please provide the following information (*List additional affiliations on a separate page).*	
Facility Name:	TIN:
Address:	
Services Provided (IP/OP):	

DIAGNOSTIC IMAGING

If the answer is "No" to any of the following questions, please provide details on separate sheet.	
1. Diagnostic Imaging procedures that require the injection or ingestion of radiopaque chemicals are performedonly under the direction or supervision of providers qualified to perform those procedures?	__Yes __No __N/A
2. Diagnostic Imaging machines are registered and inspected according to state law?	__Yes __No __N/A
3. Technicians, providers, and other personnel who work with imaging machines comply with state lawregarding monitoring?	__Yes __No __N/A
4. Screening and Diagnostic Mammography services are provided?	__Yes __No __N/A

LABORATORY

If the answer is "Yes" to the following question, please provide a copy of the CLIA Certificate. If the answer is "NO" to the following question, please provide details on a separate sheet.	
1. Does the laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)?	__Yes __No __N/A

PHARMACY

If the answer is "Yes" to the following questions, please provide a copy of any DEA Registration Certificates, State DEA/CSR Certificates, and Pharmacy Licenses. If registration/licenses are not available, please provide details on a separate sheet.	
1. Does this Facility dispense medication?	__Yes __No __N/A
2. Can a patient fill a prescription at this Facility?	__Yes __No __N/A

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		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
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/AccreditationHealthCare Commission, Inc	URAC		
Others (please list)			

HEALTHCARE PROGRAMS

Agency Name	Acronym	Applied Date	Expiration Date
Child and Adolescent Health Center and Programs	CAHCP		
Community-Based Adult Services	CBAS		
Comprehensive Perinatal Services Program	CPSP		
Genetically Handicapped Person Program	GHPP		
Laboratory Services State Serum Alpha-fetoprotein Testing Program	AFP		
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 five 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 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 Meridian provider, I am solely responsible for ensuring that any licensed providers 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 Meridian. Credentials Committee for their review and approval, and, absent such affirmative approval, Meridian 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 Meridian. Further, from time to time, such licensed providers may change, as my practice associates. In all such cases, I accept responsibility for notifying Meridian 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 Meridian credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to Meridian, I hereby fully understand that the information submitted in this application shall be held confidentialby Meridian and provided only to individuals connected with Meridian on a need-to-know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of Meridian.
- ✓ Authorize Meridian 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 othersand 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 Meridian’s accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by Meridian 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 Meridian for their acts performed and statements made, in good faith and withoutmalice, 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 credentialingstatus 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 Meridian, the Facility hereby gives permission to Meridian 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 Meridian 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 Meridian.

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 Meridian 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 Meridian 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 photocopy of this originalconstitutes our written authorization and requests to release any and all documentation relevant to this application. Said photocopy 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)

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 executing a provider agreement or submitting a provider application to disclose to managed care organizations that contract with the state Medicaid agency: 1) the identity of all persons with an ownership or control interest (e.g., has an ownership interest of 5% or more in a disclosing entity, is an officer or director of a disclosing entity organized as a corporation or a partner of a disclosing entity organized as a partnership, owns an interest of 5% or more in any mortgage, deed of trust, note or other obligation secured by the disclosing entity under certain circumstances, etc.), 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 Statement, an updated Statement should be completed and submitted to Meridian within 30 days of the change. Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network.

Practice Information

Check one that describes you: __Individual Provider __Group Practice __Disclosing Entity	
Name of Individual Provider, Group Practice, or Disclosing Entity:	
DBA Name:	
Address:	
TIN or SSN:	NPI:

Section I: Provider Ownership and Control Interest

For individuals with an ownership or control interest in the provider (e.g., an ownership interest of 5% or greater, an officer or director of a Disclosing Entity that is a corporation, etc. –refer to the definition of "person with ownership or control interest" in the instructions, list the name, address, date of birth (DOB), and Social Security Number (SSN) for each such individual.

For entities with an ownership or control interest in the provider, list the name, Tax Identification Number (TIN), and each address of each entity. (42 CFR 455.104) Attach a separate sheet if necessary.

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

Section II: Subcontractor Ownership and Control Interest

Are there any subcontractors in which the provider has an ownership or control interest of 5% or more? __Yes __No

If yes, list the name, address, DOB and SSN for each individual having an ownership or control interest in such subcontractor(s), and list the name, TIN, and each address for each entity having an ownership or control interest in such subcontractor. (42 CFR 455.104) Attach a separate sheet if necessary.

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

Section III: Relationships:

Are any of the individuals listed in Section I or Section II above related to each other? __Yes __No

If yes, list the individuals who are related to each other, and the type of relationship (spouse, sibling, parent, child). (42 CFR 455.104) Attach a separate sheet if necessary.

Names	Type of Relationship

Section IV: Convictions

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 or Title XX program? __Yes __No (verify through OIG Website)

If yes, please list those persons below. (42 CFR 455.106) Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN

Section V: Business Transitions

Has the provider had any financial transactions with any subcontractors totaling more than $25,000 during the previous 12 months? __Yes __No

Has the provider had any significant business transactions between it and any wholly owned supplier or any subcontractor during the previous five years? __Yes __No

If yes, list the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the previous 12-month period, and any significant business transaction between the provider and any wholly owned supplier or between the provider and any subcontract during the past five-year period (42 CFR 455.105). Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI: Managing Employees

Does the provider have any managing employees? __Yes __No

If yes, list each member of the Board of Directors or Governing Board and each managing employee with their name, DOB, address, SSN, and percent of interest (42 CFR 455.104). Attach a separate sheet if necessary.

Name/Title	DOB	Address	SSN	Interest Amount (%)

Disclosure of Ownership and Control Interest Statement

If “Group Practice” or “Disclosing Entity” is checked in the Practice Information section above, the undersigned hereby representsthat he, she or it is providing the information in this Statement on behalf of the Group Practice or Disclosing Entity, as appropriate,and on behalf of each provider listed on Exhibit A attached to this Statement, and the undersigned represents thathe, she or it is legally authorized, as an agent or attorney-in-fact, to provide such information and execute this Statement on behalf of the Group Practice or Disclosing Entity and each listed provider.

The undersigned certifies that the information provided herein, is true, accurate and complete. Additions or revisions to the information above will be submitted immediately after such change. Additionally, the undersigned understands that misleading,inaccurate, or incomplete data may result in a denial of participation for the affected providers.

Name of Provider:_____ **Date:** _____

Please print

_____ _____

Signature of Provider **Title**

Please return by email to **miprovidernetwork.com**.