Health-Related Social Needs Service Provider Credentialing Application

Before completing this application, please read and observe the following:

This form should be **typed or legibly written in black or blue ink**. If more space is needed, attach additional sheets and reference the question being answered. If applicable, please use a separate application for each location.

- Modification to the wording or format of the Health-Related Social Needs Service Provider Credentialing Application will invalidate the application.
- Complete the application in its entirety. Please sign and date pages 4 and 6. Submit this application via email attachment, USPS (mail), or fax:

Email
Credentialing@PacificSource.com

Fax
541-225-3644

Mail
PacificSource Health Plans
Credentialing Dept.
PO Box 7068
Springfield, OR 97475-0068

Important: Current copies of all applicable documentation requested in the list of attachments below must accompany this application. Applications that are incomplete or fail to include the required documentation will not be processed.

PLEASE USE A SEPARATE APPLICATION FOR EACH LOCATION

Attachments

The following documents should, if applicable, be submitted with this completed enrollment application. Please indicate which documents are being included with this application.

Copy(s) of all federal, state, and/or local professional licenses, certifications, and/or registrations specifically required to operate as a healthcare facility, if applicable.

Copy of business license, if applicable.

IRS documents confirming the tax identification number and legal business name.

Copy of all face sheets showing current liability insurance coverage amounts and expiration dates.

I. Provider identification

A. Corporate identification information

All payments will be issued in the provider's legal business name in compliance with IRS regulations.

Legal business name as reported to the IRS (claims will be paid to this name):

____

Doing business as (DBA) name (if applicable) ______________________

County where DBA name registered (if applicable) ______________________

Billing address ______________________

Tax identification number ______________________

B. Current practice location

Practice location name ______________________

Practice location address line 1 ______________________

Practice location address line 2 ______________________

City ______________ State ______ Zip code ________ County ____________

Phone ____________ Fax ____________ Email ____________

Administrator (full name) ______________________

NPI ____________ Medicare no. ____________ Medicaid no. ____________

Please check this box if you are **not** currently enrolled with Oregon Medicaid as an HRSN service provider and you need assistance with enrollment.

Please note: The Oregon Health Authority (OHA) now requires that an Oregon Organization Medicaid ID Agreement form be completed and submitted with each enrollment request. You may download this form or find it on our website at PacificSource.com/resources/documents-and-forms. Please include the Oregon Organization Medicaid ID Agreement form with this HRSN Service Provider Application if requesting assistance with enrollment.

If you already have an Oregon Medicaid enrollment for other non-HRSN services but haven't enrolled for the specialty code corresponding to the type of HRSN services you are providing, you will need to enroll for another Medicaid ID, or multiple Medicaid IDs corresponding to whichever HRSN services you'll be offering.

This CCO Medicaid ID registration process does not allow Fee for Service Open Card billing. If you are going to bill for Fee for Service Open Card members, you'll need to contact the OHA directly to enroll for a Medicaid ID for HRSN services. For questions regarding Medicaid enrollment, please email 3108ORMedicaidProviderEnrollment@PacificSource.com.

C. Mailing and credentialing correspondence address

This must be an address where the provider can be contacted directly.

Check here if all correspondence can be directed to the practice location in Section B.

Practice location address line 1 ______________________

Practice location address line 2 ______________________

City ______________ State ______ Zip code ________ County ____________

D. Type of Health-Related Social Needs (HRSN) service provider (check all that apply)

- Climate
- Housing
- Nutrition
- Outreach and engagement

II. Healthcare licensure, registration, certificates, and ID numbers

	License no.	Issue date	Expiration date	Licensing agency
State of Oregon				
State of Washington				
Other				

DEA no. (if applicable) ____________________ Expiration date ____________

CLIA no. (if applicable) ____________________ Expiration date ____________

If the organizational provider does not have an Oregon Medicaid ID number, please submit an explanation.

____

III. Liability insurance

This section is to be completed with information about the provider's professional liability and/or medical malpractice insurance including, but not limited to, General Liability, Excess Liability, Umbrella and/or Reinsurance policies. If there is more than one carrier, copy and complete this section for each.

A copy of all face sheets showing current coverage amounts and expiration dates must be attached.

Current coverage

Current carrier name ____________________ Policy no. ____________

Carrier address ______________________________

Practice location address ______________________________

City ____________ State ____________ Zip code ____________

Coverage type Occurrence based Claims based

Effective date ____________ Expiration date ____________

Aggregate amount ____________ Per incident amount ____________

IV. Ownership and management

Please list the names of any person who has more than a 5% stake in ownership of your facility/group, and the names of any individuals who are involved in managing the operations of the facility/group.

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V. Attestation questions

Please answer the following questions **"YES"** or **"NO."** All "yes" responses require an explanation provided on a separate sheet (as appended information). Please sign and date each additional sheet. **Modification to the wording or format will invalidate the application.**

Question		
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state healthcare program, or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service?	Yes	No
Has this 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 healthcare item or service?	Yes	No
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?	Yes	No
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to: (a) the delivery of an item or service under Medicare or a state healthcare program, or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service?	Yes	No
Has this provider, under any current or former name or business identity, ever had licensure to provide healthcare by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.	Yes	No
Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a federal or state healthcare program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?	Yes	No
Is this provider, under any current or former name or business identity, currently suspended from Medicaid or Medicare payment?	Yes	No

Printed name of authorized representative ____________________

Signature of authorized representative ____________________

Authorized representative's title ____________________ Date __________

Authorization and Release of Information Form

By submitting this application, it is agreed and understood that:

1. As a representative of the healthcare provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history, and sanctions indicated in this application is upon the contracted provider or its representative.

2. I further understand and acknowledge that The Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the NPDB reporting and information as required by law as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated, and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with The Healthcare Organization(s) or designated agent.

4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of The Healthcare Organization(s) or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to The Healthcare Organization(s) cycle of recredentialing, provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with The Healthcare Organization(s).

6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of The Healthcare Organization(s) or its respective agent(s) before initiating judicial action.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with The Healthcare Organization.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as The Healthcare Organization(s) Participating Provider or cause for summary dismissal from The Healthcare Organization(s), or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with The Healthcare Organization(s) and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by The Healthcare Organization(s).

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

This provider complies with all federal, state, and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).

Signature ______________________________ Date ______________

Title ______________________________

Printed name ______________________________

As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history, and sanctions for the above provider(s)/supplier(s):

Facility name ______________________ City ______________ State ________