Hospital Credentialing Application

Thank you for your interest in Superior HealthPlan. Please use this checklist to ensure you have all necessary contract and credentialing items to avoid processing delays.

REQUIRED DOCUMENTS

Below is a check list of documents you will need to complete and provide:

- ☐ Fully completed Hospital Credentialing Application.
- ☐ Signed and dated W-9 with IRS registered legal business name and billing address information. Use only one TIN. This legal name must match the name on the Participating Provider Agreement.
- ☐ Signed Participating Provider Agreement. Return entire original contract. Do not populate effective dates. (Not required for re-credentialing.)
- ☐ Copy of Accreditation Certificate(s):
  - ☐ If not accredited, please provide one of the following:
    - Copy of the State Site Survey.
    - Cover letter from Centers for Medicare and Medicaid Services (CMS) stating facility is in substantial compliance.
    - Copy of CMS letter certifying/recertifying facility, if deficiencies were cited.
- ☐ Copy of the State Hospital License.
- ☐ Copy of other State/Federal Licensure, as applicable: Clinical Laboratory Improvement Amendments (CLIA), Drug Enforcement Administrative (DEA), Department of Public Saftey (DPS), Bureau of Radiation Control, Radiological Laser Certificate, Mammography Certificate, Pharmacy License.
- ☐ Copy of Certificate of Insurance.
- ☐ Copy of Texas Medicaid and Health Partnership (TMHP) Texas Medicaid Provider ID Letter (TPI).
- ☐ Evidence of an agreement with the Texas Health and Human Services Commission (HHSC). Applicable to Comprehensive Outpatient Rehabilitation Facility (CORF) providers only.

Return by mail to:

Superior Network Development/Hospital Contracting
7990 Interstate 10 West, Suite 300
San Antonio, TX 78230

Recredentialing Applications

Re-credentialing applications can be returned using one of the options below:

- **Email:** Credentialing@SuperiorHealthPlan.com
- **Fax:** 1-866-702-4831
- **Mail:** Credentialing Department, 5900 E. Ben White Blvd., Austin, TX 78741

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 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 Superior collects during this process. However, this does not include references, recommendations or other information that is peer-review protected.

DEMOGRAPHIC INFORMATION

Legal Business Name: _____

Facility Name: _____

Physical Address: _____

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

Facility Phone: _____ Facility Fax: _____

Tax ID: _____ NPI: _____ Medicare Certification Number: _____ Facility TPI: _____

Specialty: _____ Sub-specialty: _____

Primary Taxonomy: _____ Additional Taxonomy: _____

Please list additional inpatient hospital facility locations operating under the same Tax ID, NPI, Medicare ID and TPI referenced above to ensure information is updated for Superior Provider Directories. Please attach an additional list if needed.

Facility Name: _____

Physical Address: _____

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

Facility Phone: _____ Facility Fax: _____

Are there additional NPI's used for claim submission purposes covered under the same facility licensure?
☐ Yes ☐ No
If Yes, complete information below.

Additional Facility NPI's: _____

Additional Specialties: _____

Is this location handicap accessible? ☐ Yes ☐ No

Is the mailing address the same as above? ☐ Yes ☐ No
If No, complete the information below.

Mailing Address: _____

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

Facility Phone: _____ Facility Fax: _____

Please note: When attaching your signed and dated W-9, please make sure you list your primary billing address.

HOSPITAL LICENSURE

(Attach a copy)

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

ACCREDITATION

(Attach a copy of the accreditation certification)

☐ Yes - Entity Name: _____

☐ No - Complete the SITE VISIT REQUIREMENT section below.

SITE VISIT REQUIREMENT

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: $ _____

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 Owned Business? ☐ Yes ☐ No

HOSPITAL SERVICES

(Please annotate all applicable services)

☐ **Hospital** - (Includes inpatient and outpatient services.) Check all that apply in this section:

- ☐ 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

Is this facility Medicare (CMS) certified? ☐ Yes ☐ No ☐ Pending

If Yes, provide current survey date: _____ and Medicare Certification Number: _____

Medicare - Certified Acute Inpatient Facility Information

Medicare Certified Bed Count: _____ ICU Bed Count (excluding Neonatology): _____

Skilled Nursing or Swing Bed Count: _____ Inpatient Psychiatric Bed Count: _____

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

Medicare-Approved Transplant Programs

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

BUSINESS DISCLOSURE

Have **You** or any **Affiliate** ever held (prior to now) a provider contract or done other **Business** with Superior HealthPlan or any of its affiliates?

☐ Yes ☐ No

As used above, the capitalized terms are defined as follows:

You - The individual, partnership, corporation or other entity that is entering into a provider agreement with Superior HealthPlan.

Affiliate - An entity that is related by ownership (of any amount) or control (by sharing the same officers or directors) to you or to Superior.

Business - Holding a contract for provider services, vendor services or other services with Superior or an affiliate of Superior.

If **You** answered Yes above, please provide the following information. Please attach additional list if needed.

Legal name of the entity with a prior contract or other business:

_____

_____

_____

Business address of such entity:

_____

_____

_____

Federal tax ID number of such entity: _____

Entity's relationship to you:

_____

_____

_____

Signed: _____ Name: _____

Title: _____ Date: _____

APPLICATION ATTESTATION

Please answer every question below in this section. Every question must be answered. For any question(s) answered Yes, please provide a detailed explanation on a separate document and attach.

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 a 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 is cause for summary dismissal from Superior HealthPlan. I understand that acceptance of this application does not constitute approval or acceptance of participating status with Superior and grants no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is obtained from Superior.

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: _____