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, 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

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: _____

Group/Practice Name should be exactly as it is on your W-9, please enclose copy of W-9

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
VA Medicaid Certified: ☐ Yes ☐ No
MD Medicaid Certified: ☐ Yes ☐ No

Accepting Medicare Patients: ☐ Yes ☐ No
Accepting Medicaid Patients: ☐ 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

Lines of Business*

Check off all lines of business you want to be contracted for:

Commercial ☐ (HMO, PPO, POS, etc.)
Medicare ☐

Provider Application for Participation

Virginia Medicaid ☐, provide licensure #: _____

Maryland Medicaid ☐, provide licensure #: _____

**Contracting will be done for each line of business as needed by Kaiser Permanente, requesting the line of business does not guarantee a contract will be made for that line of business.*

*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/.

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.

   _____
   _____
   _____
   _____

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.

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Provider Information

Provider (Group/Facility/Individual) Demographic Form

Section 1: Provider Demographic Information

Group Legal Entity Name: _____
Group Tax ID: _____ Group NPI: _____ Medicare ID:_____ VA Medicaid ID: _____MD Medicaid ID: _____

Primary Contact/Correspondence Information
Primary Contact Name: _____ Job Title: _____
Address: _____ Suite# / Floor Info: _____
Group City, State, Zip: _____
Phone Number: _____ Email: _____

Billing Information
Billing Contact Name: _____ Job Title: _____
Address: _____ Suite# / Floor Info: _____
Group City, State, Zip: _____
Phone Number: _____ Email: _____

Claims Payment Address
Claims Payment Contact Name: _____ Job Title: _____
Address: _____ Suite# / Floor Info: _____
Group City, State, Zip: _____
Phone Number: _____ Email: _____

Is the Group enrolled in Provider Services Solution ("PRSS") Portal? (Virginia Medicaid only) Yes ☐ No ☐
Is the Group enrolled in the electronic Provider Revalidation and Enrollment Portal ("ePREP")? (Maryland Medicaid only) Yes ☐ No ☐
Are you accepting new Patients? Yes ☐ No ☐
Are your Offices/Facilities ADA Compliant? Yes ☐ No ☐
Is the group telehealth only or telehealth and facility based? Telehealth Only ☐ Telehealth and Facility ☐
If Telehealth, are all Telehealth Providers licensed in Virginia, Maryland and Washington, DC? Yes ☐ No ☐ N/A ☐

Section 2: Provider Location Add(s)

1) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

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2) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____ Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

3) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____ Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

4) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____ Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

5) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____ Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

6) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____ Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

7) Practice Location Address: _____ Suite# / Floor Info: _____
Practice Location City, State, Zip: _____
Contact Name: _____ Email: _____
Practice Location Tax ID: _____ Practice Location NPI: _____
Practice Location Phone: _____ Practice Location Fax: _____

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Section 3: Provider Adds

Prior to submitting, please ensure all providers listed below have completed and updated Current Attestations (within 120 days) and Kaiser Permanente has been granted access to the CAQH Profile, failure to do so will result in processing delays.

First Name	MI	Last Name	Gender	Title	SSN	CAQH Number	License Number (VA, MD and DC)	Individual NPI	Medicare ID	Md Mcaid ID	Va Mcaid ID	Enrolled in PRSS? (Va Mcaid Only)	Enrolled in ePREP? (MD Mcaid Only)	Practice Locations (Indicate by using Practice Location # from ADD Section above)	Specialty(ies)	Foreign Languages (Spoken)	EPSDT Certified? (if Applicable)	Accept New Patients?	Telehealth?	Hospital Affiliation (Hospital Name)	Group Billing NPI(s)
												Yes	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		
												No	No				No	No	No		

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I am authorized to sign for the physicians or provider listed above in reference to the current agreement, including any amendments with the Mid-Atlantic Permanente Medical Group, P.C. and/or the Kaiser Foundation Health Plan and to bind such providers to the terms and conditions of the agreement.

Authorized Signatory: _____

Printed Name: _____ Date: _____

****FORM MUST BE SIGNED AND DATED OR IT WILL BE RETURNED AS INCOMPLETE****