

Facility Initial Credentialing Application Carelon Behavioral Health

Please indicate below each plan designation requested for this application submission

- ☐ Carelon Behavioral Health ☐ MBHP/HNE (Mass. Behavioral Health Partnership/Health New England)
☐ MEC (Michigan Engagement Center)

FACILITY CHECKLIST (2 pages)

To ensure timely processing of your application, please return the following:

- ☐ Completed Facility Application (Attached)
- ☐ Completed Service Location Addendum(s) - One Per Service Location (Attached)
- ☐ Copies of all applicable state or agency licenses
- ☐ Copy of current medical malpractice, comprehensive professional, general and/or umbrella liability insurance certificates that identifies the limits of liability of \$1mil/\$3mil and the policy period (documents must show "Professional Liability")
- ☐ Completed W-9 form or IRS Letter
- ☐ NPI (National Provider Identification)
- ☐ Staff Roster if applicable **(Required for WA state DCR's)**
[Facility Roster](#) We encourage you to submit roster updates via our template through the portal. If you are unable to submit the roster electronically, we ask that the completed excel roster be returned via email to facilityrosters@carelon.com.
- ☐ The Americans with Disabilities Act (ADA) Form
- ☐ Accreditation Certificate(s):
- AAAHC – Accreditation Association for Ambulatory Health Care
 - AOA – American Osteopathic Association
 - CARF – Council on Accreditation of Rehabilitation Facilities
 - CHAP – Community Health Accreditation Program
 - COA – Council On Accreditation
 - DNV – Det Norske Veritas
 - HFAP – Healthcare Facilities Accreditation Program
 - TJC – The Joint Commission
- ☐ Current CMS / State Site Visit / Survey (If not Accredited) (Not required if deemed rural)
[https:// findahealthcenter.hrsa.gov/](https://findahealthcenter.hrsa.gov/)

☐ Certification(s):

- Other State licensure reports (i.e., Dept. of Human Services, Dept. of Mental Health and Mental Retardation)
 - o Please Specify:
- SAMHSA – Substance Abuse and Mental Health Services Administration
- NDA Approval Letter - Department of Health and Human Services Spravato (esketamine) **(INCLUDE COPY OF LETTER)**
- CLIA - Clinical Laboratory Improvement Amendments, if applicable
- Medicaid
- Medicare

NON-ACCREDITED ORGANIZATIONS:

If your organization is not accredited by TJC, CARF, COA, AOA, CHAP, AAAHC, DNV or HFAP, then a site review of your Facility/Program will need to be conducted based upon the need for providers in your area. A site survey preparation document will be sent to you in advance of the site survey which will be scheduled at a mutually agreed upon date. A copy of a CMS Certification letter or on site survey results performed by the State may be accepted in lieu of an on-site review by Carelon or its preferred vendor. If your facility is located in a rural area as defined by the US Census Bureau, no site visit is necessary. If adding satellite clinic locations and the policies and processes are the same as main site, no additional site visits needed.

INDIVIDUAL TAX IDENTIFICATION NUMBERS AND NPI NUMBERS:

Carelon Credentials and Contracts facilities based on single Tax Identification Numbers (TIN's/EIN's). If your organization bills under multiple Tax Identification Numbers, you will need to complete multiple application packets. However, if your organization has multiple NPI (National Provider Identification) numbers, please include that information in this application with an explanation to which programs and/or locations to which the multiple NPI numbers apply.

A. Corporate Health System (Please complete if Facility/Program is part of a corporate health system):

Corporate Name	Contact Name	Title		
Mailing Address Line 1		Mailing Address Line 2		
City	State	Zip	Phone Number	Fax Number
Email Address:		Website:		

D. Business Classification

- a. Ownership (Must Check 1): ☐ Private ☐ Public ☐ Government
- b. Status (Must Check 1): ☐ For-Profit ☐ Not-for-profit
- c. Pennsylvania Medicaid Only: ☐ Single County ☐ Base Service Unit ☐ Not Applicable
- d. Colorado Medicaid Only: ☐ Rural Health Center ☐ Federally Qualified Health Center

Facility Website: _____

E. License/Certification

This organization is accredited or certified by one or more of the following:

- ☐ AAAHC ☐ CARF ☐ COA ☐ HFAP
☐ AOA ☐ CHAP ☐ DNV ☐ TJC

Other _____

Medicare # _____

Medicaid # _____

Provider Profile / Malpractice Claims History

Please attach a detailed explanation for any questions below (1-5) that were answered "YES":

A. Please answer the following questions regarding your organization's behavioral health program(s):

- 1) Has the facility/program had professional liability insurance refused, revoked, declined or accepted on special terms in the past five years? Yes ☐ No ☐
- 2) Has any government agency suspended, revoked, or taken other action against the facility/program's license to conduct business in the past five years? (To include Medicaid /Medicare) Yes ☐ No ☐
- 3) Have any memberships in professional organizations and/or accreditations been revoked, reduced, denied, or suspended by others or voluntarily given up by the facility/program in the last five years, or are any actions now under way which may lead to such sanctions? Yes ☐ No ☐
- 4) Have any owners, officers, or shareholders of the facility/program ever been convicted of a crime, excluding misdemeanors? Yes ☐ No ☐
- 5) Has the facility/program ever been previously denied acceptance into the Carelon Network, disenrolled from the Carelon Network, or withdrawn from Carelon Network participation? Yes ☐ No ☐

***Please complete the malpractice claim information worksheet on the following page for any questions below (6-7) that were answered "YES":**

- 6) Has the facility/program had any settled claims or judgments relating to sexual misconduct or civil rights violations in the past five years? If Yes, enter the total number: Yes ☐ No ☐
- 7) If the facility/program is not TJC, AOA, CARF, COA, CHAP or AAAHC accredited, please answer the following question: Has the facility/program been a defendant in five (5) or more lawsuits within the past five (5) years in regard to the practice of behavioral health treatment or any lawsuits in the past five (5) years where there has been awards or payments of \$250,000.00 (two hundred and fifty thousand dollars) or more? If Yes, enter the total number: Yes ☐ No ☐ N/A ☐ Only if accredited
- 8) Does the facility/program comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities (to include owners, officers, employees, subcontractors, and others identified in §1128)? Yes ☐ No ☐

****Please provide a detailed explanation for question 8 if answered "NO".**

MALPRACTICE CLAIM INFORMATION WORKSHEET

B. Please attach information on what the organization's response was to the allegations and what steps were taken to prevent any future incidents for each claim listed below. This page can be copied to accommodate additional claim information.

1. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: \$				

2. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: \$				

3. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: \$				

4. Date of Occurrence:	Date Claim Filed:	Date of Settlement:		
Allegations and Action Taken:				
Case Settled:	☐ In Court	☐ Out-of-Court	☐ With Prejudice	☐ Without Prejudice
Total Amount Paid to Claimant on Behalf of Facility/Program: \$				

III. DEMOGRAPHIC DATA

This information is for demographic purposes only, and will not be used for credentialing. This information will be used in the aggregate, to supply data to state and federal government agencies, as part of the state and federal contracting process.

Please be advised that the following information will be disclosed only to the state and federal government for the purposes outlined above.

1. Could your business be classified as a small business, as defined by the Small Business Administration?

*Small Business Enterprise is defined as a corporation, partnership, sole proprietorship, or other legal entity formed for the purpose of making a profit, which is independently-owned and operated, has **either** fewer than 100 employees **or** less than \$1,000,000 (one million dollars) in annual gross receipts.*

☐ Yes ☐ No

2. Could your business be classified as a women-owned business, as defined by the Department of Minority Enterprises?

Women-Owned Business is defined as a business enterprise at least 50 percent of which is owned by women or (in the case of a publicly-owned business) where at least 51 percent of the stock is owned by women.

☐ Yes ☐ No

3. Could your business be classified as a minority-owned business, as defined by the Department of Minority Enterprises?

Minority-Owned Business is defined as a business enterprise that is owned and controlled by one or more socially and / or economically disadvantaged persons. Such disadvantages may arise from cultural, racial, chronic economic circumstances or background or other similar cause. Such persons include but are not limited to African Americans, Hispanic Americans, Asian Americans, American Indians, Eskimos and Aleuts.

☐ Yes ☐ No

4. *This question is optional.

If your business could be classified as a minority-owned business, which of the following categories would it fall under may check more than one?

☐ African American

☐ Hispanic American

☐ Asian American

☐ American Indian

☐ Eskimo

☐ Aleuts

☐ Other, please specify: _____

FACILITY SITE VISIT ATTESTATION

Facility Name: _____

TAX ID: _____

Primary Location:

_____	_____	_____	_____
Street	City	State	Zip

Satellite Locations: (attach additional sheet if necessary)

_____	_____	_____	_____
Street	City	State	Zip

_____	_____	_____	_____
Street	City	State	Zip

_____	_____	_____	_____
Street	City	State	Zip

Attestation Statement:

My signature below certifies that all facility locations listed above are requesting to be associated to the Carelon provider network. The facility is attesting that all locations will be required to adhere to policies and procedures as set forth by the above facility name pertaining to the following criteria:

1. Adequate parking with parking on premises or in immediate vicinity readily available.
2. Accessible to the disabled or alternative arrangements to serve those with special needs.
3. Restrooms available to members and accessible for disabled.
4. Member access to a telephone on premises.
5. Elevator if the office is above the first floor; elevators regularly inspected and posted.
6. Office is well maintained, in reasonably good repair and has appropriate professional appearance.
7. Adequate seating in the waiting area and treatment areas.
8. Office and/or emergency exit(s) clearly marked.
9. Working smoke detector/fire alarm/sprinkler system present.
10. All documents including appointment schedules, treatment records and forms are kept out of public view and in a secured location not accessed by unauthorized persons.
11. Confidential verbal communication is not audible to unauthorized persons.
12. Computer screens with patient information are kept out of public view and are accessible only by authorized persons.
13. Appointments available for:
 - i. Life-threatening emergencies available immediately or within 30 minutes
 - ii. Non-life-threatening emergencies available within 6 hours
 - iii. Urgent needs available within 48 hours
14. Routine appointments available within 10 calendar days.
15. Ability to track member waiting time for scheduled appointments?
16. Adequate mechanism for members to contact him/her after hours and in emergency situations.
17. Member rights & responsibilities should be provided to members or posted in either waiting or treatment areas.
18. Grievance procedures should be provided to members or posted in either waiting or treatment areas.
19. Practitioner's degree and license posted in public view.
20. Written procedures for the provision of language interpretation and translation services for any enrollee who needs such services, including, but not limited to members with limited English proficiency.

Signature of Applicant

Title

Date

Signature Name