MHS Health Wisconsin Facility/Agency Credentialing Application

INSTRUCTIONS

Please complete the application thoroughly in its entirety. The checklist below may not be exhaustive of all materials, but is provided as a guide for the documents required to complete the credentialing process.

Please enclose the following with your completed Facility & Ancillary Provider Application:

- ☐ Staff Roster for all behavioral health treatment staff. Must be submitted in excel format on the template provided on the "Join Our Network" page at www.mhswi.com
- ☐ Copy of the completed Disclosure of Ownership Form – Found on the "Join Our Network" page at www.mhswi.com
- ☐ W9 Form
- ☐ A copy of your JCAHO/CARF/COA/or AOA accreditation letter with dates of accreditation
- ☐ A copy of the state or local license(s) and/or certificate(s) under which your facility operates. Include all documentation for multiple facility locations
- ☐ Medicaid enrollment/certification letter with Medicaid Number
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- ☐ A copy of your CLIA license (If applicable)
- ☐ A copy of your Pharmacy license (If applicable)
- ☐ A copy of your professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year)
- ☐ A copy of your NDMS agreement (If applicable)
- ☐ A copy of your state or local fire/health certificate (Non-accredited facilities only)
- ☐ A copy of your Quality Assurance Plan (Non accredited facilities only)
- ☐ A copy of your Credentialing Procedures (Accredited and Non accredited facilities)
- ☐ Description of Aftercare or Follow up Program (Non-accredited facilities only)
- ☐ Organizational Charts including staff to Patient Ratios (Non accredited facilities only)

***Please Note: A separate Facility & Ancillary Credentialing Application must be completed for each facility with a unique Federal Tax ID.**

Facility and Ancillary Credentialing Application

☐ Initial Credentialing

☐ Recredentialing

☐ Addition of a new site/service to a current contract

Legal Name: _____

Parent Company Health System Name (If applicable): _____

_____

d/b/a: _____

Facility Type

☐ Hospital
☐ Intensive Family Intervention
☐ Adult Living Facility
☐ Home Health Agency
☐ Federally Qualified Health Center/RHC
☐ Other: _____

☐ Community Mental Health Center
☐ Rehabilitation Center
☐ Rehabilitative Behavioral Health Services (RBHS)
☐ Assisted Long-Term Care Facility
☐ Outpatient Clinic
☐ Substance use Treatment Facility

Identify Levels of Care Offered by Facility

(If you are already contracted with Cenpatico, select only the level of care being added)

Psychiatric/Mental Health					Substance Abuse, Chemical Dependency				
	Child	Adol	Adult	Geriatric		Child	Adol	Adult	Geriatric
Inpatient	☐	☐	☐	☐	Inpatient Detox	☐	☐	☐	☐
Partial	☐	☐	☐	☐	IP Rehab	☐	☐	☐	☐
IOP	☐	☐	☐	☐	Partial	☐	☐	☐	☐
Observation	☐	☐	☐	☐	IOP	☐	☐	☐	☐
Residential	☐	☐	☐	☐	Residential	☐	☐	☐	☐
ECT	☐	☐	☐	☐	Ambulatory Detox	☐	☐	☐	☐
Other (i.e. SIPP, PRTF)	☐	☐	☐	☐	Medication Assisted Treatment	☐	Methadone	☐	Suboxone
					Other:_____	☐	☐	☐	☐

If Detoxification is offered at facility, on which unit are services offered:

☐ Located on Medical Floor/Unit ☐ Located on Behavioral Health Floor/Unit

Facility Practice Locations

Facility Locations	Age Category	Mental Health						Substance Abuse						
		Inpatient	Partial	IOP	Residential	Observation	Other:____	I/P Detox	I/P Rehab	Partial	IOP	Residential	Ambulatory Detox	Other:____
Location #1 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
F:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NPI:		ECT	☐ I/P		☐ O/P			☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds: (MH) _____ Medicare _____ (SA) _____													
	Gender treated at this location: ☐ M ☐ F							☐ ACT			☐ IHBT Services			
Location #2 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
F:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NPI:		ECT	☐ I/P		☐ O/P			☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds: (MH) _____ Medicare _____ (SA) _____													
	Gender treated at this location: ☐ M ☐ F							☐ ACT			☐ IHBT Services			
Location #3 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
F:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NPI:		ECT	☐ I/P		☐ O/P			☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds: (MH) _____ Medicare _____ (SA) _____													
	Gender treated at this location: ☐ M ☐ F							☐ ACT			☐ IHBT Services			
Location #4 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
F:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NPI:		ECT	☐ I/P		☐ O/P			☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds: (MH) _____ Medicare _____ (SA) _____													
	Gender treated at this location: ☐ M ☐ F							☐ ACT			☐ IHBT Services			
Location #5 Name:														
Addr:	Child	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
	Adol	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
P:	Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
F:	Geri	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
NPI:		ECT	☐ I/P		☐ O/P			☐ Methadone			☐ Suboxone			
Taxonomy:	# of I/P Beds: (MH) _____ Medicare _____ (SA) _____													
	Gender treated at this location: ☐ M ☐ F							☐ ACT			☐ IHBT Services			

*If additional locations are needed, please make a copy of this page

Facility Information

Administrative/Mailing Address: _____

City, State, Zip: _____ County: _____

Administrative phone: _____ Fax: _____ Email: _____

Billing Address: _____

City, State, Zip: _____

Federal Tax ID #: _____

Medicare Provider #: _____ Issue Date: _____ Expiration Date: _____

Medicaid Provider #: _____ Issue Date: _____ Expiration Date: _____

Are all of your HIPAA transactions conducted from a centralized location? Yes ☐ No ☐

(If "no", please ensure you indicate a separate NPI number per location on page 3 above)

Contact Information

	Name	Phone	Email Address
Managed Care Contact			
Credentialing Contact			
Billing Contact			
Clinical Director			

Accreditation Information

Is this facility accredited? Yes ☐ No ☐

Agency Name	Acronym	Issue Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Osteopathic Hospital Association	AOHA		
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 Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc.	URAC		
State Facility Operating License	N/A		
Others (please list):			

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.

Accreditation Information

	Issuing Entity	Type of Lic or Certificate	License Number	Expiration Date
1.				
2.				
3.				
4.				

Does the organizational provider state licensure/certification include a site visit by the state? ☐ Yes ☐ No
If "yes", please attach a copy of the audit, the site visit letter including the date of site visit, and any corrective action plan issued.

Insurance Coverage – *(Attach copy of declaration pages)*

Current Professional Carrier: _____

Amount per Occurrence: _____ Amount per Aggregate: _____

Dates of Coverage: From: _____ To: _____

Current Worker's Compensation Carrier: _____

Dates of Coverage: From: _____ To: _____

If you are self-insured, we require the portion of the facility's independently audited financial statement which shows retention of the required amounts.

Accessibility Information

Language(s) spoken at this facility:

☐ English
☐ Spanish
☐ Haitian Creole
☐ Laotian / Hmong
☐ Polish
☐ Vietnamese
☐ Cambodian
☐ Russian
☐ French
☐ Other _____

Hours of Operation: ☐ 24-hours, or

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____

Is the facility open at least five (5) days per week? ☐ Yes ☐ No
Wheelchair Accessible? ☐ Yes ☐ No

Sanctions

If any question below is responded to with a "yes", please provide an explanation on a separate sheet, and attach to this Application.

1. Have there been or are there currently pending any malpractice claims, suits, settlements or proceedings involving the facility? Yes ☐ No ☐
2. Has the facility 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 ☐
3. Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct? Yes ☐ No ☐
4. Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer, or a Regulatory Agency (CLIA, OSHA, etc.) Yes ☐ No ☐
5. Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason? Yes ☐ No ☐

Has any employee of the entity who has or will have direct care access to consumers/members ever been convicted of, pled guilty to, or pled no contest to any felony including an act of violence, child abuse or a sexual offense? Yes ☐ No ☐

6. Has the corporation, an officer or a board member ever been convicted of a felony?
   Yes ☐ No ☐

Facility Responsibility Form

I hereby understand that as a prospective/current **MHS Health Wisconsin** 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, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying MHS Health Wisconsin 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 MHS Health Wisconsin credentialing/recredentialing requirements for all such individuals associated with my practice.

By applying for participation with MHS Health Wisconsin, I hereby fully understand that the information submitted in this application shall be held confidential by the MHS Health Wisconsin 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 MHS Health Wisconsin.
- Authorize MHS Health Wisconsin 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, or other State or Federal regulatory agencies.
- Consent to an inspection by MHS Health Wisconsin 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 MHS Health Wisconsin 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.

In order to evaluate this application for participation in and/or continued participation with MHS Health Wisconsin, the Facility hereby grants permission to MHS Health Wisconsin 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 MHS Health Wisconsin 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 MHS Health Wisconsin.

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 is selected or retained, after such selection or retention, the Facility agrees to inform MHS Health Wisconsin in writing within 10 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 MHS Health Wisconsin on its own behalf and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any MHS Health Wisconsin programs or any program until such time as this Facility receives notice of participation.

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. A photo copy shall have the same force and effect as the signed original.

Signature of Facility CEO (or authorized designee): **Title:**

Name (Print): **Date:**