Request to Add New Provider
Instructions

Please follow the steps below to ensure that your request is processed without delay. Additionally, please also ensure the provider's CAQH application is accurate and up-to-date. ***NOTE:*** *If there are discrepancies between this enrollment form and CAQH, the data on this enrollment form will be used. This will include differences in address details: suite number, phone number, fax number, handicap accessibility, TDD hearing, bus route, American Sign Language, and office hours.*

STEP 1 (Pages 2-4)	Application Submission	Choose either option: 1. Submit a letter or file containing all requested information on pages 2-4 of this packet. Email to enrollment@centercare.com or fax to (270) 796-3586. 2. Complete the forms on pages 2-4 in their entirety and email to enrollment@centercare.com or fax to (270) 796-3586. **Important: Failure to supply the requested information in the following pages of the Enrollment Packet will result in a processing delay.**
STEP 2 (Page 5)	Center Care Credentialing Requirements	Should the provider require credentialing for participation, please refer to page 5 for a list of required supporting documentation. Depending on the provider type, this list outlines the various documents that will be required to complete the provider's application for participation so that credentialing may be initiated. Failure to submit the required items may result in the provider's application being deemed incomplete, requiring resubmission of the provider's application. This may also result in a delay of the provider's effective date for participation.
Step 3 (Pages 6)	Behavioral Health Clinical Specialties	For Behavioral Health providers, please provide Sub Specialties from the list provided on page 6. List these Sub Specialties in the Notes Section at the bottom of the Enrollment Form on page 2.
STEP 4 (Page 7)	Kentucky Medicaid Provider ID Number	To participate in Kentucky Medicaid, an active/valid Kentucky Medicaid Provider ID Number is required. To apply for a Kentucky Medicaid Provider ID Number, see instructions on page 7.
STEP 5 (Page 8)	Sample Claim Form(s)	A sample claim form is required to ensure accurate loading of the provider. See page 8 for instructions.
STEP 6 (Page 9)	Completed W-9 Form	A W-9 form is required to prevent delays in reimbursement. See page 9 for instructions

Should you have any questions, please call us at (270) 745-1517 or (800) 972-7038.

Request to Add New Provider

Instructions

Complete this form in its entirety and submit to the contact email or fax listed in step 1 on page 1. Provider will be enrolled in commercial, Medicare, and Medicaid lines of business, as reflected in the group's contract. If participating in Medicare or Medicaid, please make sure to indicate panel status and member capacity for each address in the spaces provided below. An "open panel" will indicate a PCP provider's willingness to accept member assignment from Medicaid and Medicare managed care organizations. Panels are only applicable to PCPs.

Will the provider be seeking enrollment with Aetna Better Health of KY?	☐ Yes ☐ No	If Yes, Center Care provides credentialing services for Aetna Better Health of Kentucky and will notify Aetna upon completion of credentialing.
Practice website*:		☐ No website
Practice email*:		☐ No email

*website and email may be published in payer directory

I. Provider Info

Provider's Full Name (Last, First, Middle)	**Degree**	**Start Date**

Individual NPI #	**Social Security Number**	**Date of Birth**	**Medicare Number**	**Medicaid Number**	**CAQH ID #**
			☐ pending	☐ pending	

Primary Specialty	**Secondary Specialty**	**Languages Spoken** ☐ English Only

Primary Taxonomy	**Secondary Taxonomy**	**Group Taxonomy**

Name of Supervising Physician (NP, PA)	**Supervising Physician's Specialty**

Primary Hospital Affiliation (MD, DO, DPM, DMD, NP, PA) ☐ No hospital privileges	**City, State**	**Affiliation Start Date**

or Covering Arrangements (admitting physician or hospitalist group)	**Hospital Name** (used by admitting physician)

II. Contact Info

Credentialing Contact Name	**Phone #**	**Fax #**	**E-mail**

Credentialing Correspondence Address 1	**Address 2**	**City**	**State**	**Zip**

Practice Contact Name	**Phone #**	**Fax #**	**E-mail**
☐ Same as above			

Practice Correspondence Address 1	**Address 2**	**City**	**State**	**Zip**
☐ Same as above				

Notes: Please include any additional notes to assist us in processing this request

III. Primary Address Information. Primary address will be listed in directory as long as provider is at location 16 hours or more (unless opted out of directory below). Covering sites will not be listed in directory. If provider practices at more than one location, please complete section IV. Additional Locations.

Address Type	Tax ID#	Group Name (include DBA)
☐ Primary Office ☐ Covering Only		

Scope of Practice for this site			Address 1	Address 2 (suite)
☐ Primary Care ☐ RHC ☐ Specialty Care	☐ Urgent Care ☐ Walk-in Care	☐ Inpatient Care ☐ Emergency Care		

If specialty care, please designate practice specialty	City, State, Zip	☐ Dir Opt-**OUT** for this location

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)			Is address handicap accessible?		
Is provider at this site at least 16 hours per week?			Is address TDD hearing equipped?		
Can patients call this site to make appointment with provider?			Is address accessible by bus route?		
Is provider accepting new patients at this site?			Does practice provide American Sign Language services at this site?		
Is provider a PCP at this site?			Does provider provide telemedicine services at this site?		
Does provider provide EPSDT services at this site?			Does provider bill for DME services? (Provide sample claim)		
If PCP, is provider's panel open at this site for Medicaid?			Does this site participate in KHIE?		
If PCP, is provider's panel open at this site for Medicare?			Is provider a locum tenens provider?		
What is the maximum panel capacity for Medicaid at this site?			Has provider completed cultural competence training?		
What is the maximum panel capacity for Medicare at this site?			Is provider certified in trauma-informed care (TIC)?		
What are the age limitations for patients seen by provider?			Has provider been trained in evidence-based practice?		
Is there a gender restriction at this site? (If yes, please specify)					

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Pay To Name (i.e., billing name)	Phone #	Fax #

Pay To Address	City	State	Zip

Correspondence Address ☐ Same as Section II Correspondence	City	State	Zip

Notes

IV. Additional Locations

Please list alternate and/or covering-only locations below. Primary address should be listed on the prior page of this packet. If more than two addresses are required, AND the Pay To address is the SAME as that of the primary, please see the Appendix on page 10 to report the additional addresses. Alternatively, additional copies of this page can be made for each additional location.

Alternate Office Sites – Secondary sites where patients can call to make appointment to be seen by physician. If patients cannot make appointments with provider at this location, please designate location as "Covering only."
Covering-only Sites – Other sites that are to be loaded only for the times when provider covers for another provider or sites where provider does not accept appointments regularly. Patients cannot schedule appointment with provider at covering locations.
"Pay To" Name – This should match exactly how the claims are submitted from your billing system to insurance carriers, including abbreviations.

Additional Address. Alternate sites will only be listed in directory if provider is at location 16 hours or more, (unless opted IN to directory to override). If opting IN to directory, provider MUST accept appointments at that location. Covering sites will not be listed in directory. Please see page 10, if more sites are required to be loaded.

Address Type	Tax ID#	Group Name (include DBA)	
☐ Alternate Office ☐ Covering Only			

Scope of Practice for this site			Address 1	Address 2 (suite)
☐ Primary Care ☐ RHC ☐ Specialty Care	☐ Urgent Care ☐ Walk-in Care	☐ Inpatient Care ☐ Emergency Care		

If specialty care, please designate practice specialty	City, State, Zip	☐ Dir Opt-IN for this location

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address handicap accessible?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address TDD hearing equipped?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Is address accessible by bus route?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does provider bill for DME services? (Provide sample claim)	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicare?	☐	☐	Is provider a locum tenens provider?	☐	☐
What is the maximum panel capacity for Medicaid at this site?			Has provider completed cultural competence training?	☐	☐
What is the maximum panel capacity for Medicare at this site?			Is provider certified in trauma-informed care (TIC)?	☐	☐
What are the age limitations for patients seen by provider?			Has provider been trained in evidence-based practice?	☐	☐
Is there a gender restriction at this site? (If yes, please specify)					

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Pay To Name (i.e., billing name)	Phone #	Fax #

Pay To Address	City	State	Zip

Correspondence Address ☐ Same as Section II Correspondence	City	State	Zip

Notes

Center Care Credentialing

IMPORTANT NOTES: This list has been prepared to assist you in providing the most commonly required documentation needed for the provider to be credentialed. Failure to submit the required items may result in the provider's application being deemed incomplete, requiring resubmission of the provider's application. This may also result in a delay of the provider's effective date for participation, resulting in a delay in reimbursement.

Notification of Practitioner Rights Please be advised that applicants for credentialing or recredentialing have the right to (1) review information submitted to support his/her credentialing application, (2) correct erroneous information, and (3) be informed of his/her credentialing or recredentialing application, upon request.

ITEM	ADDITIONAL INFORMATION
COMPLETED CAQH APPLICATION	• CAQH application "Last Attestation Date" cannot be more than 60 days old. • CAQH application should be updated to reflect the practice location(s) and relevant information for which we are to credential the provider. Attach applicable supporting documents in CAQH. • "Standard Authorization, Attestation and Release" page should be included in CAQH, signed and dated, and signature to match provider's legal name.
DEA CERTIFICATE	• Required for MD, DO, DPM, DMD. Exception for Radiologists and Pathologists. • Required for APRNs, if APRN writes/dispenses/prescribes controlled substances. • If provider will be practicing in more than one state, DEA required for each applicable state. • If provider does not have a DEA or the DEA is pending, written explanation or documentation of coverage arrangements is needed (e.g. another practitioner will write all prescriptions on his/her behalf).
STATE LICENSURE	• CAQH Section 1 to indicate state license number and a copy of the provider's license to be attached. • If provider will be practicing in more than one state, license required for each applicable state.
EDUCATION AND TRAINING	• CAQH Section 2 (or CV/resume) to indicate Professional/Medical School, start and end dates (month/year). • Required for MD, DO, DPM, DMD. CAQH Section 2 (or CV/resume) to indicate Training programs, start and end dates (month/year).
BOARD CERTIFICATION	• Required for MD, DO, DPM, DMD; excludes General Practitioners. • CAQH Section 3 should indicate if the provider is board certified in their specialty.
OFFICE HOURS/ ACCESSIBILITIES	• CAQH Section 4 to indicate Office Hours, Handicapped Access, TDD Hearing (text telephony), American Sign Language, and Accessible by Bus. If laboratory services are provided, attach CLIA certificate.
COVERING COLLEAGUE	• Required for MD, DO, DPM, DMD. May be waived for Urgent Care Providers. • CAQH Section 4 should indicate covering colleague; if not, provide explanation of the type of 24/7 coverage. • The covering physician must be like-specialty. For PCPs, Family Practice, General Practice, Internal Medicine, and Pediatrics can be considered comparable.
HOSPITAL PRIVILEGES	• Required for MD, DO, DPM, DMD, PA, APRN. May be waived for Urgent Care Providers. • Exceptions may be considered for Radiologists, Dermatologists, Pathologists and Anesthesiologists. • CAQH Section 5 should indicate Hospital Privileges or Admitting Arrangements.
CERTIFICATE OF INSURANCE	• A current copy of the Certificate of Insurance to be attached; must reflect malpractice limits of $1M/$3M, group's name, provider's name, and effective/expiration dates. • Limits of $1M/$1M are acceptable for ABA, AUD, BC-ADM, CDE, CFA, CSA, LCADC, LCSW, LMFT, LPAT, LPCC, LPP, OT, PT, RD, and SLP. For Indiana providers only, $500K/$1.5M is acceptable. • If provider will be practicing in more than one state, confirm whether the policy covers all applicable states. • If provider's name is not on the certificate, a copy of the roster or documentation that provider is covered under the group's policy is needed.
WORK HISTORY	• CAQH Section 7 (or CV/resume) to indicate complete work history (month/year) since highest level of education/training or last 5 years. If any gaps 6 months or longer, explanation is required.
SUPERVISING PHYSICIAN	• Required for PA, APRN. The supervising physician's name and specialty are to be indicated.
COLLABORATIVE AGREEMENT FOR THE PRESCRIPTIVE AUTHORITY FOR NON-CONTROLLED & CONTROLLED SUBSTANCES	• Required for APRNs practicing in KY. • Physician should be within same group/TIN; if not, explanation is needed. • If CAPA-NS, the APRN prescribes non-scheduled legend drugs. • If CAPA-CS, the APRN prescribes controlled substances, also has a DEA, and practicing over one year. • If the APRN has maintained a CAPA-NS for 4 years or more, the APRN may choose to discontinue a CAPA-NS or maintain it indefinitely after the four years. If discontinued, a copy of the "Notification to Discontinue the CAPA-NS After Four Years" form is required.

Behavioral Health Clinical Specialties Codes and Descriptions

Code	Description	Code	Description
AA	ADD/ADHD Counseling	DR	General Depression Counseling
AD	Addictionology (MD's Only)	GR	Grief and Loss Counseling
AI	Adoption Counseling	GT	Group Therapy
AF	AIDS/HIV Counseling	HV	Home-Based Behavioral Health Services
AC	Alcohol and Substance Use Counseling (certified)	LD	Learning Disabilities
AS	Alcohol and Substance Use Counseling (self-reported)	ML	Medical Illness Counseling
AM	Anger Management Counseling	MC	Marriage/Couples Counseling
AE	Appointments Available in the Evening	BS	Medication Assisted Treatment (MAT) for Substance Use: Buprenorphine/Suboxone
AW	Appointments Available on the Weekends	MV	Medication Assisted Treatment (MAT) for Substance Use: Vivitrol
AB	Autism Applied Behavioral Analysis (ABA)	MO	Menopause Counseling
AG	Autism Social Skills Training	MI	Men's Counseling
AT	Autism Testing	DD	Mental Health and Substance Use Counseling (Dual Diagnosis)
AR	Autism Treatment	NT	Neuropsychological Testing (Psychologists Only)
BP	Behavioral Pediatrics (MD)	OC	Obsessive Compulsive Disorder (OCD) Counseling
BF	Biofeedback Counseling	PM	Pain Management
BD	Bipolar Disorder (Manic Depression) Counseling	PA	Panic Disorder Counseling
BR	Borderline Personality Disorder (BPD) Counseling	PH	Phobias Counseling
CD	Conduct/Disruptive Behavior Therapy Counseling	MH	Postpartum Depression Counseling
CE	Cultural/Ethnic Counseling	PT	Post-Traumatic Stress Disorder (PTSD) Counseling
DL	Developmental Disorders Counseling	MJ	Psychiatric Medication Management: Injectable Meds
DB	Dialectical Behavior Therapy	MM	Psychiatric Medication Management: Oral Meds
DS	Dissociative Disorder (Multiple Personalities) Counseling	PS	Psychological Testing
DV	Domestic Violence Counseling	PD	Psychotic Disorders
RF	EAP: Assessment/Referral	SI	Sexual Abuse Counseling
ED	Eating Disorders Counseling	SD	Sexual Health Counseling
EC	Eye Movement Desensitization and Reprocessing (EMDR)	SO	Sexual Offender Counseling
CC	Faith-Based Counseling: Christian	GL	Sexual Orientation Counseling
FB	Faith-Based Counseling: Other than Christian Only	TM	Transcranial Magnetic Stimulation (TMS)
FY	Family Counseling	TH	Virtual Counseling Provided (via video)
FI	Fertility Counseling	TO	Virtual Counseling Only (via video)
FR	First Responder Counseling	WI	Women's Counseling
GA	Gambling Counseling		
GI	Gender Identity Counseling		
AX	General Anxiety Counseling		

Instructions for a Provider on
How to Apply for a Kentucky Medicaid ID Number

Please follow the link below to Kentucky's Department for Medicaid Services' website for instructions to enroll as a new Kentucky Medicaid provider:

https://chfs.ky.gov/agencies/dms/provider/Pages/providerenroll.aspx

Sample Claim Form (SCF) Instructions

HCFA 1500 CLAIM FORM:

A Sample HCFA 1500 Claim Form is required to ensure accurate loading of demographics. Please refer to below information:

1. The following sections of the sample claim form must be completed (all other areas are optional, and no PHI should be provided):
   a. Box 24j = This is where the NPI # must be entered.
   b. Box 25 = Federal Tax Identification #
   c. Box 31 = Rendering Provider's Name (degree is optional; name should be legal name)
   d. Box 32 = Service Location of where services were rendered. In most cases, this address should match the address that is being given as the Provider's Primary Address, or Alternate Location.
   e. Box 33 = The Provider's Pay To Address.

   NOTE: A copy of your Professional 837p is an acceptable alternative to a HCFA 1500:

      i. Bill to Loop 2010AA – Provider qualifier '85'
      ii. Rendering Loop 2310B – Provider qualifier '82'
      iii. Service Facility Loop 2310D or Loop 2420C – qualifier '77' or 'FA'

   IMPORTANT: Information in Box 33 of Sample Claim MUST match the pay-to information that is being billed electronically. Please double check this field to ensure that the PAY-TO information is reflected and not the BILL-TO.

UB04 CLAIM FORM:

A Sample UB04 Claim Form is required for Institutional Providers (i.e. Hospitals, Distinct Part Unit Psychiatric, Distinct Part Unit Rehabilitation, Home Health, etc.).

2. Sample Form UB04 is required for Institutional Providers:
   a. Box 1 = Physical Location
   b. Box 2 = Billing Address (if different)
   c. Box 5 = Vendor TIN
   d. Box 56 = NPI #

   NOTE: A copy of your Institutional 837I is an acceptable alternative to a UB04:

      i. Bill To Loop 2010AA – Provider qualifier '85'
      ii. Pay To Loop 2010AB – Provider qualifier '87'
      iii. Service Facility 2310E – qualifier 'FA'

W-9 Helpful Guidelines

At the request of the payers accessing Center Care's network, Center Care is required to collect a W-9 for every Tax Identification Number (TIN) in the network.

The W-9 must be the most current form version available from the IRS.

Please note the following to ensure your W-9 is accurate:

1. The purpose of a W-9 is to inform Payers the name and address your TIN is registered under with the IRS. If you are not sure what this is, please reference a recent document sent to you by the IRS.

2. When completing your W-9 Form:
    a. Line 1 of the W-9 is Mandatory.
    b. Line 2 of the W-9 is Optional (DBA).
    c. The address on the W-9 can, but is NOT required, to match the billing address. Again, **the W-9 address should be what the IRS has on file for the TIN**, which may or may not be the same as your billing address.
    d. Please ensure your W-9 matches EXACTLY the way the IRS has your name and address listed, including abbreviations (St vs. Saint, Rd vs. Road, Ste vs. Suite, etc.).
    e. The W-9 must be signed and dated.

3. Should your W-9 name or address change, please submit an updated W-9 along with the names of all affected providers to be updated.

Please ensure your W-9 accurately reflects the information the IRS has on file for your TIN to prevent potential delays in reimbursement.

APPENDIX

Additional Addresses. If Pay To and Correspondence Information are NOT the same as that of the Primary Address, please make copies of page 4 to include this information. If more than 4 addresses are required, please make additional copies of either this page or page 4, as appropriate.

Address Type	Tax ID#	Group Name (include DBA)	
☐ Alternate Office ☐ Covering Only			
Scope of Practice for this site		**Address 1**	**Address 2 (suite)**
☐ Primary Care ☐ RHC ☐ Specialty Care ☐ Urgent Care ☐ Walk-in Care ☐ Inpatient Care ☐ Emergency Care			
If specialty care, please designate practice specialty		**City, State, Zip**	☐ Dir Opt-IN for this location

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address handicap accessible?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address TDD hearing equipped?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Is address accessible by bus route?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does provider bill for DME services? (Provide sample claim)	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicare?	☐	☐	Is provider a locum tenens provider?	☐	☐
What is the maximum panel capacity for Medicaid at this site?			What are the age limitations for patients seen by provider?		
What is the maximum panel capacity for Medicare at this site?			Is there a gender restriction at this site? (If yes, please specify)		
Is the Pay To address the same as that of the primary address?	☐	☐	Is the Correspondence address the same as that of the primary address?	☐	☐

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Address Type	Tax ID#	Group Name (include DBA)	
☐ Alternate Office ☐ Covering Only			
Scope of Practice for this site		**Address 1**	**Address 2 (suite)**
☐ Primary Care ☐ RHC ☐ Specialty Care ☐ Urgent Care ☐ Walk-in Care ☐ Inpatient Care ☐ Emergency Care			
If specialty care, please designate practice specialty		**City, State, Zip**	☐ Dir Opt-IN for this location

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address handicap accessible?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address TDD hearing equipped?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Is address accessible by bus route?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does provider bill for DME services? (Provide sample claim)	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicare?	☐	☐	Is provider a locum tenens provider?	☐	☐
What is the maximum panel capacity for Medicaid at this site?			What are the age limitations for patients seen by provider?		
What is the maximum panel capacity for Medicare at this site?			Is there a gender restriction at this site? (If yes, please specify)		
Is the Pay To address the same as that of the primary address?	☐	☐	Is the Correspondence address the same as that of the primary address?	☐	☐

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday