Organizational Provider Application for Participation Instructions

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

STEP 1 (Page 2)	**Application Submission**	Choose either option: 1. Submit a letter or file containing all requested information on page 2 of this packet. Email to enrollment@centercare.com or fax to (270) 796-3586. 2. Complete the form on page 2 in its 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 this document will result in a processing delay.**
STEP 2 (Page 3)	**Center Care Credentialing Requirements**	Should the facility require credentialing for participation, please refer to this packet 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.
STEP 3 (Page 4)	**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#, see instructions on page 4 of this packet.
STEP 4 (Page 5)	**Sample Claim Form(s)**	A sample claim form is required to ensure accurate loading of the facility. See page 5 for instructions.
STEP 5 (Page 6)	**Completed W-9 Form**	A W-9 form is required to prevent delays in reimbursement. See page 6 for instructions.

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

Organizational Provider Application for Participation

Will the provider be seeking enrollment with Aetna Better Health of Kentucky?	☐ Yes ☐ No
If Yes, Center Care provides credentialing services for Aetna Better Health of Kentucky and will notify Aetna upon completion of provider's credentialing.	

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)	Medicare #	State License #

Facility Type: ☐ Hospital (Acute & Rehabilitation) ☐ Home Health Agency ☐ Free-Standing Surgical Center ☐ Mental Health & Substance Abuse Services ☐ Skilled Nursing Facility/Nursing Home ☐ Other:

Credentialing Contact	Credentialing Contact Phone	Credentialing Contact Email
CEO/Administrator	Business Office Manager	

MEDICAID PARTICIPATION

KY Medicaid #:	If you do not currently have a KY Medicaid #, has one already been applied for? ☐ Yes ☐ No

LABORATORY SERVICES

Does this facility offer lab services? ☐ Yes ☐ No	If yes, CLIA Certificate/Waiver #:

CURRENT ACCREDITATIONS (attach letter/certificate of accreditation)

☐ TJC ☐ CARF ☐ AAAASF ☐ CMS ☐ Other:
☐ AOA ☐ CHAP ☐ AAAHC ☐ HFAP ☐ 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)

☐ Yes ☐ No Has this facility been subject to any revocations, suspensions, or sanctions under Medicare/Medicaid?
☐ Yes ☐ No Has this facility's professional or general liability insurance ever been denied/cancelled?
☐ Yes ☐ No Has this facility's license ever been suspended, revoked, investigated, or disciplined?
☐ Yes ☐ No Does this facility have any pending malpractice claims? If so, # pending:

If the answer to any of the above questions is YES, please attach explanation on a separate sheet.

ATTACHMENTS (attach copies of the following documents)

☐ Copy of state license
☐ Copy of certificate of liability insurance
☐ Copy of accreditation letter/certificate OR CMS certification status/site assessment report (if non-accredited)
☐ Explanation for sanctions, disciplinary actions, legal restraints (if any)
☐ Sample Claim Form
☐ 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
STATE LICENSURE	• Required documentation. • 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. • Effective July 15, 2018, licensure is no longer required in Kentucky for outpatient rehabilitation services, primary care centers, and rural health clinics.
CERTIFICATE OF INSURANCE	• Required documentation. • A current copy of the Certificate of Insurance that reflects malpractice limits of $1M/$3M, name, and expiration date is required.
ACCREDITATION LETTER/CERTIFICATE	• Required documentation. • If non-accredited, a CMS certification status/site assessment report is acceptable.
SANCTIONS	• Please provide an explanation for any sanctions, disciplinary actions, legal restraints, etc.
SAMPLE CLAIM FORM	• Required documentation. • A Sample Claim Form is required to ensure accurate loading. • Please exclude/remove PHI prior to sending.
W-9 FORM	• Required documentation. • A W-9 form is required to prevent delays in reimbursement, and to ensure accurate loading. • Form submitted must be the most recent version offered by the IRS. • Form must be signed and dated.

Instructions on How to Apply for a Kentucky Medicaid ID Number

Please follow the below link to Kentucky's Department for Medicaid Services website and follow the instructions for obtaining a Kentucky Medicaid ID Number:

https://chfs.ky.gov/agencies/dms/dpi/pe/Pages/apply.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 that will be 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 #
   e. Also, Distinct Part Unit Psychiatric, Distinct Part Unit Rehabilitation, and Home Health require a sample claim on a UB04.

   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 tell 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.