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Kansas Organizational Provider Credentialing/Recredentialing Application

Sunflower KanCare Providers: Please ensure your adherence to all guidelines outlined by the Kansas Medicaid Assistance Program for both enrollment and revalidation processes.

ATTACHMENTS NEEDED. Please include with your completed application the following items for each location.

- ☐ Form W-9 completed, signed and dated.
- ☐ Disclosure of Ownership and Control Interest Statement form completed, signed, and dated.
- ☐ Copy of current State License/Approval, as applicable.
- ☐ Copy of Medicare Participation Certification, as applicable.
- ☐ Copy of Certifications and/or Accreditation Certificates (e.g. TJC, Medicare).
- ☐ Copy of CLIA certification, as applicable.
- ☐ Copy of all CDDO Affiliate Agreements (Medicaid I/DD providers only).
- ☐ Copy of State certification for HCBS services, as applicable (e.g. atypical, non BCBA autism providers and letter of documentation for 1,000 hours of treatment Medicaid providers only).
- ☐ Copy of Declaration Sheet and/or Certificate of Insurance -
  - ☐ **For I/DD-TCM and PBS and HCBS providers** who are not providing medical or behavioral health services: **General** Liability Insurance Policies (Medicaid providers only).
  - ☐ **All other provider types: BOTH** current **Professional** Malpractice and Comprehensive **General** Liability Insurance Policies.
- ☐ Copy of completed HCBS Supplemental Form (Medicaid HCBS providers only)

***Note*:**

- ☐ All applicants must complete all questions (unless otherwise noted).
- ☐ Please check the N/A box if not applicable.
- ☐ Applications that do not include all requested documents and responses to questions will not be able to be processed.

To ensure timely processing, please return all documents to the Sunflower Health Plan Contracting Department using one of the following methods:

Via the Sunflower Website:
Use the “Join our Network” request form on our website at
www.sunflowerhealthplan.com/providers/network-forms/new-provider-request.html

By Mail:

Sunflower Health Plan
Contracting Department
8325 Lenexa Dr., Ste. 410,
Lenexa, KS 66214

Email: SunflowerContracting@SunflowerHealthPlan.com
Fax: 877-285-8469

Facility/Provider Name & Address
Note: Legal name and DBA name must match Form W-9.

Legal Name: ____

DBA Name: ____

Corporate Name (if different): ____

Federal Tax ID Number:____

Is this Tax ID used for all locations? ❐ YES ❐ NO*
*If NO, list on a separate sheet of paper all Tax ID numbers and the Legal Name for each.

Primary Address: ____

City: ________________________________ County: ______________________________

State: _______________________________ ZIP code: ____________________________

Phone: __________________________ Ext: _________ Fax: ______________________

Handicap accessible: ❐ YES ❐ NO

ADA compliant: ❐ YES ❐ NO

Credentialing Contact/Office Manager: ____

Phone: __________________________ Ext: _________ Fax: ______________________

Email Address: ____

Panel/Capacity Status:

For individual providers or clinics, answer the following questions:

How many Medicaid members are you currently seeing? _________________________________

How many Wellcare members are you currently seeing? _________________________________

How many Ambetter members are you currently seeing? _________________________________

Is your panel open or closed to additional Medicaid members? ❐ OPEN ❐ CLOSED
Is your panel open or closed to additional Wellcare members? ❐ OPEN ❐ CLOSED
Is your panel open or closed to additional Ambetter members? ❐ OPEN ❐ CLOSED

How many additional Medicaid members do you have the capacity to see in each county by specialty? __________

How many additional Wellcare members do you have the capacity to see in each county by specialty?___________

How many additional Ambetter members do you have the capacity to see in each county by specialty? __________

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Type of Component (as listed on License or Accreditation) Check all that apply.

MEDICAL/LONG-TERM SUPPORT SERVICES (LTSS)

❒ Adult Care Home Nursing Facility (SNF/NF)*	❒ Federally Qualified Health Center (FQHC)	❒ Positive Behavioral Supports
❒ Adult Care Home / Nursing Facility Mental Health (NFMH)*	❒ HCBS*	❒ Public Health or Welfare Agency and Clinic
❒ Adult Care Home Assisted Living Facility*	❒ Head Injury Rehabilitation	❒ Rehabilitation Facility
❒ Adult Care Home / Home Plus*	❒ Hearing Aid Dealer	❒ Renal Dialysis Center
❒ Adult Care Home / Residential Health Care Facility (RHCF)*	❒ Home Health Agency	❒ Rural Health Clinic (RHC)
❒ Adult Care Home / Adult Day Care*	❒ Hospice	❒ Specialized Home Nursing Services
❒ Ambulance	❒ Hospital/Psychiatric	❒ Targeted Case Management
❒ Ambulatory Surgical Center	❒ Hospital/Long-Term Acute Care Hospital (LTACH)	❒ Tribe/Tribal Organization / Urban Indian Organization / Indian Health Services (IHS)
❒ Autism –Interpersonal Communication Therapy	❒ Intermediate Care Facility / Intellectually Developmentally Disabled (ICF/IDD)*	❒ Vaccine Administration
❒ Diagnostic Imaging Center	❒ Laboratory	❒ WORK Program / Independent Living Counseling*
❒ DME/Medical Supply Dealer	❒ Money Follows the Person Transition Coordination Services – HCBS*	❒ WORK Program Assistive Services*
❒ Family Planning Clinic	❒ Money Follows the Person Transition Coordination Services – Home Health*	

Medicaid providers only: Complete HCBS Supplemental Form, if providing HCBS services.

BEHAVIORAL HEALTH SERVICES

Identify what best describes the organization (check).

MH	SA		MH	SA	
		Community Mental Health Center (CMHC)			Outpatient Clinic
		Day Treatment (free standing)			Peer Support
		Detox Facility			Psychiatric Residential Treatment Facility (PRTF)
		Intensive Outpatient (IOP) (freestanding)			Residential Treatment Facility/Center
		Methadone Maintenance			Substance Use Disorder (SUD)
		Consultative Clinical & Therapeutic Service (CCTS)			Intensive Individual Support Services (IIS)

Age Ranges Served

- ❒ Geriatric (65 years or over)
- ❒ Adult (18-64 years)
- ❒ Adolescent (13-17 years)
- ❒ Child (12 years or under)

Are in-home services offered? ❒ YES ❒ NO

Number of Total Nursing Facility Beds: ______________________________

Number of Total Assisted Living Facility Beds: ______________________________

OFFICE HOURS

Open 24 hours? ❒ YES ❒ NO
If NO, complete hours of operation below.

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Billing Address	**Same as Primary** ❒ YES ❒ NO	**If Yes, do not complete this section.**
Indicate all billing addresses used and include ZIP plus four if used.		
Address		
City	State	ZIP
Phone	Ext	Fax

Mailing Address	**Same as Primary** ❒ YES ❒ NO	**If Yes, do not complete this section.**
Indicate all billing addresses used and include ZIP plus four if used.		
Address		
City	State	ZIP
Phone	Ext	Fax

CORPORATE/SYSTEM OWNER (as provided on Form W-9) ❒ **N/A**

Name: ______________________________

DBA Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________ ZIP: ____________

Phone: ____________________ Ext: __________ Fax: ____________

ADDITIONAL PRACTICE/OFFICE LOCATIONS

Do you have additional practice/office locations? ❐ YES ❐ NO

If YES, list other practice/office addresses. If additional space is needed, attach a separate page.

Address			
City	County	State	ZIP
Phone		Fax	
Languages spoken by practitioners:			
Handicap accessible ❐ YES ❐ NO ❐ N/A		ADA compliant ❐ YES ❐ NO ❐ N/A	

Open 24 hours? ❐ YES ❐ NO **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Address			
City	County	State	ZIP
Phone		Fax	
Languages spoken by practitioners:			
Handicap accessible ❐ YES ❐ NO ❐ N/A		ADA compliant ❐ YES ❐ NO ❐ N/A	

Open 24 hours? ❐ YES ❐ NO **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Address			
City	County	State	ZIP
Phone		Fax	
Languages spoken by practitioners:			
Handicap accessible ❐ YES ❐ NO ❐ N/A		ADA compliant ❐ YES ❐ NO ❐ N/A	

Open 24 hours? ❐ YES ❐ NO **If NO, complete hours of operation below.**

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

LICENSURE/CERTIFICATIONS

Medicare Certified: ❒ YES ❒ NO
If YES, attach a copy of the CMS letter indicating the Medicare number(s) and effective date(s).

Medicare Numbers:____

Number of Medicare Beds: ____

Medicaid Certified: ❒ YES ❒ NO

If YES, list active KMAP ID number(s).

Active KMAP ID numbers:____

Number of Medicaid Beds: ____

LICENSE TYPE	STATE	LICENSE NUMBER	EXPIRATION DATE
CLIA NUMBER			**EXPIRATION DATE**
OTHER LICENSE/CERTIFICATE – TYPE		**NUMBER**	**EXPIRATION DATE**

INSURANCE

Complete Section A, B, or both as applicable.

Professional Liability/Malpractice Liability ❒ **No Coverage**
Malpractice not required for HCBS providers who are not providing medical or behavioral health services.

Name of Corporate Entity on Declaration Sheet and/or Certificate of Insurance:

____

Name of Carrier	Effective Date	Expiration Date	Coverage Amount per Occurrence	Coverage Amount Aggregate	Policy Number

Comprehensive General Liability ❒ **No Coverage**

Name of Carrier	Effective Date	Expiration Date	Coverage Amount per Occurrence	Coverage Amount Aggregate	Policy Number

QUESTIONAIRE

Please answer all questions and provide an explanation for affirmative answers.

Applications that do not include all requested responses and explanations will not be processed.

1. Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced, or not renewed? ❒ YES ❒ NO
2. Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? ❒ YES ❒ NO
3. Has the business ever had its professional liability coverage cancelled but not renewed? ❒ YES ❒ NO
4. Has the business been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ❒ YES ❒ NO

ACCREDITATION/CERTIFICATION

SECTION A

Section to be completed by non-HCBS providers only. Attach a copy of current accreditation certificate or survey.

❒ AASM	❒ AAAHC	❒ AAAASF	❒ ABC	❒ ACHC	❒ ACR	❒ AOA	❒ ASDA	❒ BOC Intl
❒ CABC	❒ CACH	❒ CAP	❒ CARF	❒ CCAC	❒ CHAP	❒ COA	❒ COLA	❒ CORF
❒ ABPCO	❒ DNVHCU	❒ HFAP	❒ HQAA	❒ IAC	❒ NABP	❒ NBAOS	❒ TJC	❒ NCQA
❒ URAC	❒ OTHER Not Accredited*							

*Complete Section B below.

Date of initial accreditation: ___________________________

Date of last survey: ________________________________

Date of next survey: ________________________________

SECTION B

Has the provider had an onsite survey by CMS or State agency? ❒ YES ❒ NO

Date of last state survey: ___________________________________

If no, successful completion of a health plan onsite visit will be required to complete credentialing. You will be contacted by the Health Plan to schedule the visit.

Nonaccredited providers must provide a copy of their most recent government agency survey (may not be older than 36 months) along with their Corrective Action Plan (if deficiencies were cited), OR attach a letter from a government agency stating the facility is in substantial compliance with the most recent survey standards. Facilities who don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

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Component Attestation/Consent & Release Form **Medicaid Providers Only**

❐ **Accept Sunflower State Health Plan** ❐ **Decline Sunflower State Health Plan**

I hereby understand that as a prospective/current Sunflower State Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunflower State Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Sunflower State Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunflower State Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunflower State Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunflower State Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to-know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials, and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photocopy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photocopy shall have the same force and effect as the signed original.

Please remember to complete the below information, including signature and date (print or type).

Business Name: ____

Authorized Representative Name: ____

Title:____

Signature:____

Date: ____

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NPI Information (as applicable)

If you have multiple NPI numbers, please list all that apply:

NPI Number	Organization/ Sub-Part Name	Address	Taxonomy Code	Level Information	NPI Issue Date	NPI Cancelled*

*Please explain.

AuthentiCare Information (applicable Medicaid providers only)

Organization	Tax ID	NPI	Medicaid ID Number