HEALTH CARE ANCILLARY PROVIDER NETWORK PARTICIPATION

NAME OF FACILITY/AGENCY:
INFORMATION COMPILED BY:

Print Name:
Title:
Date:

NOTE:

- **After we receive your completed application, we will credential or re-credential 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 ANCILLARYFACILITY DOCUMENTS AS PART OF YOUR APPLICATION:

Completed by Provider:

- ☐ Disclosure of Ownership form
- ☐ ADA Attestation
- ☐ Current Operating certificate/state license
- ☐ DOH Survey Approval letter.
- ☐ Accreditation (JCAHO, CHAP)
- ☐ DEA-Drug Enforcement, if applicable
- ☐ General and professional liability malpractice insurance face sheets
- ☐ Workers Compensation Insurance
- ☐ Consent attestation
- ☐ CLIA certificate (if applicable)
- ☐ Ancillary Provider Rosters/Locations
- ☐ Completed Service & code from (last page of the application)
- ☐ W-9

Completed by Amida Care:

- ☐ Amida care Site Evaluation – Perform by Amida Care, if applicable

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

HEALTH CARE ANCILLARY APPLICATION
NETWORK PARTICIPATION

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 #:
Medicaid #	Expiration Date: ____/____/____	
OMH #:	Expiration Date: ____/____/____	
OASAS #:	Expiration Date: ____/____/____	
CLIA (Clinical Laboratory) #:	Expiration *(if applicable):* ____/____/____	
Hours of operation:		
Are all service locations handicapped accessible? Yes ☐ No ☐		

Ancillary Type:

☐ 664 - Adult Day Care	☐ 913 - Hemodialysis – Dialysis Center	☐ 738 - Portable - Mobile X-Ray
☐ 670 - Ambulance	☐ 668 - Home Care Services ☐ AIDs, ☐ CDPAP, ☐ SNP, ☐ Priv Duty	☐ 200 - Radiology/Imaging Center
☐ 993 - Ambulatory Surgery Center	☐ 032 - Home Infusion	☐ 934 - Radiation Oncology Therapy Centers
☐ 599 - Clinical Laboratory	☐ 669 - Hospice	☐ 029 - Sleep Disorder Lab
☐ 821 - Birth Center	☐ 899 - Hospital	☐ 660 - Skilled Nursing Facility –Sub-Acute LTCF
☐ 304 - Outpatient Rehab Facility (CORF)	☐ 660 - Institutional Long-Term Care	☐ 823 - Urgent Care Center
☐ 307 – DME	☐ 304 - Inpatient Acute Rehab	☐ 88 - Voluntary Foster Care – Article 29L
☐ 405 - Federally Qualified Health Centers	☐ 599 - Laboratories	☐ Other:
☐ 671 - Transportation – Non-Emergent	☐ 633 - Nursing Home Care Short Term Rehab	☐

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: ____/____/____;
☐ DNV, Expiration Date: ____/____/____;
☐ JCAHO: Expiration Date: ___/___/____
☐ CHAP, Expiration Date: ____/____/____
☐ TJC, 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.

☐ 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 misrepresents- 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: _____/_____/

PROVIDER- CONTACT INFORMATION FORM

Primary Officer – Administration/Contracting/Eblast (general email)

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

Medical Director, if applicable

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

Billing/Claims Contact

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

HEDIS/IPRO Contact

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

Medical Records Contact

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

Case Management Contact

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

Office Manager Contact

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

Credentialing Contact

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

Contract Contact

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

LYLU Contact

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

Appeals & Grievances Contact

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

Reporting Contact

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

Membership Rosters (panel reports)

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

Other: Identify contact type

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

Other: Identify contact type

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

Other: Identify contact type

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

Other: Identify contact type

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Telephone #:	Fax #:	E-mail Address:

Other: Identify contact type

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

Other: Identify contact type

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

Other: Identify contact type

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

SPECIALTY SERVICE TYPE & CODE FORM

Place an X next to the service(s) that may be applicable.

Primary Care Services:

☐ 050 - Family Practice / 056 - Adol Med	☐ 776 - General Practice	☐ 060 - Internal Medicine
☐ 066 - Infectious Disease	☐ 150 – Pediatrics ☐ 056 – Adolescent Ped.	PCP: ☐ HIV PCP / ☐ NON- HIV

Specialty Services Type:

☐ 360 - Addiction Medicine	☐ 516 - Endocrinology	☐ 105 – National Diabetes Preventive Program
☐ 290 - Acupuncturist	☐ 063 - Endocrinology & Metabolism	☐ 155 - Neonatal- Perinatal Medicine
☐ 303 - AIDs / HIV Services	☐ 906 - Family Planning	☐ 067 - Nephrology
☐ 915 - Allergy	☐ 405 - Federally Qualified Health Ctr(FQHC)	☐ 199 - Neurodevelopmental Disabilities
☐ 010 - Allergy &Immunology	☐ 009 - Fem. Pelvic Med. & Recons. Surgy.	☐ 194 - Neurology
☐ 020 - Anesthesiology	☐ 064 - Gastroenterology	☐ 070 - Neurological Surgery
☐ 640 - Audiology	☐ 210 - General Surgery	☐ 083 - Neuromuscular Medicine
☐ 028 - Behavioral Analysis	☐ 620 - Geriatric Family Medicine	☐ 085 - Neurotology
☐ 750 - Buprenorphine Prescribers	☐ 621 - Geriatric - Internal	☐ 080 - Nuclear Medicine
☐ 927 - Cardiology	☐ 905 - Gynecology	☐ 782 - Nurse Midwife
☐ 651 - Cardio-Thoracic	☐ 242 - Gynecology Oncology	☐ 779 - Nurse Practitioner
☐ 062 - Cardiovascular Disease	☐ 113 - Hand Surgery	☐ 909 - Nutritionist
☐ 095 - Certified Diabetes Education	☐ 112 - Hand Surgery - Plastic Surgery	☐ 089 - Obstetrics and Gynecology
☐ 193 - Child Neurology	☐ 111 - Hand Surgery - Ortho Surgery	☐ 183 - Occupational Medicine
☐ 191 - Child Psychiatry	☐ 613 - Harm Reduction Services	☐ 241 - Oncology
☐ 162 - Chiropractic- Osteopathic Manipulat.	☐ 480 - Hematology	☐ 934 - Oncology - Therapy (Radiat / Chemo)
☐ 180 - Clinical Biochemical Genetics	☐ 137 - Hematology - PSC Path	☐ 100 - Ophthalmology
☐ 653 - Clinical Cardiac Electrophysiology	☐ 066 - Infectious Disease	☐ 714 - Optometry
☐ 171 - Clinical Molecular Genetics	☐ 652 - Interventional Cardiology	☐ 716 - Optometrist/Diagnostic Pharm
☐ 030 - Colon & Rectal Surgery	☐ 092 - Maternal and Fetal Medicine	☐ 912 - Orthodontist
☐ 165 - Critical Care/Trauma Car	☐ 811 - Maxillofacial Surgery	☐ 801 - Orthodontics
☐ 040 - Dermatology	☐ 187 - Medical Genetics	☐ 950 - Orthopedic Medicine
☐ 800 - Dentistry - (815, 911)	☐ 304 - Medical Rehabilitation	☐ 110 - Orthopedic Surgery
☐ 903 - Diabetes	☐ 139 - Medical Microbiology	☐ 120 - Otolaryngology
☐ 250 - Emergency Medicine	☐ 074 - Medical Toxicology	☐ 630 - Pain Management

Specialty Services Type: ***Page 2***		
☐ 190 - Pain Management -Psych& Neuro	☐ 145 - Pediatric Transplant Hepatology	☐ 602 - Sports Medicine - Internal
☐ 826 - Palliative Care Provider	☐ 231 - Pediatric Urology	☐ 604 - Sports Medicine - Orthopedic
☐ 135 - Pathology - (138, 142, 146)	☐ 160 - Physical Medicine & Rehabilitation	☐ 603 - Sports Medicine - Pediatric
☐ 804 - Pedodontics	☐ 170 - Plastic Surgery	☐ 301 - Therapy: Occupational
☐ 151 - Pediatric Cardiology	☐ 114 - Plastic Surgery with Head & Neck	☐ 300 - Therapy: Physical
☐ 073 - Pediatric Dermatology	☐ 778 - Podiatry	☐ 674 - Therapy: Respiratory
☐ 156 - Pediatric Endocrinology	☐ 192 - Psychiatry (195/780)	☐ 302 - Therapy: Speech
☐ 163 - Pediatric Gastroenterology	☐ 184 - Public Health - Preventive Medicine	☐ 220 - Thoracic Surgery
☐ 152 - Pediatric Hematology- Oncology	☐ 068 - Pulmonary Diseases	☐ 144 - Transplant Hepatology
☐ 061 - Pediatric Infectious Disease	☐ 200 - Radiology	☐ 741 - Transplant Surgery
☐ 154 - Pediatric Nephrology	☐ 244 - Radiologist Oncology	☐ 075 - Undersea & Hyperbaric
☐ 072 - Pediatric Neurosurgery	☐ 304 - Rehabilitation Medicine	☐ 230 - Urology
☐ 101 - Pediatric Ophthalmology	☐ 093 - Reproductive Endocrinology	☐ 246 - Vascular and Interventional Radiology
☐ 121 - Pediatric Otolaryngology	☐ 069 - Rheumatology	☐ 243 - Vascular Medicine
☐ 157 - Pediatric Pulmonology	☐ 033 - Sleep Medicine Physician	☐ 240 - Vascular Neurology
☐ 076 - Pediatric Rehabilitation Medicine	☐ 781 - Social Work and Home based MSS	☐ 650 - Vascular Surgery
☐ 059 - Pediatric Rheumatology	☐ 071 - Spinal Cord Injury	☐ Other:
☐ 153 - Pediatric Surgery	☐ 601 - Sports Medicine - Family Med	☐

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

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