SUPERIOR HEALTH PLAN
Facility Credentialing Application

Instructions

- Type or legibly print in black or dark blue ink. ALL fields are required to be completed unless otherwise directed.
- Separate applications are required for each facility location and each facility type. This is generally denoted by NPI#.
- If you have questions, contact Credentialing at 1-800-820-5686.
- Fax, email or mail completed Credentialing Application along with all required documentation to:
  - **Fax and Email for Initial Credentialing:**
    - **866-224-3339**
    - **SHP-NETWORKDEVELOPMENT@CENTENE.COM**
  - **Fax and Email for Recredentialing:**
    - **866-702-4831**
    - **credentialing@centene.com**
  - **Mail for Initial Credentialing:**
    - **SHP Network Development PO Box 140166, Austin, TX 78714-0166**
  - **Mail for Recredentialing:**
    - **SHP Credentialing 2100 South IH-35, Suite 202, Austin, TX 78704**

Please attach a copy of the following with this completed application

- ☐ A signed and dated W9
- ☐ Copy of the Federal, State and/or local License required to operate as a Health Care Facility
- ☐ Copy of facility's General Liability Insurance Certification (showing amounts, dates of coverage, policy # and insurance carrier name)
- ☐ Copy of Accreditation Certificate(s)
- ☐ If no Accreditation Certification, a copy of CMS letter certifying/recertifying facility if deficiencies were cited, or cover letter from CMS stating facility is in substantial compliance or a copy of the State Site Survey is required.
- ☐ If deficiencies are cited, a copy of most recent DHS Licensing Review Report and Correction order including facility's corrective plan or cover letter from DHS stating all citations have been corrected is required.
- ☐ Copy of other applicable State/Federal Licensures (i.e. CLIA, Bureau of Radiation Control, Pharmacy, Mammogram Certificate, Laser Certificate, DEA, DPS)

Important Notice

Failure to legibly complete all sections of this Application and submit current copies of ALL required documentation will result in processing delays.

Initial credentialing applications WILL be discontinued if requested information is NOT provided within 60 days of Superior's receipt of an application. Any facility providing information after the 60 days will have to start the credentialing process over again.

FACILITY DEMOGRAPHICS
(must be a street address, not a post office box)

Facility Name:

Address Line 1:

Address Line 2:

City: State: Zip: County:

Facility Phone: Facility Fax:

National Provider Identifier(NPI): ____________________________ TAX ID #: ______________________ Texas Provider Identifier #: _______________________

MAILING/CORRESPONDENCE ADDRESS

❑ **Check here if correspondence address is the same as above** (if not complete the section below)

Mailing Address Line 1:

Mailing Address Line 2:

City: State: Zip:

CREDENTIALING CONTACT

Credentialing Contact Name:

Contact Title:

Phone: Fax: Email:

FACILITY TYPE
(check ONE box per application)

❑ Hospital – All types including Psychiatric
❑ Ambulatory Surgery Center – Free standing only
❑ Home Health Care Agency providing skilled services only – no PAS services
❑ Home Health Care Agency providing skilled services and PAS services
❑ Skilled Nursing Facility/Nursing Home
❑ Sleep Center/Sleep Lab – Free standing only
❑ Diagnostic Radiology
❑ DME
❑ Assisted Living
❑ Other: ________________________________

HEALTH CARE LICENSURE

(attach a copy of each license)

License Number:	**State or City:**	
License Agency:	**Effective Date:**	**Expiration Date:**

MEDICARE INFORMATION

1. Is this facility participating in the Medicare program? ❑YES ❑NO ❑PENDING

If YES, give Medicare provider number:

2. Is this facility Medicare (CMS) certified? ❑YES ❑NO ❑PENDING

If YES, give date of initial CMS certification: ______ /_______ / ______ and

Medicare Certification Number:

❑ Check here if facility is not eligible for CMS Certification.

ACCREDITATION

(check one and attach a copy of the accreditation certification)

❑ **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
❑ **AOA**	American Osteopathic Association
❑ **CARF**	Commission on Accreditation of Rehabilitation Facilities
❑ **CCAC**	Continuing Care Accreditation Commission
❑ **CHAP**	Community Health Accreditation Program
❑ **COA**	Council on Accreditation
❑ **NIAHO**	National Integrated Accreditation for Healthcare Organizations
❑ **JCAHO**	The Joint Commission
❑ **OTHER**	
❑ **NO ACCREDITATION**	Complete the SITE VISIT REQUIREMENT section

Skip the SITE VISIT REQUIREMENT section if Facility has Accreditation

SITE VISIT REQUIREMENT

(attach a copy of the State Site survey)

1. Has the Department of Human Services (DHS) or a government agency delegated by DHS completed a post-licensing onsite survey within the past 36 months?

❑ YES   Date of most recent full survey ______ /_______ / ______

❑ NO   Successful completion of a health plan onsite visit will be required to complete credentialing.

2. Were any deficiencies cited during the last survey? ❑ YES ❑ NO ❑ N/A (no recent survey)

If NO, submit verification of no deficiencies.

If YES, have all deficiencies been corrected?

❑ YES - Provide evidence of acceptance by DHS of your corrective action plan.

❑ NO - Submit your plan to correct all deficiencies

**** If citations were issued, a copy of the most recent onsite site survey with the Corrective Action Plan must be attached.**

**** If no citations were issued, a cover letter from a government agency stating facility is in substantial compliance must be attached.**

**** Attach a copy of the State Site Survey**

INSURANCE / PROFESSIONAL LIABILITY COVERAGE

(attach a copy of the Certificate of Insurance)

Current Carrier Name (not agency):   Policy Number:

Street/PO Box: City: State: Zip:

Effective Date: ______ /_______ / ______   Expiration Date: ______ /_______ / ______

Occurrence Amount: $

Aggregate: $

**** Attach Certificate showing policy number**

HANDICAP ACCESSIBLE

❑ YES Facility is handicap accessible   ❑ NO Facility is not handicap accessible

ATTESTATION

- Every question must be answered.
- Provide a detailed explanation on a separate sheet for any question(s) answered YES.
- Modifications to the wording or format will invalidate this attestation.

1. **Has this facility, under any current or former name or business entity, 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 health care item or service?**

   ❑ YES ❑ NO

2. **Has this facility, under nay current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked, suspended or been issued a conditional license? This includes the surrender of such license while a formal disciplinary proceeding was pending before a state licensing authority.**

   ❑ YES ❑ NO

3. **Has this facility, under any current or former name or business identity, ever had accreditation revoked or suspended?**

   ❑ YES ❑ NO

4. **Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by a federal or state health care program, or any disbarment from participation in any federal executive branch procurement or non-procurement program?**

   ❑ YES ❑ NO

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire application are true, accurate and complete to the best of my knowledge.

I fully understand that any falsification of participating providers or cause for summary dismissal from the health plan, I understand that acceptance of this application does not constitute approval or acceptance of participating status with the health plan and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is the health plan.

____	____
PRINTED NAME OF AUTHORIZED REPRESENTATIVE	AUTHORIZED REPRESENTATIVE'S TITLE
____	____
SIGNATURE OF AUTHORIZED REPRESENTATIVE	DATE SIGNED