CarePartners of Connecticut

ANCILLARY PROVIDER APPLICATION

Please email to AncillaryNetworkContracting@point32health.org or fax to **617.673.0909**.

TYPE OF PROVIDER

- ☐ Ambulance Service
- ☐ Ambulatory Surgical Center
- ☐ ART
- ☐ Birthing Center
- ☐ Boys & Girls Clubs
- ☐ Cardiac Monitoring
- ☐ Cardiac Rehab
- ☐ Dialysis
- ☐ Disease Management
- ☐ DME
  - ☐ Manufacturer of Medical Products
  - ☐ Medical Supplies
  - ☐ Orthotic & Prosthetic
  - ☐ Respiratory Equipment & Supplies
- ☐ Family Planning
- ☐ Fitness
- ☐ Home Health
- ☐ Hospice
- ☐ Inpatient Rehab
- ☐ Laboratory
- ☐ Long Term Acute Care (LTAC)
- ☐ Skilled Nursing Facility
  - ☐ Transitional Care Unit
- ☐ Sleep Testing
- ☐ Other: _____

GENERAL INFORMATION

Contract/Legal Entity Name _____

DBA/Facility Name (if applicable) _____

NPI _____ Is the group Medicare participating? YES ☐ NO ☐

If yes, please enclose proof of Medicare participation (e.g., Medicare award letter)

Primary Practice Address

Street _____ Phone _____

City, State ZIP _____ Fax _____

Email _____

Service Hours: Mon_____Tue_____Wed_____Thu_____Fri_____Sat_____Sun_____

_____ Handicap Access? Yes ☐ No ☐ Are translation services available? Yes ☐ No ☐

Languages other than English at this location

For additional addresses check here ☐ and attach a separate sheet. ***General liability insurance must be attached for all practice locations.***
Corporate affiliated providers with different names and locations need to complete separate applications.

Mailing Address Mailing Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Corporate Affiliation (if different) _____

Street _____ City, State ZIP _____

Managed by _____

Please explain in detail any name changes that have occurred in the past 3 years and attach appropriate documentation:

_____

PRACTICE INFORMATION

President/CEO _____

Email _____

Office Mgr/Contact Person _____ Phone _____ Fax _____

Email _____

PAYMENT INFORMATION

Payee NPI _____ Tax ID# _____-_____

To whom should checks be made payable? _____

Payment Address Payment Address Phone _____ Fax _____

Street _____ City, State ZIP _____

Internal Use:

PROV ID _____

PCAT 01 03 05 07, TOP 26 27 28 31 32 33 44 46 54 56 62 63 91 SPEC 9900

(#5102410) PI Initials _____ Date_____ PO Initials _____ Date _____ REST EX 77

CarePartners of Connecticut

ANCILLARY PROVIDER APPLICATION

CERTIFICATION, AUTHORIZATION AND RELEASE

Contract/Legal Entity Name _____

DBA/Practice Name (if applicable) _____

In submitting this application for credentialing (or recredentialing) by CarePartners of Connecticut, Inc. or any Care Partners of Connecticut affiliate (as defined in your written agreement to provide services to CarePartners of Connecticut members) (collectively "Plan") I understand that it is the Provider's responsibility to produce the required information for the proper evaluation of its application and that failure to produce this information will prevent its application from being reviewed and acted upon. The undersigned hereby acknowledges that he or she is authorized and empowered to complete this application and enter into contracts on behalf of the Provider. By submission of this application for membership in the Plan Provider Network, the undersigned hereby:

1. Certifies under pains and penalties of perjury that the information contained herein, including all supporting materials, is true and complete to the best of his/her knowledge and belief. The Provider understands that its application will be reviewed based upon the information it has provided and other information obtained by Plan in accordance with its credentialing program. The Provider further understands that information which is found to be false could result in a denial or termination of Provider's network privileges.
2. Acknowledges and agrees that Plan or its agents may solicit information from past and former associates, health care organizations and any other relevant sources and review documents which Plan, in its discretion, deems relevant in assessing Provider's qualification for membership in the Plan provider network.
3. Authorizes the release of all such relevant information by any individual or organization and release from liability Plan and any such individuals or organizations which in good faith and without malice provide information bearing on the Provider's qualifications for the Plan provider network and/or credentialing status.
4. Authorizes the licensing agencies in any state in which the Provider is or has been licensed, to release information to Plan regarding any licensure information, any pending or final disciplinary action, and any other information relevant to the Provider's professional competence or status.
5. Agrees that all employed and/or contracted clinical staff and associates have been appropriately credentialed consistently with all applicable laws, requirements and standards.
6. Authorizes and requests Provider's professional liability insurance carrier to release information regarding any claim or action for damages pending or closed during the previous ten years, whether or not there has been a final disposition.
7. Agrees to notify Plan as soon as Provider becomes aware of any event which might reasonably affect Provider's Plan credentialing status, including the initiation of any disciplinary action by any certification or accreditation entity, any health care facility or regulatory agency.
8. Understands that it may not provide healthcare services to Plan members until it is credentialed and contracted by Plan.
9. Authorizes and releases from liability Plan for the good faith disclosure of credentialing information by Plan to the extent required by law, regulations, court order or other standards or requirements applicable to Plan.

_____ _____

Authorized Representative's Signature Date

_____

Authorized Representative's Name (Please Print)

_____

Authorized Representative's Title

REQUIRED ATTACHMENTS

- ☐ Documentation of current professional liability insurance ($1 million per incident/$3 million aggregate) ***(required)***
- ☐ Documentation of current general liability "premises" insurance ($1 million per incident/$1 million aggregate). Must show addresses for any/all practice sites. This coverage should include, but not be limited to, claims for bodily injury, property damage and legal liability on the insured's premises. ***(required)***
- ☐ W-9 for payments (payee name, tax ID# and address should match above) ***(required)***
- ☐ Proof of Medicare participation ***(if applicable)*** Medicare #: _____ OR ☐ Not a Medicare provider
- ☐ Copy of state license ***(if applicable)*** License #: _____ OR ☐ State license not required for this provider type
- ☐ Copy of accreditation. Accrediting organization: ☐ Joint Commission (JAHCO) ☐ Other: _____ ☐ None ☐ Not applicable
- ☐ Copy of two most recent Department of Public Health surveys – one must have been conducted in the past 36 months ***(if applicable)***
- ☐ Articles of Organization and Organization Chart
- ☐ Other requirements specific to your provider type as indicated in separate checklist (may include additional insurance requirements)