Application Checklist for Facilities

AmeriHealth Caritas Louisiana

Please use the following checklist to complete the credentialing process. Current copies of all items listed below are required for each facility to participate with AmeriHealth Caritas Louisiana.

Use this Application Checklist as a fax cover sheet. Fax all applicable items on the checklist to the Credentialing department at **1-225-300-9199**, or signed documents may be scanned and submitted by secure e-mail to **Credentialing@amerihealthcaritasla.com.** Please ensure this checklist is submitted with the documents.

Please provide AmeriHealth Caritas Louisiana with the following:

Facility information	
Legal business name:	Facility Tax ID Number (TIN):
Facility name to appear in directory (DBA):	
Facility NPI number: (Please list all NPI numbers. Attach additional sheet if needed.)	
Medicaid ID number:	Facility type:
Taxonomy:	Health system affiliation:
County/parish:	Fax number:
Hours of operation:	Remit address:
Remit phone number:	Remit fax number:
Credentialing contact name:	
Credentialing contact email address:	Credentialing contact phone number:

Please provide current copies of the following supporting documents (Do not submit until all documents are current.):

☐ Facility credentialing application (completed, signed, and dated within the last 120 days). **Application for new credentialing only. For recredentialing, please complete this checklist and include all below applicable documents.**

☐ State license (applicable to state requirements)

- State license
- Business permit
- Occupational license
- Medical gases permit

☐ Accreditation, Certification, or Centers for Medicare & Medicaid Services (CMS) State Survey or Site Evaluation

- Note: Any hospital or ancillary facility that is not accredited requires a CMS State Survey or Plan Site Evaluation.

☐ Declarations page of malpractice insurance policy and Patient Compensation Fund certificate showing expiration dates and limits of liability

☐ Clinical Laboratory Improvement Amendments (CLIA) certificate (if applicable)

☐ Medicare/Medicaid certification (If not certified, provide proof of participation.)

☐ W-9 form

☐ Ownership Disclosure

To check the status of your application or if you have any questions or concerns regarding this process, please contact the AmeriHealth Caritas Louisiana Credentialing Department at **1-888-913-0349**.

If you are new to AmeriHealth Caritas Louisiana and you or your group does not have a provider contract, you must first call **1-877-588-2248** to discuss obtaining an AmeriHealth Caritas Louisiana Provider Agreement.

Facility Credentialing Application

AmeriHealth Caritas Louisiana

Facility identification	
Legal business name (as reported to the IRS):	Medicaid number:
Doing Business As (DBA) name (if applicable):	Medicare number:
Health system affiliation (if applicable):	Tax Identification Number (TIN):
Length of time in business with this name and TIN: _____ years _____ months	National Provider Identifier (NPI) number:

Facility information (please refer to attachment A for services provided at this location/site and additional locations).	
Facility name:	
Address line 1:	Address line 2:
City:	State:
ZIP code:	County:
Phone:	Fax:
Website:	
Credentialing contact name:	
Phone:	Fax:
Email:	
Facility administrator name:	
Phone:	Fax:
Email:	

Office hours (use HH:MM format)

Day	Start	A.M./P.M.	End	A.M./P.M.	Day	Start	A.M./P.M.	End	A.M./P.M.
Monday					Saturday				
Tuesday					Sunday				
Wednesday					Services at this location: ☐ Americans with Disabilities Act (ADA) accessibility requirements ☐ Handicap accessibility ☐ 24/7 phone coverage ☐ Answering service				
Thursday									
Friday									

Mailing/correspondence address

☐ Check here if all correspondence can be directed to the facility location above. If not, complete the section below:	
Name:	
Mailing address 1:	
Mailing address 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Email:	

Remit/billing address

Name:	
Mailing address 1:	
Mailing address 2:	
City:	State:
ZIP code:	County:
Phone:	Fax:
Email:	

Facility type

☐ Ambulatory surgical center — free-standing only
☐ Comprehensive outpatient rehabilitation facilities (CORFs)
☐ Durable medical equipment supplier
☐ Dialysis center
☐ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) clinic
☐ Free-standing radiology center
☐ Free-standing sleep center/sleep lab
☐ Home health care agency providing both skilled services and personal care assistance (PCA) services
☐ Home health care agency providing skilled services only and no PCA services
☐ Home health hospice
☐ Home infusion
☐ Hospital (acute care and acute rehabilitation)
☐ Hospital (psychiatric)
☐ Intermediate care facility — mental health
☐ Nursing home
☐ Portable X-ray suppliers
☐ Skilled nursing facility/nursing home
☐ Skilled nursing facility providing sub-acute services
☐ Other (please indicate):

Behavioral health type and description (please indicate service type.)

MH = mental health SU = substance use

☐ MH ☐ SU ☐ Both	Applied behavioral analysis
☐ MH ☐ SU ☐ Both	ASAM Level I — outpatient SA disorder (Behavioral Health Service license required)
☐ MH ☐ SU ☐ Both	ASAM Level II.1 (Intensive Outpatient SA license required)
☐ MH ☐ SU ☐ Both	ASAM Level II D ambulatory detox — with on-site monitoring (Outpatient license required)
☐ MH ☐ SU ☐ Both	Inpatient psych hospital (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.1 clinically managed low-intensity residential (halfway house) — adolescent (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.1 clinically managed low-intensity residential (halfway house) — adult (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.2D clinically managed social detoxification (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.3 clinically managed medium intensity residential — adult (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.5 clinically managed high intensity residential — adult (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.5 clinically managed high intensity residential — adolescent (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.7 medically monitored high intensity, inpatient, co-occurring — adolescent (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.7 medically monitored high intensity inpatient, co-occurring — adult (license required)
☐ MH ☐ SU ☐ Both	ASAM Level III.7D medically monitored detox (license required)
☐ MH ☐ SU ☐ Both	ASAM Level IV inpatient alcohol/drug detoxification (license required)
☐ MH ☐ SU ☐ Both	Community psychiatric supportive treatment (CPST) (Behavioral Health Service license required)
☐ MH ☐ SU ☐ Both	Crisis intervention (Behavioral Health Service license required)
☐ MH ☐ SU ☐ Both	Psychosocial rehabilitation (PSR) (Behavioral Health Service license required)
☐ MH ☐ SU ☐ Both	Psych outpatient
☐ MH ☐ SU ☐ Both	Multi-systemic therapy for juveniles (MST) (certification required)
☐ MH ☐ SU ☐ Both	Laboratory services
☐ MH ☐ SU ☐ Both	Assertive community treatment (ACT) (SAMHSA Tool Kit required; initial and quarterly)
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☐ MH ☐ SU ☐ Both	Homebuilder (certification required)
☐ MH ☐ SU ☐ Both	Substance use residential treatment facility (license required)
☐ MH ☐ SU ☐ Both	Psychiatric residential treatment facility (PRTF) (license required)
☐ MH ☐ SU ☐ Both	Psychiatric residential treatment facility (PRTF) — addiction (license required)
☐ MH ☐ SU ☐ Both	Psychiatric residential treatment facility (PRTF) — other specialization (license required)
☐ MH ☐ SU ☐ Both	Psychiatric residential treatment facility (PRTF) — hospital based (license required)
☐ MH ☐ SU ☐ Both	Therapeutic foster care (TFC) — children/adolescents
☐ MH ☐ SU ☐ Both	Supportive living community residential crisis bed
☐ MH ☐ SU ☐ Both	Outpatient eating disorder
☐ MH ☐ SU ☐ Both	Inpatient ECT
☐ MH ☐ SU ☐ Both	Group home substance abuse
☐ MH ☐ SU ☐ Both	Support wrap around services
☐ MH ☐ SU ☐ Both	Therapeutic group home (TGH) (psychiatric-license required) (cannot exceed eight beds)
☐ MH ☐ SU ☐ Both	Therapeutic group home (TGH) — substance abuse (license required)
☐ MH ☐ SU ☐ Both	Crisis stabilization (HCBS license required) (Respite care services agency/center based respite/ crisis receiving center)

Waiver services (please list waiver type and all services):	
Mental health	**Substance use disorder**

Other services:	
Mental health	**Substance use disorder**

Health care licensure

Attach a copy of each facility licensure(s). Do not submit practitioner licensure(s).

License number	State or city	Licensing agency	Initial issue date	Renewal date	Expiration date

Medicare status

1. Is this facility participating in the Medicare program? ☐ Yes ☐ No ☐ Pending

   If yes, provide Medicare number: _____

2. Is this facility Medicare (Centers for Medicare & Medicaid Services [CMS]) certified? ☐ Yes ☐ No ☐ Pending

   If yes, provide date of initial CMS certification: _____ and Medicare certification number: _____

   ☐ Check here if facility is **not eligible** for CMS certification.

Accreditation

Select accrediting agency from the list below. Attach a copy of current accreditation certificate.
If not accredited, skip checklist, and go to the **Site visit requirement** section.

☐ **AAAAPSF** — American Association for Accreditation of Ambulatory Plastic Surgery Facilities

☐ **AAAASF** — American Association for Accreditation of Ambulatory Surgery Facilities

☐ **AAAHC** — Accreditation Association for Ambulatory Health Care

☐ **AASM** — American Academy of Sleep Medicine

☐ **ACHC** — Accreditation Commission for Health Care

☐ **ACR** — American College of Radiology

☐ **AOA** — American Osteopathic Association

☐ **BOC** — Board of Certification

☐ **CABC** — The Commission on Accreditation of Birth Centers

☐ **CARF** — Commission on Accreditation of Rehabilitation Facilities

☐ **CCAC** — Continuing Care Accreditation Commission

☐ **CHAP** — Community Health Accreditation Partner

☐ **COA** — Council on Accreditation

☐ **DNVHC** — Det Norske Veritas Healthcare Inc.

☐ **NIAHO** — National Integrated Accreditation for Healthcare Organizations

☐ **The Joint Commission** — previously known as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)

Date of initial accreditation: _____

Date of last full survey: _____

Site visit requirement

Attach a copy of most recent onsite survey for each location (with Corrective Action Plan [CAP], if citations were issued); or attach cover letter from government agency stating organizational provider is in substantial compliance.

1. Has facility had a post-licensing onsite visit by a government agency such as the Department of Health (DOH) or CMS within the past 36 months?

   ☐ Yes Date of most recent standard survey: _____

   ☐ No **Successful completion of a health plan onsite visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A; no recent survey

   If yes, have all deficiencies been corrected?

   ☐ Yes **Provide evidence of state acceptance of your CAP.**

   ☐ No **Provide explanation and your plan to correct all deficiencies.**

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies**.

Practitioner credentialing

Does the facility validate, for each licensed practitioner employed or contracted at the facility, the credentials necessary to perform health care services? ☐ Yes ☐ No

If yes, indicate how the facility conducts the credentialing process for each practitioner:

☐ Credentialing procedures are performed internally.

☐ Credentialing procedures are outsourced/delegated to: _____

☐ Other, specify: _____

If no, please explain: _____

Insurance

Both facility general and professional liability are required. Minimum coverage requirement is $1 million per occurrence and $3 million aggregate.*

*Minimum coverage requirements exceptions:

- Durable Medical Equipment providers: $100,000 per occurrence and $300,000 aggregate
- Personal Care Services agencies: $100,000 per occurrence and $300,000 aggregate

General liability coverage

Attach certificate showing policy number, coverage amounts, effective date, and expiration date.

Current carrier name:	Policy number:
Street/P.O. box:	City:
State:	ZIP code:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence-based ☐ Claims-based	

Professional liability coverage

Attach certificate showing policy number, coverage amounts, effective date, and expiration date.

Current carrier name:	Policy number:
Street/P.O. box:	City:
State:	ZIP code:
Effective date:	Expiration date:
Per incident: $	Aggregate: $
Coverage type: ☐ Occurrence-based ☐ Claims-based	

Attachments

Indicate which documents are being included with this completed application.

- ☐ Copy of all federal, state, and/or local licenses required to operate as a health care organizational provider
- ☐ Copy of organizational provider's General Liability Insurance certificate
- ☐ Copy of Professional Liability Insurance certificate covering all organizational provider employees
- ☐ Copy of accreditation certificate(s), if applicable
- ☐ Copy of CMS letter certifying/recertifying organizational provider to provide partial hospitalization services, if applicable
- ☐ Copy of most recent CMS or DOH survey including your CAP, if deficiencies were cited, or cover letter from CMS/DOH stating organizational provider is in compliance

Disclosure questions

Answer every question Yes or No.
Provide a detailed explanation on a separate sheet for any question(s) answered Yes.

1. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been convicted of any health-care-related criminal offense, had adjudication withheld on any health-care-related criminal offense, pleaded no contest to any health-care-related criminal offense, or entered into a pre-trial agreement for any health-care related criminal offense?	☐ Yes ☐ No
2. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	☐ Yes ☐ No
4. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had his/her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a Consent Order issued by a licensing, certifying, or professional standards board or agency?	☐ Yes ☐ No
5. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	☐ Yes ☐ No
6. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any Federal Executive Branch procurement or non-procurement program?	☐ Yes ☐ No
7. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	☐ Yes ☐ No
8. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fine(s) have been paid in full?	☐ Yes ☐ No

Disclosure questions (continued)	
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the facility, under any current or former name or business identity?	☐ Yes ☐ No
10. Does the facility or any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	☐ Yes ☐ No
11. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health-care item or services?	☐ Yes ☐ No
12. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to the delivery of an item or service under Medicare or State health care program?	☐ Yes ☐ No
13. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
14. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been found to have violated federal or state laws, rules or regulations in any program established under Medicare, any other state's Medicaid program, or Title XX, any other publicly funded federal or state health care, or health insurance program?	☐ Yes ☐ No

Attestation

I certify that the information contained in this application is correct and complete to the best of my knowledge. I hereby authorize AmeriHealth Caritas to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation, or operations to AmeriHealth Caritas. I authorize and agree that AmeriHealth Caritas, its agents, employees, and representatives may provide AmeriHealth Caritas' subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing, or peer review. I release AmeriHealth Caritas, its affiliates, agents, employees, and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize AmeriHealth Caritas and its applicable subsidiaries and affiliates to use the information provided in their selection, credentialing, and recredentialing process, and to verify such information as appropriate.

Authorized signature	Print name
Title	Date

Attachment A: Additional Site/Location Addendum

Please copy this page for additional sites.

Complete Section C only if you are an accredited or deemed behavioral health provider organization.

List services by site.

Section A: Demographics (if primary location, please skip to Section C)	
Location/site name:	
Service site address (no P.O. box):	
Billing National Provider Identifier (NPI) or atypical number:	Medicaid number (if applicable):
Remittance address (if different from primary location/site):	

Office hours (use HH:MM format)

Day	Start	A.M./P.M.	End	A.M./P.M.	Day	Start	A.M./P.M.	End	A.M./P.M.
Monday					Saturday				
Tuesday					Sunday				
Wednesday					Services at this location: ☐ Americans with Disabilities Act (ADA) accessibility requirements ☐ Handicap accessibility ☐ 24/7 phone coverage ☐ Answering service				
Thursday									
Friday									

Section B: Site visit requirement

Attach a copy of most recent onsite survey for each location with Corrective Action Plan (CAP).

1. Has facility had a post-licensing onsite visit by a government agency such as the DOH or CMS within the past 36 months?

   ☐ Yes Date of most recent standard survey: _____

   ☐ No **Successful completion of a health plan onsite visit will be required to complete credentialing.**

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A; no recent survey

   If yes, have all deficiencies been corrected?

   ☐ Yes **Provide evidence of state acceptance of your CAP.**

   ☐ No **Provide explanation and your plan to correct all deficiencies.**

   If no deficiencies were cited during the last full survey, **submit verification of no deficiencies**.

Section C: Services available at this location/site (check all that apply)

MH = mental health SU = substance use

☐ MH ☐ SU ☐ Both	Applied behavioral analysis
☐ MH ☐ SU ☐ Both	ASAM Level I — outpatient SA disorder (Behavioral Health Service license required)
☐ MH ☐ SU ☐ Both	ASAM Level II.1 (Intensive Outpatient SA license required)
☐ MH ☐ SU ☐ Both	ASAM Level II D ambulatory detox — with on-site monitoring (Outpatient license required)
☐ MH ☐ SU ☐ Both	Inpatient psych hospital (license required)
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☐ MH ☐ SU ☐ Both	Laboratory services
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☐ MH ☐ SU ☐ Both	Family functional therapy (FFT) (certification required)
☐ MH ☐ SU ☐ Both	Homebuilder (certification required)
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