FACILITY AND ANCILLARY DEMOGRAPHIC FORM

Thank you for your interest in joining the Superior HealthPlan Network! Please use the checklist below to ensure you have all necessary contract components to avoid processing delays. You must complete all fields of this document to ensure all relevant information is captured for the services you will provide. This information may be repeated during the Credentialing process, but is necessary for proper initial data entry.

DOCUMENTS LISTED BELOW MUST BE FULLY COMPLETED AND RETURNED

- ☐ Signed and dated Participating Provider Agreement. Return entire original contract. Do not populate any effective dates. (Not required for re-credentialing.) SENT SEPARATELY
- ☐ 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. ENCLOSED
- ☐ Read and complete the **Participation Practitioner Conflict of Interest and Healthcare Entity Financial Interest Policy and Disclosure Statement** in its entirety. ENCLOSED
  - Ensure you have selected either "I do" or "I do not" on page 7, as well as "Yes" or "No" on page 8 and 9.

DOCUMENTS YOU WILL NEED TO PROVIDE

Demographic Forms may be returned to:

Mail: Superior HealthPlan, Contract Management, 7990 Interstate 10 West, Suite 300, San Antonio, TX 78230

Email: SHP.NetworkDevelopment@SuperiorHealthPlan.com

CONTRACT STEPS

UPON SUBMITTING THIS APPLICATION, YOU WILL MOVE TO THE INTAKE/CONTRACTING STEP.

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 form and submit current copies of all required documentation will result in processing delays.

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

Services Provided

- ☐ CORF/ORF Services Provided:
  - ☐ Physical Therapy (PT)
  - ☐ Speech Therapy (ST)
  - ☐ Occupational Therapy (OT)
  - ☐ Cognitive Rehab Therapy (CRT)
- ☐ Home Health Care:
  - ☐ PT ☐ ST ☐ OT ☐ PDN
- ☐ Other:
- ☐ Home Health Care with Long-Term Service and Support (LTSS):
  - ☐ PT ☐ ST ☐ OT
- ☐ Laboratory
- ☐ Targeted Case Management (TCM/Senate Bill 58 – Certificate Required)
- ☐ Therapy Services:
  - ☐ PT ☐ ST ☐ OT ☐ CRT

Minority Owned Business

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

MMP Directory Data Element Requirements

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

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

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

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

3. 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:

4. Is the provider's location an accessible public transportation route? ☐ Yes ☐ No

Long-Term Services and Supports Provider Demographic Information

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)	

Participating Provider Conflict of Interest, Health Care Entity Financial Interest Policy and Disclosure Statements

It is the policy of Superior HealthPlan, Inc. (Superior) that no provider participating in Superior's network shall use his or her position as a contracted provider, or knowledge gained in such position, in such a way that creates conflicts of interest (COI) with Superior, its parent company, an affiliate, subsidiary, or related corporation. The term COI refers to any situation or position in which personal interests (of the provider or a "related party")[1] conflict with organizational interests, affecting an individual's ability to make impartial decisions. Training and education are provided to promote COI awareness among all of Superior's providers. Superior also offers numerous avenues for providers to ask questions and receive information about identifying and disclosing COI.

Providers are responsible for disclosing actual, potential, or perceived COI on this form at the time they apply to join or to be recredentialed to remain in Superior's network. They are also responsible for promptly disclosing COI that may arise later, after they have joined Superior's network.

Process for Disclosing Actual, Potential or Perceived Conflicts Of Interest

1. All questions about, and disclosures of, COI should be directed to the Provider's local Superior ProviderServices Representative.
2. Identify COI by consulting with the Superior's Provider Services staff or referring to the examples listed in Attachment A to this Policy.
3. Disclose actual, potential, or perceived COI before taking any action that may appear to be influenced by the conflict.
4. Avoid participating in the activity in question until Superior determines whether a COI exists.
5. If a Conflict of Interest is determined to be real, Superior's Compliance Director will document and report the decision to the provider involved.

[1] A "related party" is defined as a provider's spouse, parents, step parents, children, step- children, siblings, step-siblings, nieces/nephews, aunts/uncles, grandparents, grandchildren, in-laws, same or opposite sex domestic partner.

Health Care Entity Financial Interest Disclosures

It is also the policy of Superior HealthPlan that all providers participating in its network shall disclose to Superior any and all Financial Interests, including "Controlling Interests,"[2] such providers or any of their related parties may have in a "Health Care Entity."

For purposes of this policy and the disclosure required herein, a "Health Care Entity" is defined to mean any provider of health care services, in whatever form that provider may be organized (to include but not be limited to a corporation, a partnership, a professional association, a limited liability company, or a professional corporation) and no matter what type of services the provider may provide or be licensed to provide (to include but not be limited to, therapy services, hospital services, pharmacy services, laboratory services, radiology services, physician services, home health services, etc.).

Providers are responsible for disclosing any such Financial Interest on this form at the time they apply to join or to be recredentialed to remain in Superior's network. They are also responsible for promptly disclosing any such Financial Interest that may arise later, after they have joined Superior's network.

Providers who have questions about whether an interest or relationship they have with a Health Care Entity or other provider constitutes a Financial Interest that should be disclosed to Superior should contact their local Provider Services Representative to discuss.

Examples of Health Care Entity Financial Interests that should be disclosed pursuant to this policy include:

1. A physician applying to join or being recredentialed in Superior's network owns an interest in a pharmacy;
2. The spouse of a provider joining or being recredentialed in Superior's network owns a therapy services company;
3. A provider joining or being recredentialed in Superior's network owns an interest in a hospital or owns a company that leases facility space to a hospital; or
4. A physician being contracted/credentialed or recredentialed by Superior has a Financial Interest in aHealth Care Entity that provides a "Designated Health Service" (clinical laboratory services; physical,occupational, or speech pathology services; radiation therapy services and supplies; radiology andcertain other imaging services; durable medical equipment services and supplies; prosthetics andorthotics services, and prosthetic devices and supplies; parenteral and enteral nutrients, equipment and supplies; home health services; outpatient prescription drug services; inpatient and outpatient hospitalservices; and/or nuclear medicine).

[2] A "Financial Interest" refers to any ownership interest you have in any corporation (whether for profit or nonprofit), limited liability company, partnership or other business organization other than beneficial ownership in a publicly traded company of less than 5%. A "Controlling Interest" shall include an interest by which you have the power to vote for the election of directors, managers or other management of a person or entity or the power to direct or cause the direction of the management or policies of a person or entity. A "Financial Interest" also refers to a financial arrangement you may have with the Health Care Entity, such as an employment agreement, services contract, consulting arrangement, lease or equipment-sharing agreement.

Conflict of Interest Disclosure Statement

I, _____ , hereby declare that I (or a related party) Do ☐ Do not ☐ have an actual, potential or perceived Conflict of Interest that I wish to disclose to Superior HealthPlan, Inc.

Such disclosure must include, , the legal name of the entity involved, its business address, its federal tax ID number, its principal line(s) of business, and the provider's ownership interest (by percentage) and/or management role (including title) with the entity.

If I checked "do" above, the following is a summary of my disclosure, including all material facts and the above-listed items of information (use additional paper as necessary):

Legal name of the entity involved: _____

Business address: _____

_____

Federal tax ID number: _____

Provider's ownership interest (e.g., type and percentage): _____

_____

Entity's principal line(s) of business: _____

_____

Signed: _____

Name: _____

Title: _____

Date: _____

Financial Interest Disclosure Statement

Name: _____ **Filing Period:**

Title: _____ Annual _____ Interim

FINANCIAL INTEREST

1. Do you or a related party (see definition above) have a direct or indirect ownership orinvestment interest in any entity (see definition below)?

   ☐ Yes ☐ No

2. Do you or a related party have a compensation arrangement with any entity?

   ☐ Yes ☐ No

*an entity is any provider, supplier, or business that provides any form of healthcare services or products.

Disclosure of Interest

If you answered YES to any of the above questions, please explain in detail the financial interest or relationship being reported (use separate sheet as needed). Please include the legal name of entity, business address, Federal tax ID number, ownership interest amount, and entity's line of business:

_____

_____

_____

_____

_____

CERTIFICATION

To the best of my knowledge and belief, I hereby certify that the information provided above accurately and completely describes all financial and other interests, which are required to be reported. If any situation should arise in the future which may involve me in a conflict of interest, I will promptly provide a new Disclosure Statement to Superior Health Plan, Inc.

Signature: _____ Date: _____

Typed/Printed Name: _____

Disclosure of Prior Contracts or Business with Superior HealthPlan

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

If yes, please identify the name of such entity and its relationship to You below. As used above, the capitalized terms are defined as follows:

"You" means the individual, partnership, corporation or other entity that is entering into a provider agreement with Superior HealthPlan, Inc.

"Affiliate" means an entity that is related by ownership (of any amount) or control (by sharing the same officers or directors) to You or to Superior HealthPlan

"Business" means holding a contract for provider services, vendor services or other services with Superior HealthPlan or an Affiliate of Superior HealthPlan.

If You answered "yes" above, please provide the following information (use additional paper as necessary):

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: _____

Examples of Areas for Potential Conflicts of Interest

Including but not limited to:

1. Contracts or transactions between Superior and the provider or a related party (other than the participating provider agreement).
2. Contracts or transactions between Superior and any other profit or nonprofit company, corporation,firm, association, or entity of which the provider or a related party is a director, partner, officer,consultant or other unspecified affiliate.
3. Contracts or transactions between Superior and any other corporation, firm, association, or entity inwhich the provider or a related party has some financial interest, other than an interest in securitiespublicly traded on a national exchange with a market value of less than $25,000, regional or localsecurities in which the ownership interest does not exceed five percent (5%) of those securitiesoutstanding, or securities in which the ownership interest is a time or demand deposit in a financialinstitution or an insurance policy.
4. Contracts or transactions to which Superior is a party, where the provider or a related party stands to profit individually and thus encourages Superior to purchase certain goods or services.
5. Contracts or transactions involving a business or other entity that competes with Superior's activities,where the provider or a related party has any ownership, directorship, or other similar interest in thecompeting business or entity.

   NOTE: This example is not to be construed to mean, and does not mean, that providers may notcontract with Superior's competitors to be participating providers in those competitors' networks. Thisexample is in no way meant to be interpreted as an "exclusivity provision."
6. To buy, sell or lease any kind of property, facilities or equipment from or to Superior or to anycompany, firm or individual who is or is seeking to become a contractor, supplier or customer ofSuperior, without first making disclosure of such transaction.
7. Any occasion to accept commissions, a share or other payments, loans, services, personal travel or gifts or entertainment of excessive value, from any individual or entity doing, or seeking to dobusiness with Superior.

COI and Disclosure Questionnaire

If you answered "Do" on page 7, "yes" on page 8, OR "yes" on page 9, please complete this questionnaire.

1. What type of services are provided at the conflicted entity you described above? (see definition ofentity below)

   _____
   _____
   _____
   _____

2. Are you authorized to perform services at the conflicted entity?

   _____

3. Do you currently perform services at the conflicted entity?

   _____

4. What percentage of your services are performed at the conflicted entity?

   _____

5. Please describe the billing arrangement at the conflicted entity.

   _____
   _____
   _____
   _____

6. Does the conflicted entity bill Medicare, and/or Medicaid?

   _____

*An entity is any provider, supplier, or business that provides any form of healthcare services or products.

*Complete if selected Targeted Case Management (TCM)/Senate Bill 58 (Certificate Required) on page 2 of "Certifications."

Mental Health Rehabilitation Services and Mental Health Targeted Case Management

Provider Attestation
Senate Bill 58

WHEREAS, Integrated Mental Health Services d/b/a Superior HealthPlan ("Superior"), has executed an Agreement with _____ ("Facility") dated _____ pursuant to which Facility has agreed to provide Covered Services to Superior Covered Persons through Facility Clinicians (the "Agreement"); and WHEREAS, Facility has requested that the undersigned ("Facility") attest to Mental health rehabilitative services and Mental health targeted case management as required by Senate Bill 58 of the 83rd Legislative Session; and WHEREAS, as a condition of such participation and Facility's designation as a "Facility" under this Agreement, facility provider must satisfy Superior's training and certification require criteria and execute this Attestation acknowledging his/her agreement to comply with, and be bound by, the terms and conditions of the Attestation. NOW THEREFORE, Facility hereby agrees as follows, and attests that:

1. Participating Providers are trained and certified to administer, the ANSA and/or CANS assessment tools,agrees to use these tools to recommend a level of care by using the current DSHS Clinical Management forBehavioral Health Services (CMBHS) web-based system.
2. The Participating Provider has completed all training requirements outlined in the HHSC Uniform ManagedCare Manual (UMCM) Chapter 15.3 before delivering any mental health rehabilitation and mental health targetcase management services.
3. The Participating Facility will provide Mental Health Rehabilitative Services and Targeted Case Managementusing the Department of State Health Services (DSHS) Resiliency and Recovery Utilization ManagementGuidelines (RRUMG) and the Adult Needs and Strengths Assessment (ANSA) or the Child and AdolescentNeeds and Strengths (CANS) tools for assessing a Member's needs for services.
4. The Participating Facility has the ability to provide Covered Persons with the full array of RRUMG services.
5. The Participating Facility is familiar with HHSC's cost reporting process and will participate in this process.

Signature Block to Follow

Facility Name (print): _____

Facility Signature: _____

Signature Date: _____

NPI Number: _____

State Medicaid Number: _____

For questions, call 1-800-716-5650.