Provider Network Contract and Credentialing Checklist for Ancillary and Facility Providers

Thank you for your interest in the Superior HealthPlan Network (SHP). Please use this checklist to ensure you have all necessary contract and credentialing components to avoid processing delays.

Documents contained in this packet which must be completed fully and returned

- ❑ Fully complete Ancillary and Facility Application
- ❑ Signed and dated W9 with IRS registered legal business name and billing address information. Use only *one* TIN or SSN. This legal name must match the name on the Participating Provider Agreement.
- ❑ Signed and dated Participating Provider Agreement. Return entire original contract. Do not populate any effective dates. (Not required for re-credentialing)
- ❑ Read Participation Provider Conflict of Interest and Healthcare Entity Financial Interest Policy and Disclosure Statement in its entirety. Complete and return pages 3 and 4, ensuring you have circled either "I do" or "I do not". Complete and return page 5 only if you are disclosing a prior contract or business relationship with SHP.
- ❑ Read and complete Paper Communication Request Form and return only if you are requesting to receive information in paper form instead of email communication.

Documents you will need to provide

- ❑ Copy of the Federal, State and/or local License
- ❑ Copy of Accreditation Certificate(s)
  - ❑ If not Accredited, please provide one of the following:
    - a copy of the State Site Survey, or
    - a cover letter from CMS stating facility is in substantial compliance, or
    - a copy of CMS letter certifying/recertifying facility if deficiencies were cited
- ❑ Copy of other applicable State/Federal Licensures (i.e. CLIA, Bureau of Radiation Control, Pharmacy, Mammogram Certificate, Laser Certificate, DEA, DPS)
- ❑ Copy of Certificate of Insurance
- ❑ CORF Providers must provide evidence of an Agreement with HHSC.

Return in postage paid envelope or mail to:
SHP Network Operations
PO Box 140166
Austin, TX 78714-0166

- Contact Email: SHP-NETWORKDEVELOPMENT@CENTENE.COM
  (Do not email contract packet to this email address – this is for contact only)
- Contact Phone: (866) 615-9399 x22534

RECREDENTIALING NOTICE

- Recredentialing only documents may be sent to the following:
  - **Email**: credentialing@centene.com
  - **Fax**: (866)702-4831
  - **Mail**: Credentialing Department, 2100 South IH-35, Suite 200, Austin, TX 78704

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 30 days of Superior's receipt of an application. Superior HealthPlan will obtain information from various outside sources (e.g., state licensing agencies, accreditation sources) to evaluate your application. You have the right to review any primary source information that Plan collects during this process. However, this does not include references or recommendations or other information that is peer review protected.

SUPERIOR HEALTHPLAN
Facility/Ancillary Credentialing Application

DEMOGRAPHIC INFORMATION
(must be a street address, not a post office box)

Legal Business Name:
_____

Facility DBA Name:
_____

Address: _____

City: _____ State: _____ Zip: _____ County: _____

Facility Phone: __(_____)_____-_____ Facility Fax: __(_____)_____-_____

Tax ID: _____ Facility NPI: _____ Medicare ID Number: _____Facility TPI_____

Specialty: _____Subspeciality_____

Primary Taxonomy: _____Additional Taxonomy_____
Is this location handicap accessible)? ❑YES ❑NO
Do you perform Advanced Imaging Services (CT/CTA, MRI/MRA, PET scan)? ❑YES ❑NO

MAILING ADDRESS SAME AS ABOVE? YES❑ NO❑ (IF NO, COMPLETE INFORMATION BELOW)
Address: _____

City: _____ State: _____ Zip: _____ County: _____

Facility Phone: __(_____)_____-_____ Facility Fax: __(_____)_____-_____

****SIGNED AND DATED W-9 MUST BE PROVIDED FOR BILLING ADDRESS**

FACILITY TYPES

- ❑ Hospital – (includes both inpatient /outpatient services) (check all that apply)
  - ❑Adult Acute Care
  - ❑Level 1 Trauma
  - ❑Level 2 Trauma
  - ❑Level 3 Trauma
  - ❑Level 4 Trauma
  - ❑CMS designated Children's Hospital
  - ❑Designated Children's Unit
  - ❑Other Specialized Pediatric Services
- ❑ Ambulatory Surgery Center – Free standing only
- ❑ Outpatient Chemotherapy/Infusion
- ❑ Outpatient Dialysis Center
- ❑ CORF/ORF: ❑PT ❑ST ❑OT ❑Cognitive Rehab Therapy (CRT)
- ❑ Therapy Services: ❑PT ❑ST ❑OT ❑ Cognitive Rehab Therapy (CRT)
- ❑ Nursing Facility ❑Number of Skilled Nursing Beds_____ ❑ESRD
- ❑ Long Term Service and Support (LTSS) services ONLY (Complete LTSS section on page __)
- ❑ Home Health Care: ❑PT ❑ST ❑OT ❑PDN ❑Pediatric
- ❑ Home Health Care with (LTSS) services: ❑PT ❑ST ❑OT (Complete LTSS section on page __)
- ❑ DME (Only need to provide the Facility Demographics and License information)
- ❑ LAB (Only need to provide Facility Demographics and CLIA information)
- ❑ Other: _____

HEALTH CARE LICENSURE (attach a copy)

License Number: _____ Effective Date: _____ Expiration Date: _____

TELEHEALTH SERVICES

- ❑ Telemedicine Services (Delivering medical services through technology such as phone or video) ❑Yes ❑No
- ❑ Telemonitoring Services(Patient monitoring remotely via specialized electronic devices) ❑Yes ❑No

IDD PROVIDERS

Do you have experience in treating patients with Intellectual and Developmental Disabilities? ❑ Yes ❑ No

ECP PROVIDERS (AMBETTER PRODUCT ONLY)

Are you considered an Essential Community Provider as defined by CMS? ❑ Yes ❑ No

MINORITY OWNED BUSINESS

Are you designated as a Minority Owed Business: ❑Yes ❑No

MEDICARE INFORMATION

Is this facility Medicare (CMS) certified? ❑YES ❑NO ❑PENDING
If YES, provide current survey date: ____/____ /____ and CMS Certification Number (CCN): _____

Medicare Certified Acute Inpatient Facility complete the following information:
Medicare Certified Bed Count: _____ ICU Bed Count: _____ (excluding Neonatology)
Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____
Pediatric Bed Count:_____

- ❑ Cardiac Surgery Program
- ❑ Cardiac Catherization Services
- ❑ Critical Care Services – Intensive Care Units (ICU)
- ❑ Diagnostic Radiology
- ❑ Mammography
- ❑ Outpatient Physical Therapy
- ❑ Outpatient Occupational Therapy
- ❑ Outpatient Speech Therapy
- ❑ Orthotics and Prosthetics
- ❑ Home Health
- ❑ Durable Medical Equipment
- ❑ Outpatient Infusion/Chemotherapy
- ❑ Outpatient Dialysis
- ❑ Surgical Services (Outpatient or ASC)
- ❑ Skilled Nursing Unit
- ❑ Outpatient Laboratory Services

Medicare Approved Transplant Services

- ❑ Heart Transplant Program
- ❑ Heart/Lung Transplant Program
- ❑ Intestinal Transplant Program
- ❑ Kidney Transplant Program
- ❑ Liver Transplant Program
- ❑ Lung Transplant Program
- ❑ Pancreas Transplant Program

ACCREDITATION
(attach a copy of the accreditation certification)

❑ YES (Entity Name): _____
❑ NO: (Complete the SITE VISIT REQUIREMENT section below)

SITE VISIT REQUIREMENT

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

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: $_____

Long Term Service & Support Provider Demographic Information

LTSS providers only complete pages 4 and 5

Provider Name: _____

DADs Contract ID/IDs (Required) _____, _____, _____, _____, _____

LTSS/API#: _____

Please select service type and specify Rate Enhanced Level (if applicable):

LTSS Service	**Enhancement Level**
❑Assisted Living/Residential Care (X4)	_____
❑Consumer Directed Services (X3)	_____
❑Day Activity Health Services (X1)	_____
❑Emergency Response Services (X6)	_____
❑Personal Assistance Services (X2)	_____
❑Physical Therapy (XB)	_____
❑Occupational Therapy (XC)	_____
❑Speech Therapy and/or Lang Pathology (XD)	_____
❑Adaptive Aids & Medical Supplies (X9)	_____
❑Adult Foster Care (X5)	_____
❑Home Delivered Meals (X8)	_____
❑Minor Home Modifications (XA)	_____
❑Respite Care Services (X4)	_____
❑Transition Assistance Services (X7)	_____
❑Employment Assistance Services (XE)	_____
❑Supported Employment (XS)	

Other Services:

_____

LTSS Service Delivery Areas – Please select counties where you practice.

Bexar SDA	Hidalgo SDA	MRSA Central SDA	MRSA West SDA	
Atascosa ☐	Cameron ☐	Bell ☐	Andrews ☐	Knox ☐
Bandera ☐	Duval ☐	Blanco ☐	Archer ☐	La Salle ☐
Bexar ☐	Hidalgo ☐	Bosque ☐	Armstrong ☐	Lipscomb ☐
Comal ☐	Jim Hogg ☐	Brazos ☐	Bailey ☐	Loving ☐
Guadalupe ☐	Maverick ☐	Burleson ☐	Baylor ☐	Martin ☐
Kendall ☐	McMullen ☐	Colorado ☐	Borden ☐	Mason ☐
Medina ☐	Starr ☐	Comanche ☐	Brewster ☐	McCulloch ☐
Wilson ☐	Webb ☐	Coryell ☐	Briscoe ☐	Menard ☐
	Willacy ☐	DeWitt ☐	Brown ☐	Midland ☐
Dallas SDA	Zapata ☐	Erath ☐	Callahan ☐	Mitchell ☐
Collin ☐		Falls ☐	Castro ☐	Moore ☐
Dallas ☐	**Jefferson SDA**	Freestone ☐	Childress ☐	Motley ☐
Ellis ☐	Chambers ☐	Gillespie ☐	Clay ☐	Nolan ☐
Hunt ☐	Hardin ☐	Gonzales ☐	Cochran ☐	Ochiltree ☐
Kaufman ☐	Jasper ☐	Grimes ☐	Coke ☐	Oldham ☐
Navarro ☐	Jefferson ☐	Hamilton ☐	Coleman ☐	Palo ☐
Rockwall ☐	Liberty ☐	Hill ☐	Collingsworth ☐	Pinto ☐
	Newton ☐	Jackson ☐	Concho ☐	Parmer ☐
El Paso SDA	San Jacinto ☐	Lampasas ☐	Cottle ☐	Pecos ☐
El Paso ☐	Orange ☐	Lavaca ☐	Crane ☐	Presidio ☐
Hudspeth ☐	Polk ☐	Leon ☐	Crockett ☐	Reagan ☐
	Tyler ☐	Limestone ☐	Culberson ☐	Real ☐
Harris SDA	Walker ☐	Llano ☐	Dallam ☐	Reeves ☐
Austin ☐		Madison ☐	Dawson ☐	Roberts ☐
Brazoria ☐	**Lubbock SDA**	McLennan ☐	Dickens ☐	Runnels ☐
Galveston ☐	Carson ☐	Milam ☐	Dimmit ☐	Schleicher ☐
Harris ☐	Crosby ☐	Mills ☐	Donley ☐	Scurry ☐
Fort Bend ☐	Deaf Smith ☐	Robertson ☐	Eastland ☐	Shackelford ☐
Matagorda ☐	Floyd ☐	San ☐	Ector ☐	Sherman ☐
Montgomery ☐	Garza ☐	Saba ☐	Edwards ☐	Stephens ☐
Waller ☐	Hale ☐	Somervell ☐	Fisher ☐	Sterling ☐
Wharton ☐	Hockley ☐	Washington ☐	Foard ☐	Stonewall ☐
	Hutchinson ☐		Frio ☐	Sutton ☐
Nueces SDA	Lamb ☐	**Travis SDA**	Gaines ☐	Taylor ☐
Aransas ☐	Lubbock ☐	Bastrop ☐	Glasscock ☐	Terrell ☐
Bee ☐	Lynn ☐	Burnet ☐	Gray ☐	Throckmorton ☐
Brooks ☐	Potter ☐	Caldwell ☐	Hall ☐	Tom Green ☐
Calhoun ☐	Randall ☐	Fayette ☐	Hansford ☐	Upton ☐
Goliad ☐	Swisher ☐	hays ☐	Hardeman ☐	Uvalde ☐
Jim Wells ☐	Terry ☐	Lee ☐	Hartley ☐	Val Verde ☐
Karnes ☐		Travis ☐	Haskell ☐	Ward ☐
Kenedy ☐	**Tarrant SDA**	Williamson ☐	Hemphill ☐	Wheeler ☐
Kleberg ☐	Denton ☐		Howard ☐	Wichita ☐
Live Oak ☐	Hood ☐		Irion ☐	Wilbarger ☐
Nueces ☐	Johnson ☐		Jack ☐	Winkler ☐
San Patricio ☐	Parker ☐		Jeff Davis ☐	Yoakum ☐
Refugio ☐	Tarrant ☐		Jones ☐	Young ☐
Victoria ☐	Wise ☐		Kent ☐	Zavala ☐
			Kerr ☐	
			Kimble ☐	
			King ☐	
			Kinney ☐	

APPLICATION 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 any 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

CREDENTIALING CONTACT INFORMATION

Contact Name: _____ Contact Title: _____

Phone: (____)____-_____ Fax: (____)____-_____ Email: _____