EmblemHealth®

Organizational Provider Credentialing Application

Please complete and submit this form with any required attachments to **credentialingnyc@emblemhealth.com**. You may also submit this to your contracting representative. After we receive your completed application, we will credential or recredential your facility in our networks, as applicable. Contracts will not be completed until credentialing is approved. Credentialing approval DOES NOT mean your contract and network participation has been finalized and approved. Please remember to sign and date your application and submit it with required documents shown in Section X below.

Name of Entity:	
Name (please print):	Date:
Title:	

I. PROVIDER IDENTIFICATION

A. Corporate Identification Information

Supply the provider's legal business name (as reported to the IRS), the "doing business as" (DBA) name (other trade name or public name), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

Legal Business Name (as reported to the IRS; claims will be paid to this name):			
DBA Name for Directory Listing (if applicable):	County Where DBA Name Is Registered (if applicable):		
Address:			Tax ID:

B. Primary Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

C. First Additional Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

EmblemHealth Plan, Inc., EmblemHealth Insurance Company, EmblemHealth Services Company, LLC, and Health Insurance Plan of Greater New York (HIP) are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies. .

PRINT RESET

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D. Second Additional Practice Location

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	ZIP:	County:
Phone:	Fax:	Email:	

E. If you have more than two additional locations, please provide the same information for each on a separate sheet as an attachment.

Hours of Operation:

Mon.: _____ to_____ Tues.: _____ to_____ Wed.: _____ to_____ Thurs.: _____ to_____ Fri.: _____ to_____ Sat.: _____ to_____ Sun.: _____ to_____

Phone:	Fax:	Email:
Administrator (Full Name):		

F. Mailing/Correspondence Address

☐ Check here if all correspondence should be directed to the practice location in Section B. Otherwise, supply an address where the provider may be contacted directly.

Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	ZIP:	County:

II. WHAT TYPE OF ENTITY IS YOUR ORGANIZATION?

- ☐ Adult day health care
- ☐ AIDS adult day care
- ☐ Ambulatory surgery center
- ☐ Assisted living
- ☐ Birthing center
- ☐ Certified home health agency
- ☐ Clinical laboratory
- ☐ Comprehensive outpatient rehabilitation center
- ☐ Dialysis center
- ☐ Durable medical equipment provider
- ☐ Early intervention agency
- ☐ Federally qualified health center
- ☐ Free-standing imaging center
- ☐ Home infusion therapy
- ☐ Hospice
- ☐ Hospital
- ☐ Licensed home health agency
- ☐ Meals (home and congregate)
- ☐ Outpatient diabetes self-management center/national diabetes prevention program (NDPP) center
- ☐ Outpatient physical, occupational, and/or speech language therapy
- ☐ Pathology center
- ☐ Personal care services (chores and housekeeping)
- ☐ Personal emergency response services
- ☐ Portable x-ray supplier
- ☐ Rural health clinic
- ☐ School-based clinic/diagnostic and treatment center
- ☐ Skilled nursing facility
- ☐ Social and environmental services
- ☐ Social day care
- ☐ Transportation
- ☐ Urgent care center
- ☐ Voluntary foster care agency (29-I facility)
- ☐ Urgent care (retail convenience health clinic)
- ☐ Urgent care (walk-in medical office)

Identification Numbers

NPI Number:	PFI Number:	Operating Cert./License Number:
Medicare Number:	Medicaid Number:	

Organizational Provider Credentialing Application (continued)

III. ACCREDITATION AND CERTIFICATION

Attach a copy of verification for each accreditation and certification that your facility has. If your facility received less than full accreditation, please attach a copy of a recommendation.

☐ Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Number/ID: _____ Expiration Date: _____

☐ Dot Norske Veritas (DNV) Number/ID: _____ Expiration Date: _____

☐ Accreditation Association for Ambulatory Health Care (AAAHC) Number/ID: _____ Expiration Date: _____

☐ Commission on Accreditation of Rehabilitation Entities (CARF)

☐ Council on Accreditation

☐ Community Health Accreditation Program (CHAP)

☐ Continuing Care Accreditation Commission, American Association of Diabetes Educators (AADE)

☐ American College of Radiology (ACR)

☐ American Institute of Ultrasound in Medicine (AIUM), Intersocietal Commission on Accreditation of Nuclear Laboratories (ICANL), American Association of Clinical Endocrinologists (AACE), Nuclear Medicine Technology Certification Board (NMTCB), American Academy of Urgent Care Medicine (AAUCM), Urgent Care Association of America (UCAOA), American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

☐ Clinical Laboratory Improvement Amendments (CLIA) Number: _____ Expiration (if applicable): _____

CARF Expiration Date:	CHAP Expiration Date:
DNV Expiration Date:	JCAHO Expiration Date:
Other: Expiration Date:	Other: Expiration Date:

IV. STATEMENT OF DEFICIENCIES SURVEY

Indicate any current statements of deficiencies your facility has received from any federal, state, or local regulatory agency or accreditation body. Include a copy of each statement, along with the approved plans of correction. (If your entity has more than one current deficiency issued by the same regulator, please list them on a separate sheet of paper.)

Medicare Audit or Survey Date:	Medicaid Audit or Survey Date:
Department of Health (DOH) Audit or Survey Date:	Other Audit or Survey Date:

V. GENERAL AND PROFESSIONAL LIABILITY INSURANCE

Attach a copy of your facility's general and professional liability insurance policy certificate of coverage and malpractice claims history details.

☐ Check box if facility does not have a general liability insurance policy.

Current general liability insurance carrier:

Address:	City:	State:	ZIP:
Policy Number:	Initial Date:		
Limits of Liability:	Expiration Date:		

☐ Check box if facility does not have a professional liability insurance policy.

Current general liability insurance carrier:

Address:	City:	State:	ZIP:
Policy Number:	Initial Date:		
Limits of Liability:	Expiration Date:		

VI. HEALTH SERVICE DELIVERY AND QUALITY MANAGEMENT INFORMATION

Do you subcontract for medical services with other organizations or individuals? ☐ Yes ☐ No

If yes, please provide their names and addresses and describe your relationship(s): _____

_____

Do you have a quality improvement process in place? ☐ Yes (Please attach a summary.) ☐ No

Do you have a process to measure and collect patient satisfaction? ☐ Yes ☐ No

If yes, please describe your most recent patient satisfaction measure and instrument used: _____

_____

VII. PRIMARY OFFICER/CONTACT PERSON

Name:		Title:
Phone:	Fax:	Email:

I attest that the information given or attached to this application is accurate. Any misrepresentation, misstatement, or omission from this application, whether intentional or not, will cause automatic and immediate rejection of the application, resulting in denial or nonrenewal of a contract. If a contractual arrangement is in effect prior to discovery of a misrepresentation, misstatement, or omission, such discovery may result in immediate termination of the contract.

Sign:		
Print Name:	Title:	Date:

VIII. MEDICAID AMERICANS WITH DISABILITIES ACT (ADA) ATTESTATION

If your practice has more than one location, please complete a Medicaid ADA Attestation form for each location. Additional forms can be downloaded from the "Join Our Networks" page at emblemhealth.com. Once submitted, please notify EmblemHealth within 10 business days of any change to your answers below.
Note: If you do not see patients at the address on the credentialing application (e.g., you're an inpatient provider only or administrative only), please check N/A and sign at the bottom of this section below. ☐ N/A

1.	Does the office have at least one wheelchair-accessible path from an entrance to an exam room?	☐ Yes	☐ No	☐ N/A
2.	Are examination tables and all equipment accessible to people with disabilities?	☐ Yes	☐ No	☐ N/A
3.	If parking is provided, are spaces reserved for people with disabilities and pedestrian ramps at sidewalks and drop-offs?	☐ Yes	☐ No	☐ N/A
4.	If parking is provided, are there an adequate number (see below) of accessible parking spaces (8 feet wide for a car with a 5-foot access aisle)?	☐ Yes	☐ No	☐ N/A

Total spaces	Accessible spaces
1 - 25	1
26 - 50	2
51 - 75	3
76 - 100+	4

5. a.	For a provider with a disability-accessible parking space, is there a travel path from the disability-accessible parking space to the facility entrance that doesn't require stair use?	☐ Yes	☐ No	☐ N/A
b.	Is the travel path stable, firm, and slip-resistant?	☐ Yes	☐ No	☐ N/A
c.	Except for curb cuts, is the path at least 36 inches wide?	☐ Yes	☐ No	☐ N/A
6. a.	Is there a method for persons who use wheelchairs or require other mobility assistance to enter as freely as everyone else?	☐ Yes	☐ No	☐ N/A
b.	Is that travel route safe and accessible for everyone, including people with disabilities?	☐ Yes	☐ No	☐ N/A
7.	Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following:			
a.	32 inches clear opening.	☐ Yes	☐ No	☐ N/A
b.	18 inches of clear wall space on the pull side of the door, next to the handle.	☐ Yes	☐ No	☐ N/A
c.	The threshold edge is no greater than ¼ inch high; or if beveled, no greater than ¾ inch high.	☐ Yes	☐ No	☐ N/A
d.	The door handle is no higher than 48 inches and can be operated with a closed fist.	☐ Yes	☐ No	☐ N/A

VIII. MEDICAID AMERICANS WITH DISABILITIES ACT (ADA) ATTESTATION (continued)

8. Are there ramps to permit wheelchair access? If yes, complete the following four questions:			
a. Are the slopes of the ramp wheelchair accessible?	☐ Yes	☐ No	☐ N/A
b. Are the railings sturdy and high enough for wheelchair access?	☐ Yes	☐ No	☐ N/A
c. Is the width between railings enough to accommodate a wheelchair?	☐ Yes	☐ No	☐ N/A
d. Are the ramps nonslip and free from any obstruction (cracks)?	☐ Yes	☐ No	☐ N/A
9. If there are stairs at the main entrance, is there a ramp, lift, or alternative accessible entrance?	☐ Yes	☐ No	☐ N/A
10. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance?	☐ Yes	☐ No	☐ N/A
11. Can the accessible entrance be used independently and without assistance?	☐ Yes	☐ No	☐ N/A
12. Are doormats ½ inch high or less with beveled or secured edges?	☐ Yes	☐ No	☐ N/A
13. Are waiting rooms and exam rooms accessible to people with disabilities?	☐ Yes	☐ No	☐ N/A
14. Does the layout of the interior of the building allow people with disabilities to obtain materials and services without assistance?	☐ Yes	☐ No	☐ N/A
15. Do the interior doors comply with the criteria for exterior doors in question 7?	☐ Yes	☐ No	☐ N/A
16. Are the accessible routes to all public spaces in the facility 31 inches wide?	☐ Yes	☐ No	☐ N/A
17. Is there a 5-foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered?	☐ Yes	☐ No	☐ N/A
18. Are all buttons or other controls in the hallway no higher than 42 inches?	☐ Yes	☐ No	☐ N/A
19. Do elevators in the facility meet the following standards?			
a. There are raised and Braille signs on both door jambs on every floor.	☐ Yes	☐ No	☐ N/A
b. The controls inside the cab have raised and Braille lettering.	☐ Yes	☐ No	☐ N/A
c. The call buttons in the hallway are not higher than 42 inches from the ground.	☐ Yes	☐ No	☐ N/A
20. Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances?	☐ Yes	☐ No	☐ N/A
21. Is the public restroom wheelchair-accessible?	☐ Yes	☐ No	☐ N/A
22. With respect to the public restroom, do the accessible route, exterior door, and interior stall doors comply with the criteria for exterior doors in question 7?	☐ Yes	☐ No	☐ N/A
23. Is there at least one wheelchair-accessible stall in the public restroom that has an area of at least 5 feet by 5 feet clear of the door swing, or is there at least one stall that is less accessible but provides greater access than a typical stall (either 36 by 69 inches or 48 by 69 inches)?	☐ Yes	☐ No	☐ N/A
24. In the accessible stall of the public restroom, are there grab bars behind and on the side wall nearest the toilet?	☐ Yes	☐ No	☐ N/A
25. Is there one ADA accessible public restroom with a sink that meets the following standards:			
a. 30 inches wide by 48 inches deep; deep bar space in front.	☐ Yes	☐ No	☐ N/A
b. A maximum of 19 inches of the required depth may be under the sink.	☐ Yes	☐ No	☐ N/A
c. The sink rim is no higher than 34 inches.	☐ Yes	☐ No	☐ N/A
d. There are at least 29 inches from the floor to the bottom of the sink apron.	☐ Yes	☐ No	☐ N/A
e. The faucet can be operated with a closed fist.	☐ Yes	☐ No	☐ N/A
f. The soap dispenser and hand dryers are within reach and usable with one closed fist.	☐ Yes	☐ No	☐ N/A
g. The mirror is mounted with the bottom edge of the reflecting surface 40 inches or lower from the floor.	☐ Yes	☐ No	☐ N/A

I hereby attest that I am a provider that occupies a physical site at which participants might possibly be physically present and that the answers provided are true and accurate and that I hold the authority to make these attestations.

Name:	Date:
Signature:	

IX. MEDICAID PROVIDER DISCLOSURE OF OWNERSHIP AND CONTROL

Section 1: Disclosing Provider

Provider Name:	
Provider Address:	
National Provider Identifier (NPI):	Federal Employer Identification Number (FEIN):
Type of Entity (sole proprietorship, individual, business corporation, nonprofit corporation, nonprofit membership corporation, unincorporated association, limited liability corporation, partnership, professional limited liability corporation, governmental entity, other):	

Section 2: Ownership of Provider (per 42 CFR Part 455.104(b) (1) (i) (entities and/or individuals)

Copy this page to report additional owners.

Name of Individual or Entity:		Title (if individual):	Date of Birth (if individual) (MM/DD/YYYY):
Address (home address if individual):			
Primary Address (if corporation):			
Social Security Number (if individual):	Federal Employer Identification Number (if entity):	% of Ownership (if none, put 0%):	NPI or NY Medicaid ID (if none, write None):

For Individuals Only: If you are related to another person with an ownership or control interest in the provider, complete the following.

Name of Other Owner:	**Relationship to Other Owner (parent, child, sibling, spouse):**

For Corporations Only (business and nonprofits): Use the space below to report other business addresses (per 42 CFR Part 455.104(b)(1)(i). For nonprofit membership corporations, use the space below to identify the members and their addresses.

Section 3: Ownership in Other Disclosing Entities (ODE) (per 42 CFR Part 455.104(b)(3))

Complete the following if any person(s) identified in Sections 1 and 2 have an ownership or control interest in any Other Disclosing Entity, as defined in 42 CFR 455.101 (any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare Title XVIII); Medicare intermediary or carrier; and any entity (other than an individual practitioner or group of practitioners) that furnishes or arranges for the furnishing of health-related services for which it claims payment under any plan or program established under Title V or Title XX). Copy this page to report additional ownerships in Other Disclosing Entities.

Name (from Section 1):	ODE Name:	NPI or Medicaid ID of ODE:
Name (from Section 1):	ODE Name:	NPI or Medicaid ID of ODE:
Name (from Section 1):	ODE Name:	NPI or Medicaid ID of ODE:

Organizational Provider Credentialing Application (continued)

Section 4: Ownership in Subcontractors

If the provider has an ownership or control interest of 5% or more in a subcontractor and an owner of the provider also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in Section 3 have a familial relationship (parent, child, sibling, or spouse) with a person with ownership or control interest in one of these subcontractors, complete Section 5. Copy this page to report additional ownership in subcontractors.

Owner Name (from Section 1):	Subcontractor Name:	Tax ID or Social Security Number:
Owner Name (from Section 1):	Subcontractor Name:	Tax ID or Social Security Number:

Section 5: Familial Relationship in Subcontractors

Complete if those identified in Section 4 have a familial relationship (parent, child, sibling, or spouse) with a person with ownership or control interest in one of the subcontractors identified in Section 3. Copy this page to report additional familial relationship to the subcontractors.

Owner Name (from Section 1):	Subcontractor Name:	Name and Familial Relationship:
Owner Name (from Section 1):	Subcontractor Name:	Name and Familial Relationship:

Section 6: Managing Employees and Those With a Control Interest

Including, but not limited to, the following: Facility administrator, all members of the board of directors, managing employees, compliance officer, laboratory director, and supervising pharmacist. Include familial relationship to the provider (spouse, parent, child, or sibling), if any. Copy this page to report additional managing employees and those with a control interest.

Name:	Association Type:	Familial Relationship:
Home Address:		
City, State, and ZIP Code:		
Social Security Number:	Date of Birth:	
Name:	Association Type:	Familial Relationship:
Home Address:		
City, State, and ZIP Code:		
Social Security Number:	Date of Birth:	

Section 7:

Respond to the following questions on behalf of: (i) the provider, (ii) all individuals and entities identified in Sections 1, 2, and 6, and (iii) any entity in which the provider has a 5% or more ownership. For any "yes" responses, please provide an explanation on a separate sheet of paper.

1.	Have any of the individuals or organizations noted above ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned under any of the programs established by Title XVIII (Medicare), XIX (Medicaid), XX (Social Services), or any other governmental or private medical insurance program in any state?	☐ Yes ☐ No
2.	Have any of the individuals or organizations noted above ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any state?	☐ Yes ☐ No
3.	Have any of the individuals or organizations noted above ever had their business or professional license, registration or certification, or the license of an entity in which they had an ownership interest over 5% been revoked, suspended, surrendered or, in any way, restricted by probation or agreement by a licensing authority in any state?	☐ Yes ☐ No
4.	Are there currently any pending proceedings that could result in any of the above-stated sanctions for the individuals or organizations noted above?	☐ Yes ☐ No

Organizational Provider Credentialing Application (continued)

Section 7: (continued)

5. Has there been a change of ownership or control within the last year? ☐ Yes ☐ No
   If yes, give date of change: _____
   If yes, did you inform EmblemHealth? ☐ Yes ☐ No
   If yes, give date you informed EmblemHealth: _____
6. Do you anticipate a change of ownership within the year? ☐ Yes ☐ No
   If yes, when: _____
7. Is this entity operated by a management company or leased in whole or in part by another organization? ☐ Yes ☐ No
   If yes, give date of change of operations: _____

X. Supporting Documentation

In addition to this Organizational Provider Credentialing Application, applicants must submit additional documents as applicable to the provider types noted.

1. **All applicants must submit the following documents with this application. See below for additional provider-type specific documents. Check box next to each item below to confirm it is being sent with the application.**

   ☐ Current operating certificate or state license.
   ☐ Drug Enforcement Agency/Controlled Dangerous Substance (DEA/CDS) certificate (if applicable).
   ☐ Evidence of accreditation.
   If the entity is not accredited by Joint Commission or other accreditation agency, please send a statement of deficiencies, along with a plan of correction, from the facility's most recent State Survey (i.e., DOH, CMS, NSOFA [New York State Office of the Aging]). See section III Accreditation and Certification above.
   ☐ General liability insurance certificate of coverage sheet.
   ☐ Letter verifying approval of CMS participation.
   ☐ Malpractice claims history details.
   ☐ Medicare certification.
   ☐ Professional liability insurance certificate of coverage.
   ☐ Roster of independent practitioners employed by your organization (First, Middle, Last, NPI, and State License Number).
   ☐ W-9 form (for billing).

2. **Adult day care, AIDS adult day care, assisted living, personal care services, personal emergency response services, social and environmental supports, and social day care providers must submit the following in addition to the items in sub-section one above. Initial to confirm it is being sent with the application.**

   _____ Drug policy for employees.

3. **Durable medical equipment and outpatient physical therapy providers must submit the following in addition to the items listed in sub-section one above. Initial to confirm they are being sent with the application.**

   _____ A roster of all employees (First, Middle, Last, NPI, and State License Number).
   _____ Drug policy for employees.

4. **Meal (home and congregate) providers must submit the following in addition to the items in sub-section one above. Initial to confirm it is being sent with the application.**

   _____ Food handling certification for employed individuals.

5. **Transportation service providers must submit the following in addition to the items listed in sub-section one above. Initial to confirm it is being sent with the application.**

   _____ A roster of all employees (First, Middle, Last, NPI, and State License Number).
   _____ General liability and vehicle insurance coverage.
   _____ Safe vehicle maintenance protocol tracking program.
   _____ Drug policy for employees.

6. **Urgent Care providers must submit the following in addition to the items in sub-section one above. Initial to confirm the roster is being sent with the application.**

   _____ A roster of all employees (First, Middle, Last, NPI, and State License Number).

I certify that the information contained herein is true and accurate to the best of my knowledge and belief.

Name of Authorized Representative (please type):	Job Title:
Signature:	Date: