

Application for Hospital Based Inpatient and Outpatient Psychiatric Services

***{ENTER YOUR ORGANIZATION NAME HERE}***

Please submit application competed in full with all required attachments to:

Smoky Mountain LME/MCO

Credentialing Team

200 Ridgefield Court, Suite 206

Asheville, NC 28806

Thank you for your interest in credentialing with the Closed Network of Smoky Mountain LME/MCO (Smoky) and/or Partners Behavioral Health Management (Partners). In order for us to complete the credentialing process, please submit the following:

**[ ]** Hospital Based Inpatient and Outpatient Psychiatric Services Application.

[ ]  National Provider Identifier (NPI).

[ ]  Copy of your National Plan and Provider Enumeration System (NPPES) letter.

[ ]  Copy of current license from the N.C. Division of Health Services Regulation

[ ]  Copy of current approval letter from Center for Medicare and Medicaid Services (CMS).

**Note:** The name and address on the CMS letter must match the name and address on your agreement.

[ ]  Copy of current Certified Articles of Incorporation or Articles of Organization, if applicable.

[ ]  Copy of current certificate of insurance that meets contractual requirements

[ ]  Internal Revenue Services (IRS) Form W-9.

**Note:** A valid and complete W-9 must be submitted by the applicant to certify the applicant’s Taxpayer Identification Number (TIN) and Name. Applicant is defined as the entity completing the application for enrollment. Please reference the specific instructions on pages 2 and 3 of the Form W-9 for entering your correct TIN and name.

[ ]  Attachment - Letter of Attestation for False Claims Act Education. Out-of-Network and Out-of State Hospitals must submit the Letter of Attestation at the time of application.

[ ]  **North Carolina Medicaid Providers (in-State or out-of-State):** Copy of your most current “Rate Notification for DRG, Rehabilitation, Psychiatric, Inpatient DRG Specific RCC Letter from the North Carolina Department of Health and Human Services Division of Medical Assistance.

[ ]  **Out-of-State/Border-area Providers:** Copy of a current approval letter to participate in your state’s Medicaid Program.

|  |
| --- |
| **NOTES**DO NOT submit claims to the LME/MCO until your contract has been executed or you have been notified that you can submit claims.Claims must be submitted within ninety (90) days from the date of rendered service. The LME/MCO does not reimburse for non-ancillary services or non-behavioral health related services.All claims for dates of service for the current fiscal year (7/1 – 6/30) are required to be submitted *NO LATER* than 7/31 of the following fiscal year. |

**Instructions for Credentialing of Hospital Providers**

A prospective Hospital must apply for and be enrolled as a provider with the LME/MCO to qualify for reimbursement for Hospital services under the LME/MCOs Medicaid Waiver. Hospitals must have a signed contract with the LME/MCOto qualify for reimbursement for Hospital services with State (North Carolina) funds.

The credentialing process includes the following steps:

1. Provider completes and signs the Hospital Based Inpatient and Outpatient Psychiatric Services Application and returns it along with the required credentials to:

**Smoky Mountain LME/MCO**

**Attn: Credentialing Team**

**200 Ridgefield Court, Suite 206**

**Asheville, NC 28806**

1. A provider application is considered to be invalid and must be returned to the provider for correction and/or for additional information if:
* The version date on any of the documents that comprise the provider enrollment packet is prior to June 3, 2015.
* The contact person’s name and title is not completed.
* The signatures, where required, are not original.
* The signatures are not by the individual applicant or, where applicable, an authorized agent for the group or entity.
* The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
* The responses are illegible.
* The National Provider Identifier is not a valid number.
* Any of the documents or pages that comprise the provider enrollment packet are missing.
* Any of the requested information in any of the documents that comprise the provider application is missing, with the exception of the fax number and e-mail address.
* Any of the required accreditation documentation is missing (including license, permit, certification, endorsement, Articles of Incorporation, NPPES letter, etc.).
* The provider name entered on the Medicaid Participation Agreement (for out-of-state and/or out-of-network providers) does not match the required accreditation documentation, the IRS Form W-9, and the NPPES letter (where required).

**3. Important Points to Remember**

* If services are being provided at multiple sites, you are required to list each site in this application and will be assigned a separate site ID number for each location.
* Copies of the applicable accreditation documentation must accompany the application.
* Retain a copy of your completed application and all documentation submitted for your records.
* Providers are requested to include on their application the name, e-mail address, and fax number of the individual (contact person) at their site who is responsible for receiving information.

If you have questions or need additional information, please contact the Smoky Credentialing Team at credentialingteam@smokymountaincenter.com or at 855-432-9139.

**HOSPITAL BASED INPATIENT AND OUTPATIENT PSYCHIATRIC SERVICES APPLICATION**

 **Application Date:**

Provider is completing application for the purpose of:

[ ]  Contract [ ]  Out-of-Network Status [ ] Out-of-State

**SECTION I: CORPORATE INFORMATION**

1. **Organization Name:**

(Your organization name must match the organization name on your current accreditation documentation and your current letter of approval from the Centers for Medicare and Medicaid Services)

1. **Legal Name of Organization**:

(Name used for tax reporting purposes if different from Organization Name)

1. **Doing Business As (DBA):**

If applicable, enter your DBA name:

1. **Federal Tax ID #:***Attach W-9 – Business name on W9 MUST match the business name indicated on the NC Secretary of State website.*
2. **Federal Tax Status:** **[ ]** For Profit**[ ]** Non-Profit
3. **Certificate of Insurance**

*Submit a copy of a current certificate of insurance that meets contractual requirements for each applicable LME/MCO*

1. **National Provider Identifier** #

*You MUST attach a copy of your National Plan and Provider Enumerations System (NPPES) Certification Letter with this application. Please provide the NPI #s and NPPES Certification Letter for each site you are applying for on this application.*

1. **Physical Address:** *P.O. Box address is not acceptable as a physical address*

|  |  |  |
| --- | --- | --- |
| Street:       | State:    | Zip Code (+4):       |
| County:       | Phone:       | Fax:       |
| Email Address:       |

1. Number of years doing business under this name:
2. Website Address (if applicable):

Has this Organization ever been in business under a different name? [ ]  Yes [ ]  No

If yes, what name?

1. Is your Hospital/Program an approved North Carolina Medicaid service provider? [ ]  Yes [ ]  No

If yes, please attach the most recent copy of your “Rate Notification for DRG, Rehabilitation, Psychiatric, Inpatient DRG Specific RCC Letter” from the North Carolina Department of Health and Human Services Division of Medical Assistance.

**SECTION II: CONTACT INFORMATION**

|  |
| --- |
| 1. Primary Contact:
 |
| 1. Primary Contact’s Title:
 |
| 1. Primary Contact’s E-mail Address:
 |
| 1. Telephone:
 | Office:       | Fax:       |
|  | Mobile:       | Pager:       |
| 1. Executive Director/CEO:
 |
| 1. Finance Director:
 |
| 1. Assistant Director/COO:
 |
| 1. Clinical/Medical Director:
 |
| 1. Behavioral Health Unit Director (if applicable):
 |
| 1. Emergency Department Director:
 |
| 1. Board Chairman:
 |
| 1. Please list names and titles of people authorized to sign contracts and other legal documents:
 |
|       |       |
|       |       |
|       |       |
|       |       |

1. **Organization Legal Entity Type:**

|  |  |  |
| --- | --- | --- |
|  **[ ]**  C-Corporation | **[ ]**  General Partnership | **[ ]**  Cooperative |
|  **[ ]**  S-Corporation | **[ ]**  Sole Proprietorship | **[ ]**  Not for Profit |
|  **[ ]**  Limited Liability Corporation | **[ ]**  Limited Liability Partnership | **[ ]**  Government |
|  **[ ]** Public Authority (LME, Hospital or Healthcare Authority) |

**SECTION III: FACILITIES INFORMATION**

1. **Facilities/Programs:**

Please list all Psychiatric Facilities Operated by the Hospital and covered by the Hospitals accreditation (inpatient, PRTF, Intensive Outpatient, Partial Hospitalization, Outpatient) attach additional sheets as necessary:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Name of Facility****or Program** | **Address**(include zip+4 code) | **Number of beds** (if applicable) | **Child,****Adolescent or****Adult** | **NPI Number**(please list each facility/programNPI number) | **Program****Specific Medicaid Number**(if applicable) | **Medicaid****Rate/Billing****Code** |
|        |        |        |       |        |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |
|       |       |        |       |       |       |       |

1. **Facility Psychiatric Coverage**

|  |  |  |  |
| --- | --- | --- | --- |
| **Facility/Program****Name** | **Supporting Psychiatrist(s)****Name/Address** | **Hospital employee or****other practice?** | **If Hospital employee, please list****their NPI #** |
|       |       |       |       |
|       |       |       |       |

**3. Accreditation:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Facility/Program****Name** | **Date of last****Joint Commission Review** | **Years Accredited** | **Expiration Date** | **DHSR License** **Number** (if applicable) | **Expiration Date** |
|       |       |       |       |       |       |
|       |       |       |       |       |       |
|       |       |       |       |       |       |

**SECTION IV: DISCLOSURE STATEMENT**

**1. Provider Disclosure:**

a. **Providers must disclose the following information**. List all information requested for **each person, including yourself, who has direct or indirect ownership or control interest of 5% or more in the organization/entity.** If any of the persons named are related to each other as parent, spouse, child or sibling, indicate the relationship. Failure to provide sufficient information, including complete Social Security Numbers and home addresses, to allow for the verification of the disclosed information may result in a denial for participation with the LME/MCO.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (First Name, MI Last Name)****and Complete Home Address****(Street, City, State & Zip Code)** | **Title(if applicable)** | **Social Security****Number** | **License #****(if applicable)** | **% Ownership** |
|       |       |       |       |       |
|       | **Date of Birth:** **Check business relationship that applies:**

|  |  |  |
| --- | --- | --- |
| [ ]  Ownership | [ ]  Partner | [ ]  Officer |
| [ ]  Shareholder | [ ]  Director | [ ]  Board Member |
| [ ]  Managing Employee |  |  |
| [ ]  Other |  |  |
| [ ]  Electronic Funds Transfer (EFT) authorized individual |

 |
|       |
|  Check relationship to other persons named: | [ ]  Spouse |  [ ]  Parent |  [ ]  Child |  [ ]  Sibling | [ ]  None |
|  (Check all that apply) | [ ]  Other       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (First Name, MI Last Name)****and Complete Home Address****(Street, City, State & Zip Code)** | **Title(if applicable)** | **Social Security****Number** | **License #****(if applicable)** | **% Ownership** |
|       | **Date of Birth:** **Check business relationship that applies:**

|  |  |  |
| --- | --- | --- |
| [ ]  Ownership | [ ]  Partner | [ ]  Officer |
| [ ]  Shareholder | [ ]  Director | [ ]  Board Member |
| [ ]  Managing Employee |  |  |
| [ ]  Other |  |  |
| [ ]  Electronic Funds Transfer (EFT) authorized individual |

 |
|       |
|  Check relationship to other persons named: | [ ]  Spouse |  [ ]  Parent |  [ ]  Child |  [ ]  Sibling | [ ]  None |
|  (Check all that apply) | [ ]  Other       |
| **Name (First Name, MI Last Name)****and Complete Home Address****(Street, City, State & Zip Code)** | **Title(if applicable)** | **Social Security****Number** | **License #****(if applicable)** | **% Ownership** |
|       |       |       |       |       |
|       | **Date of Birth:** **Check business relationship that applies:**

|  |  |  |
| --- | --- | --- |
| [ ]  Ownership | [ ]  Partner | [ ]  Officer |
| [ ]  Shareholder | [ ]  Director | [ ]  Board Member |
| [ ]  Managing Employee |  |  |
| [ ]  Other |  |  |
| [ ]  Electronic Funds Transfer (EFT) authorized individual |

 |
|       |
|  Check relationship to other persons named: | [ ]  Spouse |  [ ]  Parent |  [ ]  Child |  [ ]  Sibling | [ ]  None |
|  (Check all that apply) | [ ]  Other       |

b. **Providers must disclose the following information.** List all information requested for each agent of the organization/entity including individual officers, directors, managing employees (general manager, business manager, administrator), and Electronic Funds Transfer (EFT) authorized individuals. If any of the persons named are related to each other as parent, spouse, child or sibling, indicate the relationship. Failure to provide sufficient information, including complete Social Security Numbers and home addresses, to allow for the verification of the disclosed information may result in a denial for participation with the LME/MCO.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (First Name, MI Last Name)****and Complete Address****(Street, City, State & Zip Code)** | **Title(if applicable)** | **Social Security****Number** | **License #****(if applicable)** | **% Ownership** |
|       |       |       |       |       |
|       |  **Date of Birth:** **Check business relationship that applies:**

|  |  |  |
| --- | --- | --- |
| [ ]  Ownership | [ ]  Partner | [ ]  Officer |
| [ ]  Shareholder | [ ]  Director | [ ]  Board Member |
| [ ]  Managing Employee |  |  |
| [ ]  Other |  |  |
| [ ]  Electronic Funds Transfer (EFT) authorized individual |

 |
|       |
|  Check relationship to other persons named: | [ ]  Spouse |  [ ]  Parent |  [ ]  Child |  [ ]  Sibling | [ ]  None |
|  (Check all that apply) | [ ]  Other       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (First Name, MI Last Name)****and Complete Address****(Street, City, State & Zip Code)** | **Title(if applicable)** | **Social Security****Number** | **License #****(if applicable)** | **% Ownership** |
|       |       |       |       |       |
|       |  **Date of Birth:** **Check business relationship that applies:**

|  |  |  |
| --- | --- | --- |
| [ ]  Ownership | [ ]  Partner | [ ]  Officer |
| [ ]  Shareholder | [ ]  Director | [ ]  Board Member |
| [ ]  Managing Employee |  |  |
| [ ]  Other |  |  |
| [ ]  Electronic Funds Transfer (EFT) authorized individual |

 |
|       |
|  Check relationship to other persons named: | [ ]  Spouse |  [ ]  Parent |  [ ]  Child |  [ ]  Sibling | [ ]  None |
|  (Check all that apply) | [ ]  Other       |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name (First Name, MI Last Name)****and Complete Address****(Street, City, State & Zip Code)** | **Title(if applicable)** | **Social Security****Number** | **License #****(if applicable)** | **% Ownership** |
|       |       |       |       |       |
|       | **Date of Birth:** **Check business relationship that applies:**

|  |  |  |
| --- | --- | --- |
| [ ]  Ownership | [ ]  Partner | [ ]  Officer |
| [ ]  Shareholder | [ ]  Director | [ ]  Board Member |
| [ ]  Managing Employee |  |  |
| [ ]  Other |  |  |
| [ ]  Electronic Funds Transfer (EFT) authorized individual |

 |
|       |
|  Check relationship to other persons named: | [ ]  Spouse |  [ ]  Parent |  [ ]  Child |  [ ]  Sibling | [ ]  None |
|  (Check all that apply) | [ ]  Other       |

**SECTION V: DISCIPLINARY ACTION**

1. **Disciplinary Actions:** *You must answer all sections of this question*

Have you, any of the individuals or entities listed in sections 8.A or 8.B, or any individual employed in a clinical role ever:

1. Been convicted of a felony, had adjudication withheld on a felony, pled no contest to a felony or enter into a pre-trial agreement for a felony?

 [ ]  Yes [ ]  No

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

1. Had any disciplinary action taken against any business or professional license held in this or any other state? [ ]  Yes [ ]  No **Or;**

Had your license to practice restricted, reduced or revoked in this or any other state?

[ ]  Yes [ ]  No  **Or;**

Been previously found by a licensing, certifying or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided? [ ]  Yes [ ]  No  **Or;**

Entered into a Consent Order issued by a licensing, certifying or professional standards board or agency? [ ]  Yes [ ]  No

If any of the Questions in Section B were answered *yes*, please provide the following information:

Against Whom?

Action Taken?

Who Took Action?

Date of Action?

*If Yes, you must attach a complete copy of the Consent Order and or final disposition. You must also attach documentation from the proper authorities approving the reinstatement of the license.*

1. Had any action or investigation against you or any owner or qualified professional in your Organization relating to: *If yes, please attach explanation.*

 **Yes No**

1. Licensure [ ]  [ ]
2. Certification [ ]  [ ]
3. Registration [ ]  [ ]
4. Privileges [ ]  [ ]
5. Billing Organizations [ ]  [ ]
6. Sanctions [ ]  [ ]
7. Have any adverse actions been filed against you by: (If yes, please attach explanation.)

 **Yes No**

1. Medicaid [ ]  [ ]
2. Medicare [ ]  [ ]
3. Other Insurance [ ]  [ ]
4. Been denied enrollment, suspended, excluded, terminated or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state, or been employed by a corporation, business, or professional association that has ever been suspended, excluded, terminated or involuntarily withdrawn from Medicare, Medicaid or any other government or private health care or health insurance program in any state?. (If yes, please attach explanation.)

[ ]  Yes [ ]  No

If Yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) and attach a complete copy of applicable documentation.

|  |  |
| --- | --- |
| **Name** | **Provider Number** |
|  |  |
|  |  |
|  |  |
|  |  |

Has your organization been excluded from participation in Federal Health Care Programs under either Sections 1128 or 1128A of the Social Security Act? [ ]  Yes [ ]  No

1. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business, or professional association that ever had suspended payments from Medicare or Medicaid in any state?

[ ]  Yes [ ]  No

If Yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) and attach a complete copy of applicable documentation.

|  |  |
| --- | --- |
| **Name** | **Provider Number** |
|  |  |
|  |  |
|  |  |
|  |  |

1. Had civil monetary penalties levied against this organization/entity or any individuals or entities listed in Questions 1 and 2 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?

 [ ]  Yes [ ]  No

If Yes, you must attach an explanation and supporting documentation from the agency or program which levied the penalties as to the reason.

|  |
| --- |
|       |

1. Owe money to Medicare or Medicaid that has not been paid?

[ ]  Yes [ ]  No

1. Been convicted under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care goods or services?

[ ]  Yes [ ]  No

If Yes, list the name(s) of the individual(s) and attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. Applicable documentation must be attached.

|  |
| --- |
|       |

1. Been convicted under federal or state law of a criminal offense relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?

 [ ]  Yes [ ]  No

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

|  |
| --- |
|       |

1. Been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, financial misconduct, or moral turpitude?

[ ]  Yes [ ]  No

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

|  |
| --- |
|       |

1. Been found to have violated federal or state laws, rules or regulations governing North Carolina’s Medicaid program or any other state’s Medicaid program or any other publicly funded federal or state health care or health insurance program and been sanctioned accordingly?

[ ]  Yes [ ]  No

If Yes, you must list the name(s) and provider number(s) of the individual(s) or entity(ies) and attach a complete copy of applicable documentation.

|  |  |
| --- | --- |
| **Name** | **Provider Number** |
|  |  |
|  |  |
|  |  |
|  |  |

1. Been convicted of an offense against the law other than a minor traffic violation?

[ ]  Yes [ ]  No

If Yes, list the name(s) of the individual(s) and you must attach a complete copy of the criminal complaint and final disposition. Submitting only a written explanation in response to this question is not sufficient. You must attach the applicable documentation.

|  |
| --- |
|       |

1. Has anyone in your company who has an ownership, managerial or clinical role ever been sanctioned by any professional organization or government Organization for violation of ethics, professional misconduct, unprofessional conduct, incompetence or negligence in any state or country?

[ ]  Yes [ ]  No

(If yes, attach explanation.)

Are you aware of any circumstances that may result in such an action?

[ ]  Yes [ ]  No

(If yes, attach explanation.)

**2. Is the organization incorporated?**

[ ]  Yes [ ]  No

If yes, please attach a complete copy of the Certified Articles of Incorporation or Articles of Organization and any subsequent changes to the Articles of Incorporation or Articles of Organization.

**3. Is the organization/agency State-owned?**

 [ ]  Yes [ ]  No

1. **Has your organization ever had a contract cancelled by another LME/MCO in North Carolina or similar entity in another state?**

 [ ]  Yes [ ]  No

 (If yes, attach explanation.)

1. **Identify other providers, if any, which are owned or operated by the applicant under the same owner name.**

|  |
| --- |
|      Name – Provider |
| Street:       | State:    | Zip Code (+4):       |
|      Relationship type (nursing home, home health agency, community based residential facility, hospital) |

1. **Is the applicant a subsidiary company, either wholly or partially owned by another organization or business?**

[ ]  Yes [ ]  No

If yes, provide the following information:

 Legal Business Name – Parent Company

 Type of Ownership

1. **Admissions/discharge criteria for Inpatient Psychiatric Services, PRTF, IOP, PH, or**

**Outpatient Services:**

*May attach facility policy*

**SECTION VI: FINANCIAL & BILLING INFORMATION**

1. The following capacity will be needed:

a. An operational computer system to include Digital Subscriber Line (DSL) or higher speed connection to the Internet and hardware and/or software fire wall

 Is this currently available? [ ]  Yes [ ]  No

b. Current Anti-virus Protection on all devices that will store or display client identifiable information.

 Is this currently available? [ ]  Yes [ ]  No

Please supply the name, phone number and e-mail address of your agency’s billing staff:

|  |  |  |
| --- | --- | --- |
|      Name |      Phone Number |      E-mail address |

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

[ ]  Direct data entry via a web based system that you will access through a high speed internet connection

[ ]  HIPAA Compliant Transaction Sets (837P and/or 8371 electronic files)

If you plan to use HIPAA Compliant Transaction sets (837P and/or 8371), please list the name of your software and software vendor:

Do you currently have clients insured by third party payers? [ ]  Yes [ ]  No

Are you contracted with any third party payers? [ ]  Yes [ ]  No

Are you interested in electronic funds transfer of payments from the LME/MCO?

[ ]  Yes [ ]  No

**SECTION VII: QUALITY MANAGEMENT**

Please indicate your agency/hospital contact’s name, phone number, and e-mail address for follow- up on incident reports or investigations:

|  |  |  |
| --- | --- | --- |
|       Name |       Phone Number |       E-mail address |

Do you have a Client Rights Committee? [ ]  Yes [ ]  No

**Client Rights Contact:**

|  |  |  |
| --- | --- | --- |
|       Name |       Phone Number |       E-mail address |

**Quality Management Contact:**

|  |  |  |
| --- | --- | --- |
|       Name |       Phone Number |       E-mail address |

**LETTER OF ATTESTATION FOR FALSE CLAIMS ACT EDUCATION**

The Deficit Reduction Act (DRA) of 2005, which went into effect January 1, 2007, required specific changes to states’ Medicaid programs. One of the changes is the requirement for employee education about false claims recovery. Section 6032 of the DRA amended the Social Security Act, Title 42, United States Code, Section 1396(a) by inserting an additional relevant paragraph (68). This paragraph is cited below; in summary it requires any entities that receive or make annual payment under the Medicaid State Plan of at least five million dollars to have detailed, specific written policies established about the Federal and State False Claims Acts for their employees, agents and contractors.

Specifically, §1396(a)(68) of the Social Security Act requires that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall –

1. establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under section 3729 through 3733 of title 31, United States Code [31 USCS §3729-3733], administrative remedies for false claims and statements established under chapter 38 of title 31. United States Code [31 USCS §. 3801 et seq.], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f)[42 USCS § 1320-7b(l)]);
2. include as part of such written policies, detailed provisions regarding the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse; and
3. include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of the employees to be protected as whistleblowers, and the entity’s policies and procedures for detecting and preventing fraud, waste, and abuse;

Effective January 1, 2007, all providers are required to certify that they are in compliance with § 1396(a)(68) of the Social Security Act as a condition of enrollment in the North Carolina Medicaid Program.

As the owner/ operator/ manager of a North Carolina Medicaid provider, I certify that our entity has read and understands the above requirements. I also certify that our entity has established written policies and procedures that provide detailed
information concerning, the Federal False Claims Act, 31 USC 3729 *et seq.*, administrative remedies for false claims and statements established under 31 USCS §. 3801 *et seq.*, and any North Carolina State laws pertaining to civil or criminal penalties for false claims and statement, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs.

I further certify that our entity’s written policies include detailed provisions regarding our policies and procedures for detecting and preventing fraud, waste, and abuse; and that our employee handbook contains a specific discussion of the Federal and State False Claims Acts, the rights of the employees to be protected as whistleblowers, and our policies and procedures for detecting and preventing fraud, waste, and abuse.

Copies of any and all training manuals, written policies and procedures for detecting and preventing fraud, waste, and abuse, and employee handbooks will be maintained on-site for a minimum of five (5) years for inspection and auditing by the Division of Medical Assistance and/or its agents.

Signed (required) Date (required)

Printed Name (required)

Relationship to entity (self, owner, operator, manager, CFO, etc)(required) Medicaid Provider Number (required)

**Attestation and Release**

***(IMPORTANT: Submit Original Only – No Stamps or Copies)***

Note: This Application must be signed by an individual who has authorization to submit an application on behalf of this organization.

I certify that I am authorized to sign this application and attestation on behalf of the Applicant, and that the information I have provided is complete, true and accurate to the best of my knowledge. I understand that any misstatement or failure to disclose in this application may constitute grounds for denial of the application or termination of a resulting participating agreement.

In making this application for credentialing in the PBHM and/or Smoky LME/MCO Closed Network(s), I acknowledge that I am familiar with the standards and ethics of the national, state, and local associations that apply to and govern the organization and the clinical professions within. If this application is approved and the LME/MCO chooses to contract with our organization, I further agree that our organization will comply with the terms and conditions of all contracts and other written agreements with the LME/MCO, the LME/MCO Provider Operations Manual, credentialing criteria and applicable requirements of federal and state laws, rules and regulations, including but not limited to all network requirements for reporting, inspections, monitoring, human rights, cultural competency, compliance, and the continuous quality improvement process.

By submitting this application, the owner(s) and managing employee(s) signify their willingness to appear for an interview if requested. Smoky Mountain LME/MCO (“Delegate”) is hereby authorized to consult with any individuals at any organization with which the Applicant is currently or has previously been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application.

I understand and agree that I, as representative of this organization, have the burden of producing adequate information for proper evaluation of the professional competence, character, ethics, and other qualifications of the Applicant, owners and managing employees, and for resolving any doubt about such qualifications. Upon request, I will obtain and provide to Delegate any and all materials pertaining to the Applicant’s qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my clinical practice. I further authorize Delegate to collect any information necessary to verify the information in the credentialing application.

I release from liability all representatives of the Delegate and/or the applicable LME/MCO for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications. I also hereby release from liability any and all individuals and organizations that provide information to Delegate or its staff in good faith and without malicious intent concerning competence, ethics, character, and other qualifications for membership inthe Closed Network, and I hereby consent to the release of such information. I understand that if this application is rejected for reasons relating to professional conduct or competence, the Delegate or applicable LME/MCO may report the rejection to the appropriate state licensing board or oversight authority. I understand, agree and acknowledge that denial of this application does not constitute grounds for appeal in any forum.

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.

Name of Agency/facility

Name of Authorized Representative (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_       (MM/DD/YYYY)

Signature of Authorized Representative Date