Organizational Providers Credentialing Application Instructions

This CREDENTIALING/RECREDENTIALING APPLICATION is for Kaiser Permanente network organizational providers.

Important disclaimer: Submission of an application does not constitute any obligation on the part of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C. or any other or related Kaiser Permanente entity to enter into a new contractual obligation nor renew an earlier contract.

Please complete this application in its entirety. We ask that you complete the application electronically. Do not complete it by hand. We welcome any attachments, beyond those requested, that you may choose to include to support your application.

Required Documentation (Complete This Checklist Notating Included Documentation)

☐ **Accreditation certificates**

(Note: If not accredited, include a copy of your last state or Medicare survey. If neither accreditation or the survey is applicable, Kaiser Permanente will conduct a site visit).

☐ **Professional and general liability certificates of insurance**

(Note: Minimum coverage of $1,000,000/occurrence and $3,000,000 aggregate AND $3,000,000 per occurrence and $5,000,000 aggregate for hospitals).

☐ **State license**

☐ **ARTS Attestation Form, DBHDS License and staff roster (as ASAM Level requires)**

☐ **W9**

Return completed applications using one of the following options:

Email Initial Credentialing Applications to:

interested.providers@kp.org

Email or Mail Recredentialing Applications to:

ppqa-mas@kp.org

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
Attn: PPQA
2101 E. Jefferson St., Ste. 6 West
Rockville, MD 20852

Provider Credentialing Application

Organizational Provider/Facility Information

Organization Type *(Select all that apply)*

- ☐ Acute Care Hospital
- ☐ Behavioral Health Care Facility
  - ☐ Ambulatory
  - ☐ Applied Behavioral Analysis (ABA)
  - ☐ Chemical Dependency Program/Facility
  - ☐ Inpatient
  - ☐ Methadone Maintenance Program
  - ☐ Residential Treatment Facility for Behavioral Health Care
  - ☐ Residential Treatment Facility for Substance Abuse
- ☐ Clinical Laboratory
- ☐ Community Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Dialysis Center (End Stage Renal Disease (ESRD) Provider)
- ☐ Durable Medical Equipment Provider
- ☐ Federally-Qualified Health Center/Rural Health Clinic
- ☐ Free-Standing Ambulatory Surgery Center
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Hospital
- ☐ Physical Therapy Facility
- ☐ Portable X-Ray Supplier
- ☐ Skilled Nursing Facility/Nursing Home
- ☐ Speech Pathology Facility
- ☐ Urgent Care Facility

Provider Credentialing Application

Demographics

Address 1:

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

Federal Tax I.D. Number: _____ NPI: _____

Contact Name: _____

Contact's Title: _____

Contact's Phone: _____

Contact Email Address: _____

Contact Address (if different from above):

Address: _____

City: _____ State: _____ ZIP: _____

Address 2:

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

Federal Tax I.D. Number: _____ NPI: _____

Contact Name: _____

Contact's Title: _____

Contact's Phone: _____

Contact Email Address: _____

Contact Address (if different from above):

Address: _____

City: _____ State: _____ ZIP: _____

Provider Credentialing Application

Licensure

License Type: _____

License Number: _____ License Expiration Date: ____ / _____ / _____
MM / DD / YYYY

Have you ever had any action taken against your license? ☐ Yes ☐ No
If YES, provide relevant details below:

_____

_____

_____

Medicare Certification

Do you participate with Medicare? ☐ Yes ☐ No
Is your facility Medicare certified? ☐ Yes ☐ No
If YES, provide your Medicare Certification Number: _____

Is your Medicare certification in good standing? ☐ Yes ☐ No
If NO, provide relevant details below:

_____

Has your participation in Medicare ever been suspended or denied? ☐ Yes ☐ No
If YES, provide relevant details below:

_____

Last Medicare Survey Date: ____ / _____ / _____
MM / DD / YYYY

Accreditation

ARTS Provider? ☐ Yes ☐ No
If YES, provide your ASAM Level: _____

Joint Commission Accreditation? ☐ Yes ☐ No
If YES, provide your last survey date: ____ / _____ / _____
MM / DD / YYYY

Other Accreditation? ☐ Yes ☐ No
If YES, name of accrediting agency: _____
If YES, provide your last survey date: ____ / _____ / _____
MM / DD / YYYY

(Note: If not accredited, include a copy of your last state or Medicare survey. The survey must include identified deficiencies and corrective plans, if applicable. If a state or Medicare survey has not been completed, Kaiser Permanente will contact you to conduct a site visit).

Insurance/Claims

Professional Liability Insurance Carrier Name:

_____

Policy Number: _____

Level of Coverage: $ _____ Occurrence / $ _____ Aggregate

Coverage Dates: ____ / _____ / _____ TO ____ / _____ / _____

Provider Credentialing Application

MM / DD / YYYY MM / DD / YYYY

General Liability Insurance Carrier Name:

_____

Policy Number: _____

Level of Coverage: $ _____ Occurrence / $ _____ Aggregate

Coverage Dates: ____ / _____ / _____ TO ____ / _____ / _____
MM / DD / YYYY MM / DD / YYYY

(Note: Minimum coverage requirements by organization type are specified on application instructions sheet).

AUTHORIZATION/ATTESTATION:

I hereby submit this application for credentialing/re-credentialing into the provider network administered by Kaiser Permanente of the Mid-Atlantic States (KPMAS) and understand that this application will be reviewed based on the information I have provided. I certify that the information and documentation provided is true and correct, and that this facility is in good standing with all applicable state, federal and other regulatory agencies.

I understand that any information found to be false could result in denial or subsequent termination of this facility's membership in the KPMAS network. I am an officer of the above named organization with the authority to provide KPMAS the requested information, documentation and to execute this attestation.

By the signature below, I hereby attest to the accuracy, validity and completeness of the information and documentation.

Printed Name and Title:

Signature:

Date: