



## Organizational Provider Application for Participation Instructions

*Please follow these steps to ensure that your request is processed without delay:*

<b>STEP 1 (Page 2)</b>	<b>Application Submission</b>	<p>Choose either option:</p> <ol style="list-style-type: none"> <li>1. Submit a letter or file containing all requested information on page 2 of this packet. Email to <a href="mailto:enrollment@centercare.com">enrollment@centercare.com</a> or fax to <b>(270) 796-3584</b>.</li> <li>2. Complete the form on page 2 in its entirety and email to <a href="mailto:enrollment@centercare.com">enrollment@centercare.com</a> or fax to <b>(270) 796-3584</b>.</li> </ol> <p><b>Important:</b> Failure to supply the requested information in the following pages of this document will result in a processing delay.</p>
<b>STEP 2 (Page 3)</b>	<b>Center Care Credentialing Requirements</b>	<p>Should the facility require credentialing for participation, please refer to page 3 for a list of required supporting documentation. Depending on the facility type, this list outlines all documentation required to complete the application for participation and initiate credentialing. Failure to submit the required items may result in the application being deemed incomplete. This may also result in a delay in the effective date for participation.</p>
<b>STEP 3 (Page 4)</b>	<b>Kentucky Medicaid Provider ID Number</b>	<p>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 4.</p>
<b>STEP 4 (Page 5)</b>	<b>Sample Claim Form(s)</b>	<p>A sample claim form is required to ensure accurate loading of the facility. See page 5 for instructions.</p>
<b>STEP 5 (Page 6)</b>	<b>Completed W-9 Form</b>	<p>A W-9 form is required to prevent delays in reimbursement. See page 6 for instructions.</p>

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



## Organizational Provider Application for Participation

FACILITY INFORMATION			
Facility Name (Legal Name, DBA Name)		Date Facility Opened	
Physical Address		Phone	Fax
Pay-to Address		Phone	Fax
Correspondence Address		Phone	Fax
Federal Tax ID #	National Provider Identifier (NPI)	Is Facility compliant with ADA (Americans with Disabilities Act)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare #	State License #	DEA # (if applicable)	
Facility Type: <input type="checkbox"/> Hospital (Acute & Rehabilitation) <input type="checkbox"/> Home Health Agency <input type="checkbox"/> Free-Standing Surgical Center <input type="checkbox"/> Mental Health & Substance Abuse Services <input type="checkbox"/> Skilled Nursing Facility/Nursing Home <input type="checkbox"/> Other:			
Credentialing Contact		Credentialing Contact Phone	Credentialing Contact Email
CEO/Administrator		Business Office Manager	
Facility Website (for directory)		Facility Email (for directory)	
MEDICAID PARTICIPATION			
KY Medicaid #:		If you do not currently have a KY Medicaid #, has one already been applied for? <input type="checkbox"/> Yes <input type="checkbox"/> No	
LABORATORY SERVICES			
Does this facility offer lab services? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, CLIA Number:	CLIA Expiration:
CURRENT ACCREDITATIONS (attach letter/certificate of accreditation)			
<input type="checkbox"/> TJC <input type="checkbox"/> CARF <input type="checkbox"/> AAAASF <input type="checkbox"/> CMS <input type="checkbox"/> Other: <input type="checkbox"/> AOA <input type="checkbox"/> CHAP <input type="checkbox"/> AAAHC <input type="checkbox"/> HFAP <input type="checkbox"/> Unaccredited (site visit must be performed)			
LIABILITY INSURANCE (attach certificate of insurance)			
Carrier Name		Expiration Date	Limits (Occurrence/Aggregate)
SANCTIONS, DISCIPLINARY ACTIONS, LEGAL RESTRAINTS (attach explanation of any affirmative responses)			
<input type="checkbox"/> Yes <input type="checkbox"/> No Has this facility been subject to any revocations, suspensions, or sanctions under Medicare/Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Has this facility's professional or general liability insurance ever been denied/cancelled? <input type="checkbox"/> Yes <input type="checkbox"/> No Has this facility's license ever been suspended, revoked, investigated, or disciplined? <input type="checkbox"/> Yes <input type="checkbox"/> No Does this facility have any pending malpractice claims? If so, # pending: <p style="text-align: center;"><b><i>If the answer to any of the above questions is YES, please attach explanation on a separate sheet.</i></b></p>			
ATTACHMENTS (attach copies of the following documents)			
<input type="checkbox"/> State license and/or DEA certificate <input type="checkbox"/> Certificate of liability insurance <input type="checkbox"/> CLIA Certificate (if applicable) <input type="checkbox"/> Explanation for sanctions, disciplinary actions, legal restraints (if any) <input type="checkbox"/> Accreditation letter/certificate <u>OR</u> CMS certification status/site assessment report (if non-accredited) <input type="checkbox"/> Sample Claim Form <input type="checkbox"/> W-9 Form			
ATTESTATION			
I hereby certify the information provided by me in this application is true and complete, and I understand that falsification of this information is grounds for loss of participation with Center Care. I agree to provide information as required to support this application.			
Authorized Signature: _____ Title: _____ Date: _____			

## CENTER CARE CREDENTIALING for Organizational Providers

### IMPORTANT NOTES

- This list has been prepared to assist you in providing the most commonly required documentation needed for credentialing.
- Failure to submit the required items may result in the facility's application being deemed incomplete, and potentially a delay in the effective date for participation.

ITEM	ADDITIONAL INFORMATION
<b>STATE LICENSURE</b>	<ul style="list-style-type: none"> <li>• A current copy of valid license in the state of practice is required. License must be issued by state of the location applying for credentialing/participation.</li> <li>• Effective July 15, 2018, licensure is no longer required in Kentucky for outpatient rehabilitation services, primary care centers, and rural health clinics.</li> </ul>
<b>DEA CERTIFICATE</b>	<ul style="list-style-type: none"> <li>• A current copy of DEA certificate in the state of practice is required (if applicable). DEA must be issued by state of the location applying for credentialing/participation.</li> </ul>
<b>CLIA CERTIFICATE</b>	<ul style="list-style-type: none"> <li>• If the facility performs and bills for lab services, a copy of the CLIA Certificate or Waiver is required.</li> </ul>
<b>ACCREDITATION LETTER/CERTIFICATE</b>	<ul style="list-style-type: none"> <li>• A copy of accreditation report, certificate, or decision letter is required.</li> <li>• If non-accredited, a CMS certification status/site assessment report is acceptable.</li> </ul>
<b>CERTIFICATE OF INSURANCE</b>	<ul style="list-style-type: none"> <li>• A current copy of the Certificate of Insurance that reflects malpractice limits of \$1M/\$3M, name, and expiration date is required.</li> </ul>
<b>SANCTIONS</b>	<ul style="list-style-type: none"> <li>• Please provide an explanation for any sanctions, disciplinary actions, legal restraints, etc.</li> </ul>
<b>SAMPLE CLAIM FORM</b>	<ul style="list-style-type: none"> <li>• A Sample Claim Form is required to ensure accurate loading.</li> <li>• Please exclude/remove PHI prior to sending.</li> </ul>
<b>W-9 FORM</b>	<ul style="list-style-type: none"> <li>• A W-9 form is required to prevent delays in reimbursement, and to ensure accurate loading.</li> <li>• Form submitted must be the most recent version offered by the IRS.</li> <li>• Form must be signed and dated.</li> </ul>

## **Instructions 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 reimbursement delays.**