Credentialing Application Packet Instructions

In support of Washington State Senate Bill 5346 (An act relating to establishing streamlined and uniform administrative services for payors and providers) Coordinated Care requires communication of provider data materials using one of the two centralized single source to enter your provider data for purposes of credentialing:

- OneHealthPort (OHP) hosts the ProviderSource)
- Council for Affordable Quality Healthcare (CAQH)

Note: *You will only see Coordinated Care listed after you are logged into your application.*

This service is free to Practitioners entering their data. When you use this service to complete the Washington Practitioner Application, please upload images of the documents identified below (Practitioner/Group). All other types (Ancillary/Clinic/Hospital/Facility) must supply documents separately with the appropriate application.

☐ **Practitioner/Group**	☐ **Ancillary/Clinic/Facility**	☐ **Hospital**
☐ Washington Practitioners Application Authorization and Release of Information (*Signed and dated within the last 120 days from submission*)	☐ Hospital/Facility Provider Credentialing Application (*one per Facility/Clinic/Ancillary Provider*)	☐ Hospital/Facility Provider Credentialing Application (*one per Hospital Provider*)
☐ W-9 for each unique Tax ID	☐ W-9 for each unique Tax ID	☐ W-9 for each unique Tax ID
☐ Provider Data Form (*single practitioner*) or Completed Roster (*multiple practitioners*)	☐ Disclosure of Ownership and Control Interest Statement (*Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individual practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.)*	☐ Disclosure of Ownership and Control Interest Statement (*Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individual practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.)*
☐ Disclosure of Ownership and Control Interest Statement (*Refer to Section I of the document - Federal Law requires all entities, applicants, individual practitioners and group of individual practitioners having an ownership or control interest in the provider entity of 5% or greater and participate in federally funded programs to provide information on ownership and controls.)*	☐ Copy of State Operational License	☐ Copy of State Operational License
☐ NPI matches NPPES and NPIs used on the app are consistent throughout	☐ Other applicable State/Federal/Licensures (*i.e. CLIA, DEA, Pharmacy, or Department of Health*)	☐ Other applicable State/Federal/Licensures (*i.e. CLIA, DEA, Pharmacy, or Department of Health*)
Documents to upload to CAQH or OHP:	☐ Copy of Accreditation/certification *(by a nationally-recognized accrediting body, i.e. TJC/JCAHO*) If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency.	☐ Copy of Accreditation/certification (*by a nationally-recognized accrediting body, i.e. TJC/JCAHO*) If not accredited by a nationally-recognized body, Site Evaluation Results by a government agency.
☐ Copy of Declaration Page of Professional Policy	☐ Copy of Current General Liability coverage (*document showing the amounts and dates of coverage*)	☐ Copy of Current General Liability coverage (*document showing the amounts and dates of coverage*)
☐ Copy DEA Controlled Substance Registration (*Current Year*)	☐ Copy of Medicaid/Medicare Certification (*if not certified, provide proof of participation*)	☐ Copy of Medicaid/Medicare Certification (*if not certified, provide proof of participation*)
☐ Board Certification Certificate (*If applicable*)	☐ NPI matches NPPES and NPIs used on the app are consistent throughout	☐ NPI matches NPPES and NPIs used on the app are consistent throughout
☐ Education Certificate for Foreign Medical Graduates - ECFMG (*If applicable*)	☐ Completed Practitioner/Location Roster	☐ Completed Practitioner/Location Roster

Note: If you have already completed your application with CAQH or Provider Source, please ensure that you have authorized Coordinated Care to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding Coordinated Care to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Coordinated Care. Please submit this and all documents via email to: CONTRACTING@coordinatedcarehealth.com.

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Disclosure of Ownership And Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Coordinated Care within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

Section I

For individuals, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

For entities, list the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person (individual or entity) who has an ownership or control interest in the provider, or is an agent or managing employee of the provider, ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information above) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ **Title (or indicate if authorized Agent)** _____

Name (please print) _____ **Date** _____

Please return the completed form by fax to 1-877-644-4602, by email to contracting@coordinatedcarehealth.com or by mail to:

Coordinated Care
Attention: Provider Contracting
1145 Broadway, Suite 300
Tacoma, WA 98402

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Provider Data Form – Single Practitioner

(*For Credentialing & Provider Directory Purposes*)

Date:	Are you registered with CAQH: ☐ Yes ☐ No If Yes, CAQH ID# _____ Last Attestation Date[1]:	Are you registered with OneHealthPort/ProviderSource: ☐ Yes ☐ No If Yes, OHP ID: _____ Last Attestation Date[1]:	
Last Name:		First Name:	MI:
Date of Birth:	Social Security #:	ProviderOne ID#[2]:	Medicaid ID#:
Title/Degree (MD, DO, LICSW):	Individual NPI (*Type 1*):	Tax ID:	
Group NPI (*Type 2*)	Email Address:	Applying As: ☐ Specialist ☐ Primary Care (PCP) ☐ Both (PCP/Specialist) ☐ Behavioral Health[3]	
Group/Practice Name:			
Practitioner Primary Specialty Board Status: ☐ Board Certified ☐ Board Eligible ☐ Not Applicable ☐ Not Certified			
If Yes, Board Name:		Expiration Date:	
Secondary Specialty Board Status: ☐ Board Certified ☐ Board Eligible ☐ Not Applicable ☐ Not Certified			
If Yes, Board Name:		Expiration Date:	
Gender Restrictions: ☐ Yes ☐ No *If Yes, Indicate*: ☐ Female Only ☐ Male Only		Age Restrictions: ☐ Yes ☐ No *If yes, Indicate*: Lowest Age Highest Age	
Languages Spoken (*Non-English*): ☐ Yes ☐ No If Yes, please Indicate:			
Are you affiliated (do you have admitting or attending privileges at) with any Hospital? ☐ Yes ☐ No			
If Yes, please list:			
Privilege Type - please provide (*i.e. Active, Temporary, Provisional, Admitting, Attending*):			
Are you able to provide services to any of the following special needs population (check all of those that apply): ☐ Deaf/Hearing Impaired ☐ Physical Disability ☐ Blind/Vision Impaired ☐ Developmental Disability ☐ Other (please specify)			
Type of Services Provided:			
Do you provide Telemedicine Services: ☐ Yes ☐ No	If Yes to Telemedicine Services, please describe:		
Contract Contact Name (*Enter the name of the person who can confirm your contract status with Coordinated Care*):			
Contract Contact Role (*Contract Admin, Billing Rep, Office Manager*):	Contact Ph.:	Contact Email:	
If you provide direct laboratory services, please indicate the Tax ID utilized and provide Clinical Laboratory Information Act (CLIA) information below: CLIA Name: Tax ID:			
Do you have a CLIA Certificate: ☐ Yes ☐ No	Do you have a CLIA Waiver: ☐ Yes ☐ No		
Certificate #:	Expiration Date:		

1. Attestations must be current within 120 days of completion of this form/application to become a Coordinated Care contracted provider
2. The HCA requires that all Managed Care Organizations ensure that providers we contract with, either have a Core Provider Agreement (CPA) with the HCA or register as a "non-billing provider". Providers register here: http://www.hca.wa.gov/medicaid/providerenroll/pages/enroll.aspx
3. Behavioral Health practitioners should complete the Provider Specialty Profile (CC_Behavioral Health Profile_v2) in addition to this Provider Data Form

Service Locations

Primary Location Name (to appear in Public Directory)			
Location Address (Street):			Suite #
City:	State:	County:	Zip:
Phone:	Fax:	Handicap Access: ☐ Yes ☐ No	
Do you carry a panel (*are you available on an ongoing outpatient basis to see all members*) at this location: ☐ Yes ☐ No If No, please explain below: ☐ Seeing existing members only ☐ Panel is temporarily closed ☐ Seeing Foster Care members only			
Office Hours. *Indicate the hours your are available for member appointments* **(***24 hrs, hh:mmAM-hh:mmPM, Closed***)**			
Monday:	Tuesday:	Wednesday:	Thursday:
Friday:	Saturday:	Sunday:	*Notes*:
Secondary Location (to appear in Public Directory)			
Location Address (Street):			Suite #
City:	State:	County:	Zip:
Phone:	Fax:	Handicap Access: ☐ Yes ☐ No	
Do you carry a panel (*are you available on an ongoing outpatient basis to see all members*) at this location: ☐ Yes ☐ No If No, please explain below: ☐ Seeing existing members only ☐ Panel is temporarily closed ☐ Seeing Foster Care members			
Office Hours. *Indicate the hours your are available for member appointments* **(***24 hrs, hh:mmAM - hh:mmPM, Closed***)**			
Monday:	Tuesday:	Wednesday:	Thursday:
Friday:	Saturday:	Sunday:	*Notes*:
Additional Service Location Name (to appear in Public Directory):			
Location Address (Street):			Suite #
City:	State:	County:	Zip:
Phone:	Fax:	Handicap Access: ☐ Yes ☐ No	
Do you carry a panel (*are you available on an ongoing outpatient basis to see all members*) at this location: ☐ Yes ☐ No If No, please explain below: ☐ Seeing existing members only ☐ Panel is temporarily closed ☐ Seeing Foster Care members only			
Office Hours. *Indicate the hours your are available for member appointments* **(***24 hrs, hh:mmAM - hh:mmPM, Closed***)**			
Monday:	Tuesday:	Wednesday:	Thursday:
Friday:	Saturday:	Sunday:	*Notes*:

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If you have successfully completed and saved the above information in CAQH or ProviderSource, the fields (if applicable) do not have to be completed here; however, if this information is left blank/not provided it will delay contracting/credentialing.

Please submit this form by email to: CONTRACTING@coordinatedcarehealth.com

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Provider Specialty Profile – Mental Health Practitioners ONLY

Please place an "x" in the box next to the area of specialty that applies to the practitioner (any and all that apply)

Practitioner Name:					Practitioner NPI:
Types of Services					
	Individual Therapy		Group Therapy		Intensive Outpatient
	Couples Therapy		Medication Management		Psychological Testing
Certifications					
	Art Therapy		Emergency Services Provider		SBIRT
	Center of Excellence		Lead Behavior Analysis Therapist		Trauma Informed Care
	Emergency Services Provider		Positive Behavior Support		
Settings/Populations Treated					
	Adolescents		Gay/Lesbian		Physical Disability
	Adults		Geriatric		Serious Emotional Disturbance
	Blind/Visually Impaired		Hospital Based		Serious Mental Illness
	Children		Home Based		Severe Persistent Mentally Ill
	Community Based		Homelessness		School Based
	Deaf/Hearing Impaired		Men		Telemedicine
	Developmental Disability		Mobile Crisis		Women
	Emotionally Disturbed		Nursing Home		Young Children
Treatment Modalities/ Approaches					
	Applied Behavioral Analysis (ABA)		Dialectical Behavioral Therapy		Parent Child Interaction Therapy (PCIT)*
	Addictive Disorders		Developmental Evaluation		Play Therapy
	Adolescent Psychotherapy		Dialectical Behavioral Therapy		Psychological Testing
	Adolescent Sex Offender		Developmental Evaluation		Psychoanalytic Therapy
	Adolescent Psychiatry		Domestic Violence		Psychodynamic Therapy
	Adoption Issues		ECT		Psychopharmacology
	Alcohol/SA Treatment		Child Psychiatry		Pain Management
	Anger Management		EMDR		Rationale Emotive Therapy
	Art Therapy		Evaluation/Assessment		Relapse Prevention
	Attachment Therapy		Family Therapy		Relationship Disorders
	Behavioral Therapy		Family Systems		Sensory Processing/Integration
	Brief Therapy		Gay/Lesbian/Bisexual		Sex Therapy
	Biofeedback		Group Therapy		Sexual Compulsions/Addictions
	Chemical Dependency Assessment		Geriatric Psychiatry		Solution Empowerment Therapy
	Child Parent Psychotherapy (CCP)		Gestalt		Strengthening Families Program*
	Child Psychological Testing		Hypnosis		Stress Management
	Christian Counseling		Intensive Family Intervention		Theraplay Model (Promising Practice)*
	Client Centered Therapy		Individual Therapy		Tobacco
	Cognitive Therapy		Intensive Outpatient		Tobacco Cessation
	CBT+ for Anxiety, Behaviors and Depression*		Intake Assessment		Trauma Focused- CBT*
	Community Support Program		Medication Management		Trauma Focused Cognitive Behavioral Therapy (TF-CBT)*
	Community Support Program for the homeless		Methadone/Suboxone		Trauma Informed Care (TIC)
	Cognitive Rehab Therapy		Mood Disorders		Triple P (Positive parenting program) □ Level 2 □ Level 3*
	Couples Therapy		Neuropsychological Testing		Trust Based Relational Intervention (TBRI)
	Crisis Intervention/Stabilization		Neuro-Linguistic Programming (NLP)		Weight Management
	Critical Incident Debriefing		Outcomes Oriented Therapy		

* MCOs are required by the HCA to report on services billed by practitioners utilizing these Evidence/Research Based Practices for clients under the age of 21 covered under Apple Health

Provider Specialty Profile – Mental Health Practitioners ONLY

Disorders/Issues					
	Addictive Medicine		Separation/Divorce		Organic Mental Disorder
	ADD/ADHD		Domestic Violence		Parenting Issues
	Addictive Disorders		Dual Diagnosis		Personality Disorders
	Adjustment Disorder		Depression		Post-Partum Disorder
	Adolescent Behavior Disorders		Disabled		PTSD
	Adoption Issues		Eating Disorders		Panic Disorder
	Adult ADD		Equine Assisted Therapies		Phobias
	AIDS/HIV		Family Dysfunction		Physical Abuse
	Anger Management		Feeding Disorders		Reactive Attachment Disorder
	Anxiety/Panic Disorder		Gay/Lesbian/Bisexual		Relapse Prevention
	Attachment Disorder		Gender Identity Issues		Sexual/Physical Abuse (Adults)
	Autism/Asperger's		Grief/Loss/Bereavement		Sexual/Physical Abuse (Children)
	Bipolar Disorders		Head Trauma		Schizophrenia
	Chemical Dependency		Home Visits		Serious/Persistent Mental Illness
	Christian/Spiritual		Impulse disorders		Sexual Disorders
	Chronic Pain/Pain Management		Infertility		Sexual Dysfunction
	Crisis Stabilization		Inpatient Attending		Sexual Abuse/Incest
	Cultural Issues		Inpatient Consult MD		Sleep Disorder
	Child/Parent Bonding		Learning Disability		Step/Blended Families
	Co-occurring Disorders		Medical Evaluation		Stress Management
	Cognitive Disorder		Medical Illness/Chronic Illness		Self-Injury
	Concussion		Men Issues		Sexual Offender
	Criminal Offenders		Mood Disorders		Substance Abuse
	Dementia Disorders		Marital Issues		Suicide
	Developmental Disorder		Mental Retardation		Tobacco Cessation
	Disruptive Behavior		Obsessive Compulsive Disorder		Women Issues
	Dissociative Disorder		Oppositional Defiant Disorder		Work Related Problems

* MCOs are required by the HCA to report on services billed by practitioners utilizing these Evidence/Research Based Practices for clients under the age of 21 covered under Apple Health

The above information will be made available to Coordinated Care members on our public directory for more successful, targeted self-referral.