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KPCO HMO and PPO Interested Participating Provider Request Application/Justification Form

Must submit current W9.

Thank you for your interest in becoming a contracted provider with Kaiser Permanente HMO and or PPO network of physicians for Colorado.

- Please fill out the below information. N/A any questions not applicable. If the necessary information is not received your request form will not be reviewed.
- **PLEASE NOTE: FOR HMO AND PPO PRODUCTS, THERE IS NOT A GUARANTEE THAT AN APPROVAL WILL BE FOR BOTH PRODUCTS. REQUESTS MAY ONLY BE APPROVED FOR ONE PRODUCT BASED ON REVIEW CRITERIA**
- After submitting a completed request form, a Provider Experience Consultant will have your request form reviewed.
- Status updates will be directed to the contact email address given.
  - **If form/application is approved to be added to the Network**: A CONGRATULATIONS: Email will be sent with a link to the Combined New Practitioner and New Office template. To be emailed to the assigned contact. Please filled out and returned for provider. demographics/contracting/credentialing processing.
  - **If form/application is declined**: Provider/Group information will be saved on file along with an email stating reason of decline.
- You will not be able to re-apply for 365 days from date of your request below.
- Return to Email: **IPPNew@kp.org**
- If you are a behavioral health provider **requesting HMO product (ONLY)** within Colorado Springs, Pueblo, Canon City or Northern Colorado or surrounding areas and would like to join the Kaiser Permanente Colorado **HMO** network, please contact Carelon Behavioral Health (formally Beacon Health Options) enrollment requests may be submitted at the following link **https://www.carelonbehavioralhealth.com/providers/join-our-network** if you have questions contact Carelon Behavioral Health at 1-800-397-1630.

PROFESSIONAL/FACILITY GENERAL INFORMATION	
1. Interested Provider/Group Legal Entity Name **As Listed on the W9**	•
2. Interested Provider/Group Tax ID/ NPI	Tax ID: NPI:
3. Contact Name/Email/Phone number/Fax number	•
4. Date of Request:	Click or tap to enter a date.
5. Prior Request:	☐ Yes ☐ No
6. Type of Request	☐ New
7. Service Area: A. Primary Location Address: B. Product Type- HMO and/or PPO	☐ D/B ☐ NoCO ☐ Co Springs ☐ Pueblo • •
8. *List name or third-party entity handling contract negations?* (Name, Email address, Phone number)	
9. *Office manager or communication contact:* (Name, Email address, Phone number)	

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PROFESSIONAL/FACILITY/ANCILLARY REQUEST - INFORMATION	
10. Type of Request: (Based on billing. CMS-1500/UB-04)	☐ Professional ☐ Facility ☐ Ancillary **As Listed on the W9 for Billing (Remittance)**
11. Telehealth Only:	☐ Yes ☐ No
12. Size of Practice:	☐ Single Provider ☐ Multiple Providers – number:
13. Practice Specialty	☐ Single Specialty ☐ Multiple Specialties- *List primary specialties; or specialized skill set*
14. Care Experience *15. Wait time/ Appointment access*	• Access, New Visit / Consult Wait times:
16. Specialty / Facility Type **Please note if BH: please specify if Applied behavior analysis (ABA)**	☐ Home Health ☐ SNF ☐ ASC ☐ BH ☐ Other *Comments:*
17. Open panel- are you and or the group accepting new patients? 18. Patient Ages Accepted (Check ALL that apply):	☐ Yes ☐ No ☐ Child: (Ages-_____) ☐ Adolescent: (Ages-_____) ☐ Adult: (Ages-_____) ☐ Geriatric: (Ages-)_____)
19. Lines of business accepted? (Medicare, Medicaid, Commercial) A. Is the group and are all practitioners participating Medicare providers?	
Please list ALL Provider(s), Hospital(s), ASC(s) affiliations and or rendering service(s) facilities.	•
20. Practice Description- What services does your office provide? Please provide specific details. **A. Does your practice prescribe opioids? If so, please describe your opioid monitoring program.** ***21.* Provide website, as appropriate**	• • ☐ NA ☐ Yes ☐ No • Website:
22. Interoperability/Systems	• EMR: ☐ Epic ☐ WEBPT/REVFLOW ☐ Other ☐ No • HIE: ☐ CORHIO ☐ Other ☐ No • If not Epic, please answer the following questions: • Do you participate in any of the following interoperability exchange platforms: o ☐ Carequality ☐ Commonwell ☐ CORHIO ☐ eHealth ☐ No • If participating in one of the above platforms: o Are you sharing the following discretely via the exchange? o ☐ Notes ☐ Results ☐ Encounter diagnoses ☐ Plans of Care

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	○ If yes, are you sending industry standard codes with the diagnosis and results? (i.e. ICD-10, LOINC, SNOMED) ○ ☐ Yes ☐ No • If not participating: ○ Can you provide a timeline for engaging in this effort? ○ ☐ <6 mo ☐ 6-12 mo ☐ No current plan ○ Are you able to utilize Direct messaging to share a CCDA or PDF? ○ ☐ Yes ☐ No ○ Are you utilizing any API's (Application Program Interface) for exchange? ○ ☐ Yes ☐ No Willingness to use Affiliate Link (Epic Link portal): ☐ Yes ☐ No
	•

DO NOT USE BELOW: KAISER OFFICE USE ONLY

ASSESSMENT	
Google/Yelp Rating:	
Network Adequacy/member count in county:	
Previously in Network? If so, include term date and any applicable notes.	
Market Need – Do they fill an unmet need or niche in the market?	☐ Yes ☐ No
For services provided, are their competing practices in good standing who are engaged and can demonstrate quality and efficient care?	☐ Yes ☐ No
Anticipated negative impact with currently contracted groups/facilities? *list negative impacts*	☐ Yes ☐ No
Are there external stakeholder or sales considerations:	☐ Yes ☐ No
Does inclusion or exclusion of the group provide a clear strategic advantage or disadvantage? *growth potential associated with brand or service or efficiency?*	☐ Yes ☐ No
RECOMMENDATION	
Add as a network provider or non-participating provider with LOA? *Consider LOA option if needed only for very select referral services or hospital coverage. If limited or LOA, specify services*	☐ Yes ☐ No ☐ Fully Participating Provider ☐ Limited Services Contract ☐ Letter of Agreement
APPROVAL:	
Process	• If no network need or decision not to contract, notify IPP. • If decision to contract, send completed request for approval / signature. ○ Email to Executive Director Network Operations, CPMG ○ If facilities included Exec Director to send signed form to VP Care Continuum, HP
Approved, Executive Director Network, CPMG	
Date of Approval:	

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Approved, VP Care Continuum, HP	
Date of Approval:	
Declined by: Executive Director Network, CPMG	
Decline date:	
Decline Reason:	

ALL VP APPROVED SIGNED FORMS TO FOLDER WITH DATE
ALL DECLINED/REASON SEND TO FOLDER WITH DATE