HEALTH CARE FACILITY APPLICATION FOR NETWORK PARTICIPATION

NAME OF FACILITY/AGENCY:
INFORMATION COMPILED BY:

Print Name:
Title:
Date:

NOTE:

- **After we receive your completed application, we will credential or recredential your facility in our networks, as applicable.**
- An application for a group with a nonstandard fee schedule is not considered complete until rates are negotiated and agreed upon.
- Please remember to sign and date your application.

INCLUDE THE FOLLOWING FACILITY DOCUMENTS AS PART OF YOUR APPLICATION:

- Current operating certificate/license.

- Evidence of TJC or other accreditation.
- If the facility is not accredited by TJC or other accreditation agency, please send a statement of deficiencies, along with a plan of corrections, from the facility's most recent State Survey i.e.; DOH, OMH, OASAS or CMS.
- General and professional liability insurance face sheets.
- Malpractice claims history details.
- Form W-9.
- CLIA certificate (if applicable).
- Drug Enforcement AG/Controlled Dangerous Substance (DEA/CDS) certificate (if applicable).
- **Completed Service Type & Code form (last page of the application).**

RETURN THE COMPLETED APPLICATION

E-mail or fax the completed application, including all requested documents, to:

Provider Services
Amida Care
Phone: **1-646-757-7200**
Fax: **1-646-786-1803**
E-mail: ***providerservices@amidacareny.org***

You may also mail the completed application to:

Amida Care
14 Penn Plaza, 2nd floor
New York, NY 10122

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What networks are you applying for?

☐ Medicaid
☐ Medicare (including: Amida Care Live Life Advantage, Amida Care True Life Advantage, Amida Care True Life Plus Plan)
☐ Managed Long Term Care (MLTC)
_____All of the above

Organization and Service Address Information

If services are provided from multiple sites, please attach a list of additional sites to your application.

Name of Organization:		Tax ID:
Service Address:		
Telephone #:	Fax #:	
Billing Address:		
Telephone #:	Fax #:	
NPI #:	Operating Certification #:	PFI #:
OMH #:	Expiration Date: ____/____/____	
OASAS #:	Expiration Date: ____/____/____	
CLIA (Clinical Laboratory) #:	Expiration *(if applicable)*: ____/____/____	
Hours of operation:		
Are all service locations handicapped accessible? ☐ Yes ☐ No		

What type of facility is your organization?

☐ Ambulatory surgery center
☐ Clinical laboratory
☐ Comprehensive outpatient rehabilitation center
☐ Dialysis center
☐ Federally qualified health center
☐ Free standing imaging center
☐ Home health agency
☐ Home infusion therapy
☐ Hospice
☐ Hospital
☐ Outpatient alcohol and drug abuse center
☐ Outpatient diabetes self-management center
☐ Outpatient mental health center
☐ Outpatient mental health and substance abuse center
☐ Outpatient physical therapy and speech language pathology center
☐ Portable X-ray supplier
☐ Psychiatric hospital
☐ Rural health clinic
☐ Skilled nursing facility
☐ Substance abuse residential rehabilitation center
☐ Urgent care center
☐ Other ________________

Accreditation and Certification

Attach a copy of verification for each accreditation and certification that your facility has. If your facility received less than full accreditation, please attach a copy of a recommendation.

☐ CARF, Expiration Date: ____/____/____;
☐ CHAP, Expiration Date: ____/____/____;
☐ DNV, Expiration Date: ____/____/____;
☐ TJC, Expiration Date: ________/____/____;
☐ Other: ___________________________________, Expiration Date: ____/____/___
☐ Medicaid #: ___________________________________, Expiration Date: ____/____/____
☐ Medicare #: ___________________________________, Expiration Date: ____/____/____

Statement Of Deficiencies Survey

Indicate any current statements of deficiencies/survey your facility has. Include a copy of each statement, along with a plan of corrections.

☐ Medicare, Audit or Survey Date: ______/______/

☐ Medicaid, Audit or Survey Date: ______/______/

☐ DOH, Audit or Survey Date: ____/____/

☐ Other: ____________________________________, Audit or Survey Date: ____/____/

General and Professional Liability Insurance

Attach a copy of your facility's general and professional liability insurance policy face sheets and malpractice claims history details.

☐ My facility does not have a general liability insurance policy.

Present General Liability Insurance Carrier:	
Address:	
Policy #:	Initial Date: ____/____/____
Limits of Liability:	Expiration Date: ____/____/____

☐ My facility does not have a professional liability insurance policy.

Present Professional Liability Insurance Carrier:	
Address:	
Policy #:	Initial Date: ____/____/____
Limits of Liability:	Expiration Date: ____/____/____

Health Service Delivery and Quality Management Information

- Do you subcontract for medical services with other organizations or individuals? ☐ Yes ☐ No
  If yes, please provide their names and addresses and describe your relationship(s):
  ____
  ____
- Have you ever been restricted from participating with Medicare, Medicaid or any other government or private insurance program?
  ☐ Yes ☐ No (If yes, please provide details as an attachment.)
- Do you have a quality improvement process in place? ☐ Yes ☐ No (If yes, please attach a brief summary as an attachment.)
- Do you have a process in place to measure and collect patient satisfaction? ☐ Yes ☐ No
  If yes, please describe your most recent patient satisfaction measure and instrument used:
  ____
  ____

Primary Officer/Contact Person

Name:		Title:
Telephone #:	Fax #:	E-mail Address:

I attest that the information given or attached to this application is accurate. As a condition to making this application, any misrepresentation or misstatement in or omission from this application, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial or non-renewal of a contract. In the event that a contractual arrangement is in effect prior to this discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such contract.

Name:	Title:	Date: ____/____/____

SERVICE TYPE & CODE FORM

Place an X next to the service(s) that may be provided by your facility.

X	Code	Description	X	Code	Description	X	Code	Description	X	Code	**Description**
	907	Abortion		**OTHR**	All Other		**311**	Clinic Treatment- Children/Youth		**902**	Endocrine
	355	AIDS Center (renamed)		**915**	Allergy		**780**	Clinical Psychology Services		**516**	Endocrinology
	757	Alcohol/Subst Abuse Community Residential Services		**20**	Anesthesiology Services		**281**	Clinical Social Work		**935**	ENT, Head & Neck Surgery
	759	Alcohol/Subst Abuse Gen. Residential (Non-Inpat)		**916**	Arthritis		**325**	Cln Sp Cd Early Intervention		**282**	Certified Drug & Alcohol Services
	752	Alcohol/Subst Abuse Inpat/ Residential		**997**	Audiology Service Center		**329**	Community Residence-Adult		**930**	Gastroenterology
	753	Alcohol/Subst Abuse Inpatient Rehabilitation Svc		**BEHV**	Behavioral Health		**330**	Community Residence-Children/Youth		**919**	Eye/Vision Center
	765	Alcohol/Subst Abuse Intensive/ Enhanced Treatment		**131**	Blood Banking		**992**	Comprehensive Psychiatrics Emergency Prog (CPEP)		**328**	Family Based Treatment-Children/Youth
	989	Alcohol/Subst Abuse Medically Managed Detox Svc		**521**	Blood PH and Gases		**611**	Congregate Meals		**360**	Family Care
	754	Alcohol/Subst Abuse Medically Monitored Withdrawal		**933**	Cancer Detection Center		**312**	Continuing Day Treatment (CDT)		**906**	Family Planning
	922	Alcohol/Subst Abuse Methadone Treatment Services		**927**	Cardiology Center		**283**	Counseling Services		**372**	Family Support Services-Children/Youth
	755	Alcohol/Subst Abuse Outpatient		**928**	Cardiovascular		**361**	Crisis Residence		**321**	General Clinic Services
	984	Alcohol/Subst Abuse Outpatient Clincial Services		**371**	Case Management		**975**	Day Treatment-Children/Youth		**911**	General Dentistry
	987	Alcohol/Subst Abuse Outpatient Rehabilitation Svc		**908**	CHAP		**DENT**	Dental		**11**	General Hospital (Article 28)
	758	Alcohol/Subst Abuse Supportive Living Services		**963**	Child Psychiatry		**956**	Dermatology Center/Clinic		**914**	General Medicine
	749	Alcoholism & Substance Abuse General Outpatient		**CHLD**	Children’s Services		**903**	Diabetes		**955**	Genito-Urinary
	017	Alcoholism & Substance Abuse Inpatient Service		**760**	Clinic Pharmacy (EMEVS Use Only)		**307**	DME (Other than Orthotic and Prosthetic)		**905**	Gynecology
	599	**All laboratories**		**974**	**Clinic Treatment**		**373**	Drop-In Center			

SERVICE TYPE & CODE FORM

Place an X next to the service(s) that may be provided by your facility.

X	Code	Description	X	Code	Description	X	Code	Description	X	Code	Description
	996	Hearing Services (Ordered Ambulatory)		**365**	Mental Health Residential (Non-Inpatient)		**135**	Pathology Services		**946**	Psychiatry-Group
	926	Hematology Center/Clinic		**979**	MR/DD Clinic Treatment		**937**	Pediatric Allergy		**370**	Psychosocial Club
	482	Hematology-General		**954**	Nephrology		**940**	Pediatric Cardiac		**929**	Pulmonary
	913	Hemodialysis		**931**	Neurology Center		**960**	Pediatric Dermatology		**200**	Radiology
	309	HIV Co-located Substance Abuse Services and Clinic		**932**	Neurosurgery Clinic		**961**	Pediatric Diabetes		**362**	Residential Treatment Facility (RTF)-Child/Youth
	310	HIV Primary Care Medicaid Program (Community Based)		**016**	Non-Institutional Home Health Care		**944**	Pediatric Endocrine		**840**	Respiratory Therapy
	308	HIV Primary Care Services and Clinic		**015**	Non-Institutional Long Term Care (Cert HHC, LTHHCP)		**936**	Pediatric General Medicine		**917**	Rheumatology
	HIVS	HIV Services		**614**	Nursing Services		**939**	Pediatric Hematology		**306**	School Supportive Health Care
	356	Home & Community Based Services (HCBS) Waiver		**909**	Nutrition Program		**938**	Pediatric Neurology		**612**	Social Day Care
	610	Home Delivered Meals		**OBGY**	Obstetrics/Gynecology		**943**	Pediatric Orthopedic		**781**	Social Work
	993	Hospital Based and/or Freestanding Ambulatory Surgery		**904**	Obstetrics		**942**	Pediatric Pulmonary		**983**	Specialty Clinic-Mental Retardation
	73	Hospice Care		**301**	Occupational Therapy Services		**941**	Pediatric Renal		**302**	Therapy Service
	969	Hospital DME, Orthotic & Prosthetic Appl Vendor		**007**	OMH-Operated Psych Ctr (Article 31 state op)		**962**	Pediatric Surgery		**ABUS**	Substance Abuse
	1	Hospital Inpatient		**934**	Oncology-Therapy (Radiation or Chemo)		**613**	Personal Care		**362**	Supported Housing
	925	Hypertension		**958**	Ophthalmology Center/Clinic		**615**	Personal Emergency Response System (PERS)		**SURG**	Surgery
	966	Infectious Disease		**715**	Optician Center, Optician Est & Contact Lens Priv		**014**	Pharmacy		**952**	Surgical, General
	12	Institutional Long Term Care		**716**	Optometrist/Diagnostic Pharmaceuticals		**013**	Pharmacy with 24 hour access		**951**	Surgical, Minor
	314	Intensive Psychiatric Rehabilitation Treatment		**912**	Orthodontic		**967**	PHC Speech and Hearing		**019**	Transportation (Emergency Ambulance Only)
	LTC	Long Term Care		**950**	Orthopedics Clinic/Center		**300**	Physical Therapy Services		**965**	Tuberculosis
	305	Maternal and Pediatric HIV Care Center		**979**	MR/DD Clinic Treatment		**918**	Podiatrist Center		**250**	Urgent Care Center

If you answer "Yes" to any question below, please provide a detailed explanation on a separate sheet.	
Has this provider, under any current or former name or business identity ever had or currently has any pending malpractice claims, suits, settlements or proceedings involving professional practice? (Please attach explanation)	☐ Yes ☐ No
Has this provider, under any current or former name or business identity 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
Has this provider, under any current or former name or business identity 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
Has this organization ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a third party payor, or a Regulatory Agency?	☐ Yes ☐ No
Has any officer of this organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including any act of violence, child abuse or sexual offense?	☐ Yes ☐ No
Has the corporation, an officer or a board member ever been convicted of felony?	☐ Yes ☐ No
Has this provider under any current or former name or business entity, ever had its accreditation revoked or suspended?	☐ Yes ☐ No
Is this provider, under any current or former name or business identity, currently suspended from Medicare or Medicaid payment under any Medicare or Medicaid billing number?	☐ Yes ☐ No
Has any of this provider's managing employees been convicted of any criminal activities related to Medicare, Medicaid or Title xx programs?	☐ Yes ☐ No
Do you check the exclusion lists (OIG, OMIG, GSA) for all employees and vendors monthly?	☐ Yes ☐ No