

Managed Long-Term Care (MLTC) Medicaid



Please complete the form in its entirety. If a field/section does not apply, write "N/A". Attach additional information on separate sheets as needed.

The completed form can be submitted:

- Online: <https://nascentiahealthoptions.org/provider-info/service-provider-application/providerrelations@477home.org>
- Email: providerrelations@477home.org
- Fax: 315.671.5129
- Mail: Nascentia Health Options
Attn: Provider Relations Department
1050 West Genesee Street
Syracuse, NY 13204-2215

Questions: Call 315.477.9820

Service Provider Application

General Information

Name:			
Street Address:			
City:	State:	Zip Code:	
County:			
Phone:	()	Fax (for authorizations):	()
Billing Address:			
City:	State:	Zip Code:	
County:			
Phone:	()	Fax (for authorizations):	()
Tax ID (EIN) #:			
Medicaid Provider Number:			
Medicare Certification:	Yes	No	N/A
Medicare Provider Number:			
NPI #:			

If your facility has more than one NPI #, please list the NPI # and the facility name below:

NPI #:

Facility Name:

NPI #:

Facility Name:

NPI #:

Facility Name:

License/Facility Operating Certificate#:

Parent Company Information (if applicable):

Parent Company:

Street Address:

City:

State:

Zip Code:

Primary Contact
Person:

Contact Person
Title:

Contact Person
Phone:

()

Contact Person
Email:

Location Information

Please indicate counties serviced by main address location:

Address and Phone Number of Branch or Satellite Offices (with counties serviced):

1.

2.

3.

4.

5.

Operating Hours: Please list hours (a.m. and p.m.)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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Hours:							
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Contact Information (include name, title, phone and email):

Compliance:

Contracts:

Credentialing:

Scheduling:

Billing:

If your facility uses a third-party billing agency, please provide the legal name and address below:

[Empty text box for third-party billing agency name and address]

Billing Format and Forms Used:

(i.e. UB-92, HCFA-1500)

[Empty text box for billing format and forms used]

Select all items applicable to your location:

<input type="checkbox"/>	Public Transportation Accessibility		
<input type="checkbox"/>	Wheelchair Accessible		
<input type="checkbox"/>	Foreign Languages Spoken	If selected, list languages:	<input type="text"/>
<input type="checkbox"/>	American Sign Language		
<input type="checkbox"/>	Network Hearing System (TDD)		
<input type="checkbox"/>	Elevator		
<input type="checkbox"/>	Vision Accessible		
<input type="checkbox"/>	Other	If selected, list "Other Services" offered:	<input type="text"/>

******THE FULLY EXECUTED CONTRACT WILL BE MAILED BACK TO THE PERSON WHO SIGNED IT. IF YOU WISH FOR IT TO BE MAILED TO A DIFFERENT PERSON/ADDRESS PLEASE LIST BELOW******

Name:

Street Address:

City: <input type="text"/>	State: <input type="text"/>	Zip Code: <input type="text"/>
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Service Provider Applications:

Please select what type of service provider(s) you are applying for:

<input type="checkbox"/>	Adult Day Care (page 6)
<input type="checkbox"/>	Certified Home Care Agency (CHHA) / Licensed Home Care Services Agency (LHCSA) (pages 7-10)
<input type="checkbox"/>	Consumer-Directed Personal Aid (FI) (pages 11-12)
<input type="checkbox"/>	Durable Medical Equipment / Personal Emergency Response System (pages 13-14)
<input type="checkbox"/>	Home and Safety Modification (page 15)
<input type="checkbox"/>	Licensed / Certified Professional Services (pages 16-17)
<input type="checkbox"/>	Meals Provider (page 18)
<input type="checkbox"/>	Skilled Nursing Facility (SNF) (pages 19-20)
<input type="checkbox"/>	Transportation Provider (page 21)

Complete the required sections for each service provider you are applying for.

The page number for the required sections for each service provider are listed in the table above.

After completing pages 1-4 and the necessary Service Provider Applications REMEMBER TO COMPLETE the Attestation, Credentialing Attestation and Release Form and Certification / Affirmation of Accuracy and Completeness on pages 22-23.

Adult Day Care:

Please attach the following documents:

- Business Associates Agreement (Social adult day only)
 - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information below; Medicaid Provider Number required for Medical Adult Day Program)
- W-9 with legal name and remit address
- Proof of OMIG Certification (Social adult day only)
- Proof of adequate insurance coverage
 - General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204 listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Note: Before contract may be executed, an in-person site inspection visit must be completed. Your regional Provider Relations Representative will request to schedule one upon receipt of all necessary credentialing documentation listed above.

Adult Day Care Services offered (Check all that apply):

<input type="checkbox"/>	Adult Medical Day Care – Full Day
<input type="checkbox"/>	Adult Medical Day Care – Half Day
<input type="checkbox"/>	Adult Social Day Care – Full Day
<input type="checkbox"/>	Adult Social Day Care – Half Day
<input type="checkbox"/>	Meals Included
<input type="checkbox"/>	Day Care Transportation – Taxi
<input type="checkbox"/>	Day Care Transportation – Wheelchair

Certified Home Care Agency (CHHA) / Licensed Home Care Services Agency (LHCSA):

Please attach the following documents:

- Valid state license(s) or operating certificate(s)
- JCAHO accreditation report (if applicable)
- Most recent NYSDOH State Survey & Plan of Correction
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Copy of patient satisfaction survey
- FLSA Attestation Form (complete form(s) on pages 9 and/or 10 and sign)
- Proof of adequate insurance coverage
 - General Liability, Professional Liability and Transportation (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

JCAHO Accreditation:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A
CARF Accreditation:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>	N/A

Home Health Care Agency Services offered (Check all that apply):

Certified	Licensed			
		Home Health Aide		
		Housekeeping (Personal Care Aide, Level I)		
		Personal Care Aide, Level II		
		Medical Social Work		
		Medication Dispensing Services		
		Nutritional Counseling		
		Nursing, in home (LPN, RN)		
		Occupational Therapy		
		Physical Therapy		
		Speech Therapy		
		Personal Emergency Response Systems (PERS) – Landline		
		Personal Emergency Response Systems (PERS) – Cellular		
		Personal Emergency Response Systems (PERS) – GPS		
		Personal Emergency Response Systems (PERS) – Fall Detection		
		PRI & Screen Assessment Services		
		Private Duty Nursing, LPN		
		Private Duty Nursing, RN		
		Respiratory Therapy		
		Telehealth Services		
		UAS Assessment Services		
		Wound Care		
		Other Certified Home Health Services	If selected, list "Other Certified Home Health Services":	
		Other Licensed Home Health Services	If selected, list "Other Licensed Home Health Services":	

NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

CERTIFIED HOME HEALTH AGENCY

Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby certify that funding for all Medicaid home care services provided by my organization in accordance with the Department’s April 2017 Dear Colleague Letter on FLSA Implementation, will be passed through to the home care worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (including required licensed home care service agency attestations and information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Check the appropriate box:	<input type="checkbox"/>	Fee-For-Service	<input type="checkbox"/>	Managed Care
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Name of CHHA:	<input type="text"/>
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Operating Cert. #:	<input type="text"/>	Date	<input type="text"/>
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Signature:	<input type="text"/>
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Name (Please print):	<input type="text"/>
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Title (Please print):	<input type="text"/>
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Please note that in accordance with Parts 86-1.2 of Title 10 of the Commissioner’s Administrative Rules and Regulation, only the following individuals may sign this attestation:

- Proprietary Sponsorship – Operator/ Owner
- Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer),
Chief Executive officer, Chief Financial Officer or Chairperson
- Public Sponsorship – Public Official Responsible for the Operation of the Facility

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 Dear Colleague Letter on FLSA Implementation.

NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

LICENSED HOME CARE AGENCY

Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby certify that funding for all Medicaid home care services provided by my organization in accordance with the Department’s April 2017 Dear Colleague Letter on FLSA Implementation, will be passed through to the home care worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (including this attestation and related information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Check the appropriate box:	<input type="checkbox"/>	Fee-For-Service	<input type="checkbox"/>	Managed Care
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Name of LHCSA:	<input type="text"/>
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License #:	<input type="text"/>	Date	<input type="text"/>
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Signature:	<input type="text"/>
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Name (Please print):	<input type="text"/>
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Title (Please print):	<input type="text"/>
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Please note that in accordance with Parts 86-1.2 of Title 10 of the Commissioner’s Administrative Rules and Regulation, only the following individuals may sign this attestation:

- Proprietary Sponsorship – Operator/ Owner
- Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors
- Public Sponsorship – Public Official Responsible for the Operation of the Facility

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 Dear Colleague Letter on FLSA Implementation.

Consumer-Directed Personal Aid (FI):

Please attach the following documents:

- EIN, Medicaid Provider Number & NPI number (provide information below)
- W-9 with legal name and remit address
- FLSA Attestation Form (complete form on page 12 and sign)
- Proof of adequate insurance coverage
 - General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

NEW YORK STATE DEPARTMENT OF HEALTH OFFICE OF HEALTH INSURANCE PROGRAMS

CONSUMER DIRECTED FISCAL INTERMEDIARY

Attestation of Compliance with Fair Labor Standards Act (FLSA) Funding

I hereby attest that funding for all Medicaid consumer directed personal assistance services provided by my organization in accordance with the Department’s April 2017 Dear Colleague Letter on FLSA Implementation, will be passed through to the consumer directed worker, in its entirety. I further certify that I will maintain all records necessary to verify compliance with this directive (including this attestation and related information) for a period of no less than ten years from the end of the applicable calendar year; and that such records will be subject to audit by the Department and/or its agents for possible retroactive recoupment of Medicaid payments for services that are determined to be in less than full compliance.

In addition, I will provide the managed care organization, if applicable, and/or the Department (when applicable) with all information to verify my compliance with the terms of this directive (including this attestation) and that such information shall be made available to the Department upon request.

Check the appropriate box:	<input type="checkbox"/>	Fee-For-Service	<input type="checkbox"/>	Managed Care
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Name of FI:	<input type="text"/>
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MMIS No. (Medicaid ID):	<input type="text"/>	Date	<input type="text"/>
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Signature:	<input type="text"/>
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Name (Please print):	<input type="text"/>
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Title (Please print):	<input type="text"/>
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The following individuals may sign this attestation:
Proprietary Sponsorship – Operator/ Owner
Voluntary Sponsorship – Officer (President, Vice President, Secretary or Treasurer), Chief Executive Officer, Chief Financial Officer or any Member of the Board of Directors

Please note that the Department reserves the right to request additional information in the future to ensure compliance with terms of the April 2017 Dear Colleague Letter on FLSA Implementation.

Durable Medical Equipment / Personal Emergency Response System:

Please attach the following documents:

- Business Associates Agreement
 - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information below)
- W-9 with legal name and remit address
- Incontinence Products Verification (only applicable to DME providers who offer incontinence supplies)
- Proof of adequate insurance coverage
 - General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Durable Medical Equipment/Personal Emergency Response System Services offered (Check all that apply):

<input type="checkbox"/>	Durable Medical Equipment and Supplies
<input type="checkbox"/>	Incontinence Supplies
<input type="checkbox"/>	Medicare-Authorized DME Provider (Lift Chairs, Wheelchairs, Walkers, etc.)
<input type="checkbox"/>	Medication Dispensing Systems
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – Basic / Landline
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – Cellular
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – GPS
<input type="checkbox"/>	Personal Emergency Response Systems (PERS) – Fall Detection
<input type="checkbox"/>	Other
	If selected, list "Other Services" offered:

For Durable Medical Equipment (DME) vendors who supply incontinence products:

The Department of Health (DOH) issued an incontinence supply initiative effective September 1st, 2016. DME companies must now ensure that incontinence products that they dispense to Medicaid members meet minimum quality standards put in place by the DOH.

The minimum standards include:

- No plastic (Non-breathable) backed products
- Rewet rate of <2.0g
- Rate of Acquisition (ROA) of <6 seconds
- Retention Capacity >250g
- Presence of breathable zones with a minimum value of >100 cubic feet per minute (cfm)
- Presence of closure system which allows for multiple fastening and unfastening occurrences

Verification that your incontinence products meet minimum standards must be on file with Provider Relations at VNA Options. Verification must be in the form of test results obtained from an independent testing laboratory.

IF your company purchases incontinence products from Twin Med, LLC, the State's new preferred supplier, you do not have to verify incontinence product quality standards. Proof that your products are being purchased from Twin Med, LLC will suffice.

Further, most First Quality and Covidien brands meet minimum quality standards, however, verification for these brands must also be on file.

	Twin Med verification		or Minimum quality standards verification
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Home and Safety Modification:

Please attach the following documents:

- Business Associates Agreement
 - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information below)
- W-9 with legal name and remit address
- Copy of contractor's license
- Proof of adequate insurance coverage
 - General Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Environmental Modifications and Support Services offered (Check all that apply):

<input type="checkbox"/>	Installation of Ramps (Portable, Threshold, Modular)		
<input type="checkbox"/>	Installation of Wheelchair Lifts (Platform, Incline)		
<input type="checkbox"/>	Installation of Stair Lifts (Straight, Curved)		
<input type="checkbox"/>	Installation of DME Supplies (Grab Bars, Handheld Shower, etc.)		
<input type="checkbox"/>	Other Services	If selected, list "Other Services offered:"	<input type="text"/>
<input type="checkbox"/>	Other Home and Safety Modifications	If selected, list "Other Home and Safety Modifications" offered:	<input type="text"/>

Licensed / Certified Professional Services:

Please attach the following documents:

- Valid state licensure information (provide Licensure/Certification information on page 2)
- EIN, Medicaid Provider Number & NPI number (provide information below)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
 - General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Services offered (Check all that apply):

<input type="checkbox"/>	Audiology (exam only)		
<input type="checkbox"/>	Audiology (hearing aid services available)		
<input type="checkbox"/>	Nutritional Counseling		
<input type="checkbox"/>	Outpatient Occupational Therapy		
<input type="checkbox"/>	Outpatient Physical Therapy		
<input type="checkbox"/>	Outpatient Speech Therapy		
<input type="checkbox"/>	Podiatry, in Home		
<input type="checkbox"/>	Podiatry, in Outpatient Setting		
<input type="checkbox"/>	Podiatry, in Skilled Nursing Facility		
<input type="checkbox"/>	Prosthetics and Orthotics		
<input type="checkbox"/>	Respiratory Therapy		
<input type="checkbox"/>	Other Services	If selected, list "Other Services" offered:	<input type="text"/>

Please list License/Certification information for all professionals employed at your facility. Applicable to all licensed staff, including but not limited to: Audiologists, Dietitians, Nutritionists, Optometrists, Opticians, Outpatient Therapists (PT, OT, ST, Respiratory) and Podiatrists. Copy this page if you need more space.

1. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
2. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
3. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
4. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
5. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

Meals Provider:

Please attach the following documents:

- Business Associates Agreement
 - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
 - General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 2 million aggregate, or umbrella coverage)

Meal Services offered (Check all that apply):

<input type="checkbox"/>	Congregate Meals
<input type="checkbox"/>	Home Delivered Meals

Skilled Nursing Facility (SNF):

Please attach the following documents:

- Valid state license(s) or operating certificate(s) (provide Licensure/Certification information on page 2)
- JCAHO accreditation report (if applicable)
- Most recent NYSDOH State Survey & Plan of Correction
- EIN, Medicaid Provider Number & NPI number (provide information below)
- W-9 with legal name and remit address
- Copy of patient satisfaction survey
- Proof of adequate insurance coverage
 - General Liability and Professional Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 3 million aggregate, or umbrella coverage)

Permanent Facility Identifier:					
JCAHO Accreditation:		Yes		No	N/A
CARF Accreditation:		Yes		No	N/A
Covered Services offered:					
	Adult Medical Day Care (ADHC)				
	Adult Social Day Care (SADC)				
	Audiology (hearing aid dispensing)				
	Audiology (hearing exam services)				
	Dentistry (on-site)				
	Outpatient Occupational Therapy				
	Outpatient Physical Therapy				
	Outpatient Speech Therapy				
	Podiatry (on-site)				
	Transportation (Day Care)				
	Transportation (to member appointments)				
	Vision Care (on-site)				

Skilled Nursing Facility Services:

	Daily Room and Board
	Specialty Beds (Behavioral, Neurological, Ventilation)
	Respite Care

For SNFs providing OUTPATIENT THERAPY: Please list License/Certification information for all OT/PT/ST professionals employed at your outpatient facility. Copy this page if you need more space.

1. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
2. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
3. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			
4. Name:		License #:	
Occupation:		Individual NPI:	
Practitioner Medicaid ID:		Practitioner Medicare ID:	
Practice Location(s):			

Transportation Provider:

Please attach the following documents:

- Business Associates Agreement
 - Nascentia will send for review and signature along with finalized contract
- EIN, Medicaid Provider Number & NPI number (provide information in this form)
- W-9 with legal name and remit address
- Proof of adequate insurance coverage
 - General Liability (ACORD Form with Nascentia Health Options, 1050 West Genesee St, Syracuse, NY 13204, listed in the certificate holder box; minimum requirement of 1 million per occurrence and 2 million aggregate, or umbrella coverage)
 - Automobile coverage (may be listed on the same or different ACORD form detailed above)

DOT Certificate #:

Transportation Services offered (Check all that apply):

<input type="checkbox"/>	After Hours Transportation
<input type="checkbox"/>	Door to Door Assist
<input type="checkbox"/>	Non-Emergent Ambulance
<input type="checkbox"/>	Stretcher
<input type="checkbox"/>	Wheelchair
<input type="checkbox"/>	Bariatric Wheelchair
<input type="checkbox"/>	Taxi

After filling out the necessary Service Provider Applications REMEMBER TO COMPLETE the Attestation, Credentialing Attestation and Release Form and Certification / Affirmation of Accuracy and Completeness on pages 22-23.

Attestation

I agree to use best efforts to inform Nascentia Health Options in writing within 15 business days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to signing this application.

I agree that a photocopy or facsimile of this document with my signature may be accepted with the same authority as the original.

Credentialing / Recredentialing Attestation and Release Form

In the past 3 years or presently, has your company or any of its representatives:

Had disciplinary actions, criminal proceedings, or other adverse actions initiated against them (this includes license or certification limitations, revocations, suspensions, terminations, or voluntary relinquishment)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Yes

No

Been subject of an investigation, or ever been suspended, sanctioned or otherwise excluded from participating in any private, state, or federal health insurance program (examples – Medicare, Medicaid, other Managed Care Organization)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Yes

No

Been subject to (in whole or in part) professional liability or malpractice claims, suits, settlements, arbitration proceedings, or complaints?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Yes

No

Been subjected to any investigation, claim, or disciplinary action due to unethical conduct?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Yes

No

Been denied liability insurance (in whole or in part) or had your insurance canceled, involuntarily restricted, denied renewal, or rated up because of the nature volume of claims against your company?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Yes

No

If you answered “yes” to any of the above questions, please explain below.

Subcontractor Initials

Please initial:

I confirm that there is a process in place to monitor and screen employees, volunteers, governing body members, and downstream entities for Healthcare related criminal convictions.

I confirm that there is a process in place to monitor and screen employees, volunteers, governing body members, and downstream entities against the List of Excluded Individuals (LEIE) – <https://exclusions.oig.hhs.gov/>, Excluded Parties List System (EPLS) <https://sam.gov/SAM/> , and the New York Exclusions Database – <https://www.omig.ny.gov/search-exclusions> prior to hiring and monthly thereafter.

Certification / Affirmation of Accuracy and Completeness

I hereby affirm that all information provided in or attached to this application for credentialing/re-credentialing is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I understand that any misrepresentation or omission of any fact requested, whether intentional or not, is cause for automatic and immediate rejection and/or termination of the credentialing/re credentialing process.

I hereby agree to immediately notify Nascentia Health Options if such representation ever ceases to be accurate and true. I understand that this credentialing/re-credentialing review process will occur prior to approval of participation. I hereby authorize Nascentia Health to consult with any third party who may have information bearing on any services that my company provides. I hereby release any person, institution or other party from any liability in connection with the provision of such information or documentation.

Name of Organization:

Authorized Representative
Signature:

Authorized Representative
Printed Name:

Authorized Representative
Title:

Date: