## Credentialing Initiation Form

# Licensed Practitioner

*Use this form to initiate the LME/MCO credentialing process.*

*Completion of this form is required in addition to the CAQH Application.*

Vaya Health (Vaya) is responsible for processing all applications for credentialing submitted by applicants seeking to become a member of the closed networks of Vaya. LME/MCO is responsible for making its own independent decisions about credentialing approval, enrollment, network membership and contracting. Vaya's responsibility is limited to processing the application.

This form and required attachments must be submitted via secure electronic transmission to: CredentialingTeam@vayahealth.com. Alternatively, this form and attachments may be submitted to:

Credentialing Team
Vaya Health
200 Ridgefield Court, Suite 206
Asheville, NC 28806

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## INSTRUCTIONS

All licensed practitioners seeking to provide clinical services to enrollees of a Local Management Entity/Managed Care Organization (LME/MCO) must be credentialed. This includes licensed practitioners who bill through an agency, group practice or facility (LPs) and Licensed Independent Practitioners (LIPs) seeking a direct contract with the LME/MCO. The credentialing process for practitioners includes submission of this CIF and attachments, completion of a CAQH application, verification of credentials and review of the application by the LME/MCO Credentialing Committee. The Credentialing Committee will make a final determination about approval of any applicant's credentials. The credentialing effective date may not be earlier than the date a complete application has been received by Vaya. For LPs, the billing effective date cannot be earlier than the credentialing effective date. ***The provision of services prior to receiving notification of approved credentials is at the risk of the agency***. For LIPs, the billing effective date may not be earlier than the effective date of the contract between the credentialed applicant and the LME/MCO.

This CIF must be completed in its entirety, with all questions addressed and required information submitted. Any required attachments should be easily identifiable and submitted with the CIF in sequential order. Applicants will be notified if the CIF is incomplete. Previous versions of this CIF will not be accepted. A clean CIF includes a signed attestation and all required information and documentation in order for the credentialing verification to be completed, i.e., that Vaya has determined no further information is required and that all information provided is complete, accurate and contains no conflicting information. A CIF is considered to be incomplete if:

- All spaces in the CIF have **not** been completed. (Please indicate "N/A" or "None" if the question is not applicable.)
- The Attestation and Consent for Release are not signed and dated.
- The text has been altered, highlighted, struck through or obstructed through the use of correction fluids.
- The responses are illegible.
- Any of the required documents or pages are missing.

Note: An individual NPI number is now required for all practitioners, including associates.

To apply for a new NPI number, visit https://nppes.cms.hhs.gov/NPPES/Welcome.do.

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*Use this form to initiate the LME/MCO credentialing process*

**Name:** ________________________ _____________ ___________________________ ________________
First Middle Last Maiden

**Applying as (check one):**

☐ An employee of an agency, group practice or facility

**If yes, enter agency name:** ____________________________________________________

**Start date with current agency, if applicable:** ________________________________

☐ A Licensed Independent Practitioner (**Note: Independent practitioners must receive prior approval to submit this form from the LME/MCO with which you are seeking to contract.)**

**Individual NPI Number:** ___________________ **TIN (Tax ID #):**____________________ **CAQH number:**_______________

**License Number:** ________________________ **Primary Taxonomy Number:** ________________________

**Are you**: ☐ Fully licensed **or** ☐ Associate (provisionally) licensed

| | | |
|---|---|---|
| ☐ MD | ☐ Clinical Psychologist | ☐ Adv. Practice Psychiatric CNS (APPCNS) |
| ☐ DO | ☐ Physicians Assistant (PA) | ☐ Psychiatric Mental Health NP (PMHNP) |
| ☐ LPC | ☐ Neuropsychologist | ☐ Out of State License Type: |
| ☐ LCSW | ☐ Psychological Associate | |
| ☐ LMFT | ☐ Alcohol/Drug Counselor (LCAS) | |
| **For specialized consultative IDD services only:** | | |
| ☐ Physical Therapist (PT) | ☐ Occupational Therapist | ☐ Speech Therapist |
| ☐ BCBA | ☐ Certified Therapeutic Recreational Therapist | ☐ Nutritionist |

**Contact person:** ___________________________________________ **Contact phone:** ______________________________________

**Contact email:** ________________________________________ **Pract. agency email:** ________________________________________

**Practitioner personal email:** ______________________________________________________________________________________

**Home address:** ____________________________________________________________________________________________
Street City State ZIP

**Site address:** _____________________________________________________________________________________________
Street or PO Box City State ZIP+4 ***(required)***

**Site County**: ___________________________________________________

**Employment gaps**: Please explain any gaps longer than six months in the last five years. Use a separate sheet if necessary.

## 5% OWNERSHIP OR CONTROL DISCLOSURE

**Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services?**

☐ Yes ☐ No **If you answered yes**, complete the following information for each relevant entity.

| Entity's legal name | Federal tax ID # | Medicaid # |
|---|---|---|
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## Credentialing Initiation Form – Licensed Practitioner

*Use this form to initiate the LME/MCO credentialing process*

### PRACTICE INFORMATION

Help us communicate to consumers, staff and others what they need to know about you. *Credentialing cannot be initiated without receipt of this form. Check below all that apply to your scope of practice/expertise (proof may be requested).*

| **General Categories** | **Ages** | |
|---|---|---|
| ☐ Mental Health | ☐ Young Child (3-5) | ☐ Older Child (6-12) |
| ☐ Intellectual/Developmental Disabilities | ☐ Adolescent (13-20) | |
| ☐ Substance Use | ☐ Adult (21-64) | ☐ Geriatrics (65+) |

| **General & Applied Approaches** | | | |
|---|---|---|---|
| ☐ ADHD | ☐ Conduct Disorders | ☐ Group Therapy | ☐ Post-Traumatic Stress |
| ☐ Alcohol and other Drug Use | ☐ Co-occurring MH/SU Issues | ☐ HIV/AIDS | ☐ Psychological Testing |
| ☐ Anger Management | ☐ Dementia | ☐ Learning Disabilities | ☐ Psychotic Disorders |
| ☐ Anxiety Disorders | ☐ Dialectical Behavior Therapy | ☐ Mood Disorders | ☐ Sex Offender Treatment |
| ☐ Applied Behavioral Analysis | ☐ Eating Disorders | ☐ Neurodegenerative Disorders | ☐ Sexual Behavior Problems |
| ☐ Autism Spectrum | ☐ Faith-Based Counseling | ☐ Neuropsychological Disorders | ☐ Trauma Focused Treatment |
| ☐ Behavior Therapy | ☐ Family Systems | ☐ Parent Training | ☐ Traumatic Brain Injury |
| ☐ Biofeedback | ☐ Forensic Screening/ Evaluation* | ☐ Personality Disorders | ☐ Women's Issues |
| ☐ Cognitive Behavior Therapy | ☐ Gay/Lesbian/Transgender | ☐ Play Therapy | ☐ Other [Specify] |

| **Clinician Certification/Expertise (may require verification)** | | | |
|---|---|---|---|
| ☐ Addiction psychiatry fellowship, board, or ASAM certification | ☐ Addiction treatment (LCAS, CSAC, CCS) | ☐ Child psychiatry fellowship or board certification | ☐ Forensic psychology/ psychiatry *N.C. state certification required to complete forensic screenings and evaluations* |

| **Culturally diverse populations that you feel competent to treat** | | |
|---|---|---|
| ☐ Caucasian | ☐ Black or African American | ☐ American Indian/Alaska Native |
| ☐ Asian/Pacific Islander | ☐ Hispanic/Latino | ☐ Other [Specify] |

| **Language(s) other than English in which you are able to communicate fluently** | | |
|---|---|---|
| ☐ Spanish | ☐ American Sign Language | ☐ Other [Specify] |
| ☐ Available Interpreter Types: | | |

| **Gender/Race/Ethnic Background (Information is voluntary and can be used publicly.)** |
|---|
| ☐ Black/African American ☐ Hispanic/Latino ☐ Asian/Pacific Islander ☐ Caucasian<br>☐ American Indian/Alaska Native American ☐ Other [Specify] |

**Do you have any current contracts with other Medicaid managed care organizations (including LME/MCOs or out-of-state MCOs), or have you had any such contracts in the past three years?**

☐ Yes ☐ No If yes, please identify the MCO(s): ____________________________________________________________

**Please indicate the method you will use to perform electronic billing:**

☐ Web-based billing via high-speed internet connection

☐ HIPAA-compliant transaction sets (837 transactions and 835 remittances)

*Note: You must be able to send 837 transactions and receive 835 remittances* ***OR*** *participate in the LME/MCO web-based billing portal as a condition of participation.*

## Credentialing Initiation Form – Licensed Practitioner

*Use this form to initiate the LME/MCO credentialing process*

| | Yes | No |
|---|---|---|
| **Check "yes" or "no."** *For each question answered "yes," provide a detailed explanation on a separate page and any documentation supporting your explanation. The explanation should describe the circumstances that led to the event.* **Lack of disclosure will result in the denial of the application.** | | |
| A. Have you ever been identified on the List of Excluded Individuals/Entities maintained by the U.S. Health and Human Services Office of Inspector General or the U.S. System for Award Management list? | ☐ | ☐ |
| B. Have you ever had an overpayment in excess of $50,000.00 identified by Medicare or a Medicaid program in any state, or have you been employed by an organization that had an overpayment in excess of $50,000.00 identified by Medicare or a Medicaid program in any state, even if the overpayment has been paid in full? | ☐ | ☐ |
| C. Have you ever had civil monetary penalties levied by Medicare, Medicaid or other state or federal agency or program, including the Division of Health Service Regulation (DHSR), or been employed by an organization that had civil monetary penalties levied by Medicare, Medicaid or other state or federal agency or program, including the Division of Health Service Regulation (DHSR), even if the fine(s) have been paid in full? | ☐ | ☐ |
| D. Do you owe money to Medicare or any state Medicaid program that has not been paid? | ☐ | ☐ |
| E. Have you ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other state Medicaid program, or any other publicly funded federal or state healthcare or health insurance program, and been sanctioned accordingly? | ☐ | ☐ |
| F. Have you ever been convicted of any criminal offense related to the neglect or abuse of a patient in connection with the delivery of any healthcare goods or services? | ☐ | ☐ |
| G. Have you ever been convicted of any criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance? | ☐ | ☐ |
| H. Have you ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct? | ☐ | ☐ |
| I. Have you ever been convicted of a misdemeanor or felony, including but not limited to, traffic violations? | ☐ | ☐ |
| J. Have you ever been convicted of any criminal offense in a country outside the jurisdiction of the United States? | ☐ | ☐ |
| K. As of the date of this application, do you have any pending charges related to the above categories of "A" through "J"? | ☐ | ☐ |

## Arrangements for 24-hour/7-day coverage:

Please provide a name and telephone number of the on-call designee or an explanation of 24-hour/7-day coverage.

_______________________________________________ Name

_______________________________ Phone number

**Credentialing Initiation Form – Licensed Practitioner**
*Use this form to initiate the LME/MCO credentialing process*

**Please attach the following documents (all applicants):**

___ Resume and/or Curriculum Vitae that includes all training and professional history following graduation from Medical, Dental or other professional school

**Please attach the following documents (if applicable):**

___ Collaborative Practice Agreement (applicable only to Nurse Practitioners not billing through an agency)

**LIPs Only: Please attach/complete the following**

___ Attach a copy of the NC Secretary of State (SOS) filing documents (if registered with SOS)

___ Do you have 100% ownership of this practice? ☐ Yes ☐ No

**If your answer is no**, complete the following information for each relevant individual/entity with 5% or more direct or indirect ownership or control interest. Any individuals listed below must complete the release form provided on page 8 of this document.

| Entity legal name | Federal tax ID # | Medicaid # |
|---|---|---|
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**Please attach the following documents (LIP only):**

___ W-9 form (not required for Licensed Practitioners employed within an agency)

___ Copy of the Certificate of Insurance (COI) for current general liability insurance policy coverage amounts of $1,000,000/$3,000,000

___ Copy of the Certificate of Insurance (COI) for current Automobile Liability insurance policy coverage in the required amounts OR signed and dated attestation that LIP does not transport consumers

## ATTESTATION AND SIGNATURE

All information submitted by me in this document, provided in my CAQH application or submitted as an attachment or supplemental information (collectively, "application"), is true, current and complete to the best of my knowledge and belief as of the date of signature below. I understand that any misstatement or failure to disclose may constitute grounds for denial of the application or termination of a resulting participating agreement. I attest that I am not aware of any conflict of interest existing between myself and the applicable LME/MCO(s).

By application for membership in **Vaya Health (Vaya)**, I signify my willingness to appear for interview in regard to my application. I authorize **Vaya** to consult with any individuals at any organization with which I am currently or have previously been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in the credentialing application or any associated documents. I further authorize **Vaya** to collect any information necessary to verify the information in the credentialing application. Upon request, I will obtain and provide to **Vaya** materials pertaining to my qualifications and competence, including materials relating to complaints filed, any disciplinary action, suspension or action to curtail my clinical privileges. I further consent to the inspection by representatives of **Vaya** all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that as an applicant, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of **Vaya** for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability all individuals and organizations that provide information to **Vaya** in good faith and without malice concerning this application, and I hereby consent to the release and verification of information relating to any disciplinary action, suspension or curtailment of clinical privileges to **Vaya**. I understand, agree and acknowledge that denial of this application does not constitute grounds for appeal in any forum.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, **Vaya** may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. In the event I am accepted for participation in **Vaya**, I hereby consent to **Vaya** for inspection of my patient records relating to **Vaya** enrollees as necessary for its peer and utilization review purposes as permitted by state and federal law and regulation.

In the event that this application for credentialing is approved, I agree to notify the applicable LME/MCO within five (5) business days of any changes to the information requested on the initial application.

Signature of Practitioner: ____________________________________ Date: _________________________

## Authorization, Consent and Release to Perform Criminal Background and Exclusion Checks pursuant to the Fair Credit Reporting Act (FCRA) and the Federal Driver's Privacy Protection Act (DPPA)

**This form must be completed by every practitioner, owner, and managing employee identified in the Agency Credentialing Application (Question 20).**

Name of agency, group practice, facility or hospital submitting application:

Last name: __________________________ First name: _______________________________ Middle initial: __________

Maiden and/or other last names used: ________________________________ Gender: ☐ Male ☐ Female

Driver's license no.: ____________________ State Issued: ____________ Expiration Date: ________________________

Date of Birth: __________________________ Social Security Number: ____________________________________________

Please list all counties and states where you have resided for the past five (5) years:

| County and state | From month/year | To month/year |
|---|---|---|
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By signing below, I authorize Vaya Health ("Vaya"), its staff, authorized representatives and/or its agent, Accurate Background, to conduct background investigations as part of an application for credentialing or re-credentialing submitted by the organization listed above, whether the records are of a public, private or confidential nature. These investigations are limited to searches of motor vehicle records and criminal history information on file in local, state or federal agencies, searches of local, state or federal records necessary for participation in public healthcare programs, including but not limited to the U.S. Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED), the System of Award Management (SAM), the Social Security Administration's Death Master File, and the National Plan and Provider Enumeration System; and verification of education, employment history, and professional liability/ licensure history as applicable. Vaya does not perform searches of commercial or retail credit agencies.

I understand that these searches will be used to determine eligibility for credentialing and participation in the applicable LME/MCO Closed Network, that information obtained pursuant to this authorization is confidential, and that disclosure of this information will be limited only to those persons or entities to whom such disclosure is necessary or authorized for purposes of credentialing verification. Therefore, I authorize and consent for full release of records (either orally or in writing) to Vaya, its staff, authorized representatives and/or its agent, Accurate Background. In addition, I release and discharge Vaya, its staff, authorized representatives and its agent and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs expenses or any other charge or complaint filed with any agency arising from retrieving and reporting this information. I understand that according to the Federal Fair Credit Reporting Act, I am entitled to know whether credentialing was denied based upon the information obtained and to receive, upon written request, a copy of the background report. After reading this document, I fully understand its contents and authorize the background investigation. This authorization shall expire one (1) year from the date signed below, or, if the applicant is approved for participation in the Closed Network, upon termination of such participation.

I hereby certify that all information provided in this authorization and release is true, correct and complete.

Signed this _________________ day of __________________________________, 20_____

Applicant (print name) ____________________________________________________________________________

Applicant signature _______________________________________________________________________________