Provider Application for Participation Instructions

This is a PRACTITIONER APPLICATION for consideration into Kaiser Permanente's network of providers.

This application is only for providers, such as physicians, behavioral health practitioners, physical, occupational and speech therapists and other professionals. For consideration for inclusion into our network of providers, please complete this application in its entirety and submit it as indicated below. This application should not be used by existing network providers to make demographic changes or add providers to your practice.

Important disclaimer: All Information provided will be assessed against Kaiser Permanente's network needs. Submission of an application does not constitute any obligation on the part of Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., the Mid-Atlantic Permanente Medical Group, P.C. or any other or related Kaiser Permanente entity to enter into a contractual obligation.

It is important that you clearly describe the services you offer so that we can best assess our need for your offered services. Your completed application must also include the attached Disclosure of Ownership and Control Information form. Additional pages are provided to list additional providers.

Please complete this application electronically. Do not complete it by hand. We welcome any attachments, brochures or descriptions you may choose to include to support your application.

Incomplete applications will be automatically denied and returned to you at the contact address within ten (10) days of receipt. We will process complete applications and provide notice of our decision in writing within thirty (30) days.

For questions, please contact us at interested.providers@kp.org.

Return completed applications using one of the following options:

Email PDFs to:

interested.providers@kp.org

Postal Mail

Kaiser Foundation Health Plan
of the Mid-Atlantic States, Inc.
Attn: Provider Contracting
2101 E. Jefferson St., Ste. 2 East
Rockville, MD 20852

Provider Application for Participation

Practitioner/Ancillary Information

General Information

Group/Practice Name: _____

Federal Tax I.D. Number: _____ NPI: _____

Contact Name: _____

Contact Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

Email: _____

Additional Locations for Multi-Location Practices

Street Address: _____

City: _____ State: _____ ZIP: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Practice Setting

Does this group practice exclusively in a hospital setting? ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____

2. _____ 4. _____

Provider Specialty (Including Subspecialties)

1. _____ Age range for specialty: _____

2. _____ Age range for specialty: _____

3. _____ Age range for specialty: _____

4. _____ Age range for specialty: _____

Languages Spoken

1. _____ 3. _____

2. _____ 4. _____

Medicare Certified: ☐ Yes ☐ No Accepting Medicare Patients: ☐ Yes ☐ No

Medicaid Certified: ☐ Yes ☐ No Accepting Medicaid Patients: ☐ Yes ☐ No

Do you maintain general liability insurance of at least $1,000,000/$3,000,000? ☐ Yes ☐ No

Do you agree to facilitate all necessary credentialing activities? ☐ Yes ☐ No

Provider Application for Participation

Additional Practitioner Information

For more than 10 providers, include a roster with all of the noted information below.

Additional Provider #1

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

*CAQH (Council for Affordable Quality Healthcare) is a universal national data source for standardizing the provider credentialing application process. Visit www.caqh.org. **Please ensure that all provider information is updated and current on CAQH**.

**EPSDT (Maryland Healthy Kids/ Early Periodic Screening, Diagnosis and Treatment Program). Visit http://dhmh.maryland.gov/epsdt/.

Additional Provider #2

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Provider Application for Participation

Additional Practitioner Information

For more than 10 providers, include a roster with all of the noted information below.

Additional Provider #3

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Additional Provider #4

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Provider Application for Participation

Additional Practitioner Information

For more than 10 providers, include a roster with all of the noted information below.

Additional Provider #5

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Additional Provider #6

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Provider Application for Participation

Additional Practitioner Information

For more than 10 providers, include a roster with all of the noted information below.

Additional Provider #7

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Additional Provider #8

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

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Provider Application for Participation

Additional Practitioner Information

For more than 10 providers, include a roster with all of the noted information below.

Additional Provider #9

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

*CAQH (Council for Affordable Quality Healthcare) is a universal national data source for standardizing the provider credentialing application process. Visit www.caqh.org. **Please ensure that all provider information is updated and current on CAQH**.

**EPSDT (Maryland Healthy Kids/ Early Periodic Screening, Diagnosis and Treatment Program). Visit http://dhmh.maryland.gov/epsdt/

Additional Provider #10

Provider Name: _____

Provider Title: _____

Social Security Number: _____ *CAQH Number: _____

Medicare Number: _____ Medicaid Number: _____

Specialties:

1. _____ Age range for specialty: _____
2. _____ Age range for specialty: _____
3. _____ Age range for specialty: _____

**EPSDT Certified: ☐ Yes ☐ No Accepting New Patients: ☐ Yes ☐ No

Hospital Based: ☐ Yes ☐ No Culturally Competent Care Training Complete: ☐ Yes ☐ No

If YES, please name the hospital(s) where providers have admitting/staffing privileges.

1. _____ 3. _____
2. _____ 4. _____

*CAQH (Council for Affordable Quality Healthcare) is a universal national data source for standardizing the provider credentialing application process. Visit www.caqh.org. **Please ensure that all provider information is updated and current on CAQH**.

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Provider Application for Participation

Disclosure of Ownership & Control Information

This section must be completed by an authorized representative of the participating provider practitioner, group or facility. An authorized representative is defined as an individual with designated authority to act on behalf of the individual, group of practitioners or disclosing entity. If not a solo practitioner, then the authorized representative must be a partner, president or secretary of the group of practitioners.

1. **Ownership and Control Information for Disclosing Entity, 42 C.F.R. §455.104**
   List any individual who has any ownership or controlling interest in this provider entity or in any subcontractor. List the name, title, (e.g., CEO, President), address, Tax ID Number of any organization, corporation or entity having any ownership or controlling interest in this provider entity. The ownership or controlling interest is an ownership interest of 5% or more in this provider entity.

   _____
   _____
   _____
   _____

2. **Relationships**
   List any individuals named in Question 1 whom are related to each other (e.g., spouse, parent, child or sibling). List their name, state their relationship and include their Social Security Number.

   _____
   _____
   _____
   _____

3. **Subcontractor**
   List any individual with an ownership or control interest in any subcontractor that the disclosing entity has direct or indirect ownership of 5% or more.

   _____
   _____
   _____
   _____

4. **Other Disclosing Entity**
   List the name, address and Tax ID Number of any other disclosing entity other than a subcontractor in which a person with an ownership or controlling interest in this disclosing entity has an ownership or control interest of 5% or more.

   _____
   _____
   _____
   _____

Continued on next page.

Provider Application for Participation

Disclosure of Ownership & Control Information

5. **Criminal Offenses**
   Has any individual or organization listed in Questions 1, 2, 3 and 4 ever been convicted or assessed fines or penalties for any health-related crimes or misconduct and/or excluded from any federal or state health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct? If your answer to this question is YES, please provide the name, address, Social Security Number, Tax ID Number and percentage of ownership for these individual(s) and/or organization(s).

   ☐ Yes ☐ No

   _____
   _____
   _____
   _____

6. **Criminal Offenses**
   Has ANY individual or contractor connected with your practice been convicted or assessed fines or penalties for any health-related crimes or misconduct, or excluded from any federal or state health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct? If your answer to this question is YES please provide the name, address, and Social Security Number/Tax ID Number for individual(s) or contractor(s).

   ☐ Yes ☐ No

   _____
   _____
   _____
   _____

7. **Criminal Offenses**
   Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid or any other federal or state agency or program, or any licensing or certification agency?

   ☐ Yes ☐ No

   _____
   _____
   _____
   _____

   If yes, please provide a copy of relevant final disposition.