Facility and Ancillary 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.

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

- ☐ Fully completed **Facility and Ancillary Credentialing Application**.
- ☐ Signed and dated **Participating Provider Agreement**. Return entire original contract. Do not populate any effective dates. (Not required for re-credentialing.)
- ☐ 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.
- ☐ 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 selected either "Yes" or "No". Complete and return page 7 only if you are disclosing a prior contract or business relationship with Superior HealthPlan.

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:
    - 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 other applicable State/Federal Licensures (i.e. Clinical Laboratory Improvement Amendments [CLIA], Bureau of Radiation Control, Pharmacy, Mammogram Certificate, Laser Certificate, Drug Enforcement Agency [DEA], Department of Public Safety [DPS])
- ☐ Copy of Certificate of Insurance.
- ☐ Copy of Texas Medicaid and Healthcare Partnership (TMHP) Medicaid Letter (when applicable).
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF) providers must provide evidence of an Agreement with the Texas Heath and Human Services (HHS).

Credentialing Applications may be returned to:

- **Mail:** Superior HealthPlan, Contract Management, 7990 Interstate 10 West, Suite 300, San Antonio, TX 78230
- **Email:** SHP.NetworkDevelopment@SuperiorHealthPlan.com

Re-Credentialing Applications may be returned to:

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

For any questions, please reach out to the Superior Provider Services department at 1-877-391-5921.

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

Demographic Information

Legal Business Name: _____

Facility DBA Name: _____

Physical Address (must be a street address): _____

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

Facility Phone: _____ Facility Fax: _____

Tax ID: _____ NPI: _____ Medicare Identification Number: _____

Facility TPI: _____ Specialty: _____ Sub-Specialty: _____

Primary Taxonomy: _____ Additional Taxonomy: _____

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

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.)

Mailing Address (must be an address): _____

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

Facility Phone: _____ Facility Fax: _____

PLEASE NOTE: SIGNED AND DATED W-9 MUST BE PROVIDED FOR BILLING ADDRESS

Ancillary Services

☐ Ambulatory Surgery Center

Are you a Medically Dependent Children Program Provider (MDCP)?
☐ Yes ☐ No

Are you a Prescribed Pediatric Extended Care Center (PPECC)?
☐ Yes ☐ No

☐ CORF/ORF:
- ☐ Physical Therapy (PT)
- ☐ Speech Therapy (ST)
- ☐ Occupational Therapy (OT)
- ☐ Cognitive Rehab Therapy (CRT)

☐ Durable Medical Equipment (DME)

Do you provide Pediatric Services?
☐ Yes ☐ No
If Yes, age range: _____

☐ Home Health Care:
☐ PT ☐ ST ☐ OT ☐ PDN
☐ Home Infusion

☐ Home Health Care with Long-Term Service and Support (LTSS):
☐ PT ☐ ST ☐ OT

☐ Home Infusion

☐ Infusion Center: Outpatient Chemotherapy/Infusion

Is this facility Medicare (CMS) certified (required to participate in Medicaid networks)?
☐ Yes ☐ No ☐ Pending
If Yes, provide current survey date:
_____/ _____/ _____ and
CMS Certification Number (CCN):
_____

☐ Laboratory (only need to provide Facility Demographics and CLIA information)

☐ LTSS

☐ Outpatient Dialysis Center

☐ Therapy Services:
☐ PT ☐ ST ☐ OT ☐ CRT

☐ Urgent Care Center

☐ Other: _____

(Complete LTSS section on page 5, Counties Served on page 6.)

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

1. Has the Texas Department of Health and Human Services (HHS) or a government agency delegated by HHS 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 HHS of your corrective action plan.
   ☐ No - Submit your plan to correct all deficiencies.

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

Intellectual and Developmental Disabilities (IDD) Providers

Do you have experience in treating patients with IDD? ☐ Yes ☐ No

Essential Community Providers (ECP)

(Exchange/Commercial Only)

Are you considered an ECP as defined by CMS? ☐ Yes ☐ No

Minority Owned Business

Are you designated as a Minority Owed Business? ☐ Yes ☐ No

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 Amount: $ _____

MMP Directory Data Element Requirements

(MMP providers - Please complete page 4. A response is required in each section.)

1. Has the practitioner completed cultural competence training?

African American	☐ Yes	☐ No	Hispanic/Latino	☐ Yes	☐ No
Alaskan Native	☐ Yes	☐ No	Pacific Islander	☐ Yes	☐ No
American Indian	☐ Yes	☐ No	Other	☐ Yes	☐ No
Asian	☐ Yes	☐ No			

2. Does your location offer Non-English languages on site by qualified health-care interpreters?

American Sign Language (ASL)	☐ Yes	☐ No	Polish	☐ Yes	☐ No
Arabic	☐ Yes	☐ No	Portuguese	☐ Yes	☐ No
Cantonese	☐ Yes	☐ No	Russian	☐ Yes	☐ No
Haitian	☐ Yes	☐ No	Spanish	☐ Yes	☐ No
Hindi	☐ Yes	☐ No	Tagalog	☐ Yes	☐ No
Italian	☐ Yes	☐ No	Vietnamese	☐ Yes	☐ No
Japanese	☐ Yes	☐ No	Other	☐ Yes	☐ No
Korean	☐ Yes	☐ No			
Mandarin	☐ Yes	☐ No			

3. Do you supply translation services for written materials? ☐ Yes ☐ No

4. Please specify what accessible types of options you have for individuals with physical disabilities?

Parking spaces, curb ramps or loading zones at building entrance: ☐ Yes ☐ No
Doorways wide enough to ensure safepassage by individuals using mobility aids: ☐ Yes ☐ No
Wheelchair accessible restrooms with grab bars and accessible: ☐ Yes ☐ No
ASL signage and raised tactile text characters at office or elevator: ☐ Yes ☐ No
Medical equipment accessible to patients using mobility aids: ☐ Yes ☐ No
Exam rooms accessible to patients using mobility aids: ☐ Yes ☐ No

Other: _____

5. Does the practitioner have specialized training and experience in treating the following?

Physical disabilities	☐ Yes	☐ No
Intellectual and developmental disabilities	☐ Yes	☐ No
Chronic illness	☐ Yes	☐ No
HIV/AIDS	☐ Yes	☐ No
Serious mental illness	☐ Yes	☐ No
Substance abuse	☐ Yes	☐ No
Homelessness	☐ Yes	☐ No
Deafness or hard-of-hearing	☐ Yes	☐ No
Blindness or visual impairment	☐ Yes	☐ No
Co-occurring disorder	☐ Yes	☐ No

Other: _____

6. Is the practitioner's location an accessible public transportation route? ☐ Yes ☐ No

Long-Term Services and Supports Provider Demographic Information

(LTSS providers - Please complete pages 5 and 6.)

Provider Name: _____

DADS Contract ID(s) (Required): _____, _____, _____, _____, _____

NPI or LTSS/API Number: _____

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

LTSS Service	**Enhancement Level**
☐ Adult Day Care (X1)	
☐ Primary Home Care/PAS (X2)	
☐ Transitional Assistant Services (TAS) (XY)	
☐ Financial Management Services (FMS) (XU)	
☐ Value Added (X3)	
☐ Assisted Living/Respite Care (X4)	
☐ Adult Foster Care (X5)	
☐ Emergency Response System (X6)	
☐ Nursing Facility (X7)	
☐ Home Delivered Meals (X8)	
☐ Adaptive Aides/Medical Equipment (X9)	
☐ Minor Home Modifications (XA)	
☐ Physical Therapy (XB)	
☐ Occupational Therapy (XC)	
☐ Speech Therapy (XD)	
☐ Employment Assistance Services (XE)	
☐ Habilitation (XH)	
☐ PAS for CFC only (XN)	
☐ Supported Employment (XS)	

Counties Served

(Please select each county where services can be provided, per each Service Delivery Area [SDA].)

Statewide ☐

Bexar SDA

- ☐ Atacosa
- ☐ Bandera
- ☐ Bexar
- ☐ Comal
- ☐ Guadalupe
- ☐ Kendall
- ☐ Medina
- ☐ Wilson

Dallas SDA

- ☐ Collin
- ☐ Dallas
- ☐ Ellis
- ☐ Hunt
- ☐ Kaufman
- ☐ Navarro
- ☐ Rockwall

El Paso SDA

- ☐ El Paso
- ☐ Hudspeth

Harris SDA

- ☐ Austin
- ☐ Brazoria
- ☐ Galveston
- ☐ Harris
- ☐ Fort Bend
- ☐ Matagorda
- ☐ Montgomery
- ☐ Waller
- ☐ Wharton

Nueces SDA

- ☐ Aransas
- ☐ Bee
- ☐ Brooks
- ☐ Calhoun
- ☐ Goliad
- ☐ Jim Wells
- ☐ Karnes
- ☐ Kenedy
- ☐ Kleberg
- ☐ Live Oak
- ☐ Nueces
- ☐ San Patricio
- ☐ Refugio
- ☐ Victoria

Hidalgo SDA

- ☐ Cameron
- ☐ Duval
- ☐ Hidalgo
- ☐ Jim Hogg
- ☐ Maverick
- ☐ McMullen
- ☐ Starr
- ☐ Webb
- ☐ Willacy
- ☐ Zapata

Jefferson SDA

- ☐ Chambers
- ☐ Hardin
- ☐ Jasper
- ☐ Jefferson
- ☐ Liberty
- ☐ Newton
- ☐ San Jacinto
- ☐ Orange
- ☐ Polk
- ☐ Tyler
- ☐ Walker

Jefferson SDA

- ☐ Carson
- ☐ Crosby
- ☐ Deaf Smith
- ☐ Floyd
- ☐ Garza
- ☐ Hale
- ☐ Hockley
- ☐ Hutchinson
- ☐ Lamb
- ☐ Lubbock
- ☐ Lynn
- ☐ Potter
- ☐ Randall
- ☐ Swisher
- ☐ Terry

Tarrant SDA

- ☐ Denton
- ☐ Hood
- ☐ Johnson
- ☐ Parker
- ☐ Tarrant
- ☐ Wise

MRSA Central SDA

- ☐ Bell
- ☐ Blanco
- ☐ Bosque
- ☐ Brazos
- ☐ Burleson
- ☐ Colorado
- ☐ Comanche
- ☐ Coryell
- ☐ DeWitt
- ☐ Erath
- ☐ Falls
- ☐ Freestone
- ☐ Gillespie
- ☐ Gonzalez
- ☐ Grimes
- ☐ Hamilton
- ☐ Hill
- ☐ Jackson
- ☐ Lampasas
- ☐ Lavaca
- ☐ Leon
- ☐ Limestone
- ☐ Llano
- ☐ Madison
- ☐ McLennan
- ☐ Milam
- ☐ Mills
- ☐ Robertson
- ☐ San Saba
- ☐ Somervell
- ☐ Washington

Travis SDA

- ☐ Bastrop
- ☐ Burnet
- ☐ Caldwell
- ☐ Fayette
- ☐ Hays
- ☐ Lee
- ☐ Travis
- ☐ Williamson

MRSA West SDA

- ☐ Andrews
- ☐ Archer
- ☐ Armstrong
- ☐ Bailey
- ☐ Baylor
- ☐ Borden
- ☐ Brewster
- ☐ Briscoe
- ☐ Brown
- ☐ Callahan
- ☐ Castro
- ☐ Childress
- ☐ Clay
- ☐ Cochran
- ☐ Coke
- ☐ Coleman
- ☐ Collingsworth
- ☐ Concho
- ☐ Cottle
- ☐ Crane
- ☐ Crockett
- ☐ Culberson
- ☐ Dallam
- ☐ Dawson
- ☐ Dickens
- ☐ Dimmit
- ☐ Donley
- ☐ Eastland
- ☐ Ector
- ☐ Edwards
- ☐ Fisher
- ☐ Foard
- ☐ Frio
- ☐ Gaines
- ☐ Glasscock
- ☐ Gray
- ☐ Hall
- ☐ Hansford
- ☐ Hardeman
- ☐ Hartley
- ☐ Haskell
- ☐ Hemphill
- ☐ Howard
- ☐ Irion
- ☐ Jack
- ☐ Jeff Davis
- ☐ Jones
- ☐ Kent
- ☐ Kerr
- ☐ Kimble
- ☐ King
- ☐ Kinney
- ☐ Knox
- ☐ La Salle
- ☐ Lipscomb
- ☐ Loving
- ☐ Martin
- ☐ Mason
- ☐ McCulloch
- ☐ Menard
- ☐ Midland
- ☐ Mitchell
- ☐ Moore
- ☐ Motley
- ☐ Nolan
- ☐ Ochiltree
- ☐ Oldham
- ☐ Palo
- ☐ Pinto
- ☐ Parmer
- ☐ Pecos
- ☐ Presidio
- ☐ Reagan
- ☐ Real
- ☐ Reeves
- ☐ Roberts
- ☐ Runnels
- ☐ Schleicher
- ☐ Scurry
- ☐ Shackelford
- ☐ Sherman
- ☐ Stephens
- ☐ Sterling
- ☐ Stonewall
- ☐ Sutton
- ☐ Taylor
- ☐ Terrell
- ☐ Throckmorton
- ☐ Tom Green
- ☐ Upton
- ☐ Uvalde
- ☐ Val Verde
- ☐ Ward
- ☐ Wheeler
- ☐ Wichita
- ☐ Wilbarger
- ☐ Winkler
- ☐ Yoakum
- ☐ Young
- ☐ Zavala

Application Attestation

- **Every question on this page must be answered.**
- **Please provide a detailed explanation on a separate sheet for any question(s) answered Yes.**
- **Modifications to the wording or format of this page 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 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 HealthPlan, 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 received.

Printed Name of Authorized Representative	Title of Authorized Representative
Signature of Authorized Representative	Date Signed

Credentialing Contact Information

Contact Name: _____ Contact Title: _____

Phone: _____ Fax: _____

Email: _____