Provider Application for Participation Instructions

This is a BEHAVIORAL HEALTH FACILITY/GROUP APPLICATION ONLY for consideration into Kaiser Permanente's network of providers. This application is for providers located in MD, VA, and DC only.

This application is only for organizations providing Behavioral Health Services, whether as a group and/or a facility. 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.

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

Behavioral Health Provider Facility/Group Information

General Information

Behavioral Health Facility ☐ **Behavioral Health Group** ☐

Group/Facility Name: _____

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

Contact Name: _____

Contact Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

Email: _____

Provider Types/Services:

Please include Provider Types/Levels and counts (ex. Psychotherapist, LCSW, etc.):

Type 1: _____ Number of Therapists: _____
Type 2: _____ Number of Therapists: _____
Type 3: _____ Number of Therapists: _____
Type 4: _____ Number of Therapists: _____
Type 5: _____ Number of Therapists: _____
Type 6: _____ Number of Therapists: _____

1. Does the provider offer services to children <5, adolescents, and adults? ☐ Yes ☐ No
2. Does the provider see patients virtually and in-person? ☐ Yes ☐ No
    a. If No, do you see patients only: ☐ Virtual ☐ In Person
3. Does the provider have protocols in place for emergency services and repatriation? ☐ Yes ☐ No
4. Does the provider submit survey outcome information? (PHQ-9/GAD-7) ☐ Yes ☐ No
5. Does the provider allow patients to select an appointment directly from the website? ☐ Yes ☐ No
6. Can the provider support KP's exchange system and reporting requirements via file share? ☐ Yes ☐ No
7. Are you ASAM certified? ☐ Yes ☐ No
8. If ASAM Certified, what level (s)? _____

Provider Application for Participation

If you are a **Behavioral Health Facility only**, please list available services and age range(s) serviced:

A. Intensive Outpatient Program (IOP) ☐ Yes ☐ No Age Range: _____
If yes, please indicate any specific program services:_____
_____

B. Partial Hospitalization Program (PHP) ☐ Yes ☐ No Age Range: _____
If yes, please indicate any specific program services:_____
_____

C. Residential/Inpatient Services ☐ Yes ☐ No
Substance Abuse? ☐ Yes ☐ No Age Range: _____
Mental Health? ☐ Yes ☐ No Age Range: _____
Eating Disorder? ☐ Yes ☐ No Age Range: _____
Other? (Indicate services and age ranges below) ☐ Yes ☐ No

_____ Age Range: _____
_____ Age Range: _____
_____ Age Range: _____
_____ Age Range: _____

D. Outpatient Mental Health? ☐ Yes ☐ No Age Range: _____

E. Other Services (Indicate any services not captured above)? ☐ Yes ☐ No
_____ Age Range: _____
_____ Age Range: _____
_____ Age Range: _____
_____ Age Range: _____
_____ Age Range: _____

Lines of Business*
Check off all lines of business you offer:

Commercial ☐ (HMO, PPO, POS, etc.): _____
Virginia Medicaid ☐, provide licensure #: _____
Maryland Medicaid ☐, provide licensure #: _____
Medicare Advantage ☐, 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

****Please review list of services at end of application and check all applicable services you provide***

Provider Application for Participation

Provider Facility/Group Information

Clinical Locations (Only Include Locations Where Services Are Performed)

Street Address: _____

City: _____ State: _____ ZIP: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Street Address: _____

City: _____ State: _____ ZIP: _____

Insurance

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

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

Provider Application for Participation

Additional Services/Specialties

Indicate if you provide any of the services below:

- ☐Anxiety
- ☐Depression
- ☐Addiction
- ☐Career counseling
- ☐Couples counseling
- ☐Eating disorders & disordered eating
- ☐Existential crisis & challenges
- ☐LGBTQIA, gender, & sexuality topics
- ☐Life transitions
- ☐Loss, grief, and bereavement
- ☐Relationship issues
- ☐Sexual health & dysfunction
- ☐Stress management
- ☐Trauma
- ☐Work stress
- ☐Abandonment issues
- ☐Abortion & post abortion challenges
- ☐Academic challenges
- ☐ADHD
- ☐Adjustment difficulties & disorders
- ☐Adolescent mental health
- ☐Adoption & foster care
- ☐Aging related concerns
- ☐Alcohol use disorder & addiction
- ☐Anger management
- ☐Anorexia nervosa
- ☐Artists' mental health
- ☐Assertiveness
- ☐Attachment issues
- ☐Autism spectrum disorder
- ☐Binge eating disorder
- ☐Bipolar disorder
- ☐Body dysmorphia
- ☐Body image
- ☐Borderline personality disorder
- ☐Bulimia nervosa
- ☐Burnout
- ☐Caregiver stress & support

Provider Application for Participation

- ☐Child mental health
- ☐Childhood trauma
- ☐Chronic illness
- ☐Chronic pain
- ☐Climate anxiety
- ☐Clinical supervision
- ☐Codependency
- ☐College & graduate student mental health
- ☐Commitment challenges
- ☐Communication issues
- ☐Complex PTSD (C-PTSD)
- ☐Compulsive behavior
- ☐Concussions
- ☐Conflict resolution
- ☐Creative blocks & writer's block
- ☐Cultural adjustment
- ☐Custody issues
- ☐Dating
- ☐Depersonalization & derealization
- ☐Developmental disorders
- ☐Dissociative disorders
- ☐Divorce & separation
- ☐Domestic violence
- ☐Drug addiction & abuse
- ☐Emotion regulation
- ☐Entrepreneur mental health
- ☐Family issues
- ☐Financial stress
- ☐Forensic psychology
- ☐Functional Medicine
- ☐Gender identity & transgender health
- ☐Guilt
- ☐Hoarding
- ☐Identity development
- ☐Imposter syndrome
- ☐Impulse control issues
- ☐Infertility counseling
- ☐Infidelity
- ☐Insomnia & sleep issues
- ☐Irritability
- ☐Isolation
- ☐Jealousy

Provider Application for Participation

- ☐Learning disabilities
- ☐Life coaching
- ☐Life purpose & meaning
- ☐Loneliness
- ☐Medical professionals' mental health
- ☐Men's issues
- ☐Mind-body connection
- ☐Mood disorders
- ☐Neuropsychological testing
- ☐Nonmonogamy, polyamory, and kink
- ☐Obsessive compulsive disorder (OCD)
- ☐Panic attacks / panic disorder
- ☐Parenting
- ☐Perfectionism
- ☐Performance anxiety
- ☐Personality disorders
- ☐Phobias & fears
- ☐Physical wellness
- ☐Post-traumatic Stress Disorder (PTSD)
- ☐Postpartum depression
- ☐Pregnancy, perinatal, postpartum mental health
- ☐Premarital counseling
- ☐Premenstrual dysphoric disorder
- ☐Procrastination
- ☐Psychological evaluations & testing
- ☐Psychotic disorders
- ☐Race & cultural identity
- ☐Racism, oppression, and discrimination
- ☐Schizophrenia
- ☐Seasonal Affective Disorder (SAD)
- ☐Self harm
- ☐Self-care
- ☐Self-doubt
- ☐Self-esteem
- ☐Sensitivity
- ☐Sex addiction
- ☐Sexual harassment & assault
- ☐Shame
- ☐Skin picking (excoriation)
- ☐Smoking cessation
- ☐Social anxiety
- ☐Somatization

Provider Application for Participation

- ☐Spirituality & religion
- ☐Sports psychology
- ☐Stepfamily / Blended Family Issues
- ☐Substance abuse
- ☐Suicidal ideation
- ☐Transition to new parenthood
- ☐Traumatic brain injury
- ☐Trichotillomania (hair pulling)
- ☐Trust issues
- ☐Values clarification
- ☐Veterans' issues
- ☐Weight loss & management
- ☐Women's issues
- ☐Worry
- ☐Worthlessness

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.

   _____
   _____
   _____
   _____

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.

Organizational Providers Credentialing Application Instructions

This CREDENTIALING/RECREDENTIALING APPLICATION is for Kaiser Permanente network organizational providers.

Important disclaimer: 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 new contractual obligation nor renew an earlier contract.

Please complete this application in its entirety. We ask that you complete the application electronically. Do not complete it by hand. We welcome any attachments, beyond those requested, that you may choose to include to support your application.

Required Documentation (Complete This Checklist Notating Included Documentation)

☐ **Accreditation certificates**

(Note: If not accredited, include a copy of your last state or Medicare survey. If neither accreditation or the survey is applicable, Kaiser Permanente will conduct a site visit).

☐ **Professional and general liability certificates of insurance**

(Note: Liability insurance policy with limits equal to or greater than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) annual aggregate, or greater amounts if required by local jurisdiction regulation.

☐ **State license**

☐ **ARTS Attestation Form, DBHDS License and staff roster (as ASAM Level requires)**

☐ **W9**

Return completed applications using one of the following options:

Email or Mail Initial Credentialing Applications to:

provider-contracting@kp.org

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

Email Recredentialing Applications to the Practitioner and Provider Quality Assurance Department at:

ppqa-mas@kp.org

Provider Credentialing Application

Organizational Provider/Facility Information

Organization Type *(Select all that apply)*

- ☐ Acute Care Hospital
- ☐ Behavioral Health Care Facility
    - ☐ Ambulatory Clinic/Center
    - ☐ Applied Behavioral Analysis (ABA)
    - ☐ Chemical Dependency Program/Facility
    - ☐ Inpatient
    - ☐ Methadone Maintenance Program
    - ☐ Residential Treatment Facility for Behavioral Health Care
    - ☐ Residential Treatment Facility for Substance Abuse
- ☐ Clinical Laboratory
- ☐ Community Health Center/Mental Health Center
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ Dialysis Center (End Stage Renal Disease (ESRD) Provider)
- ☐ Durable Medical Equipment Provider
- ☐ Federally-Qualified Health Center/Rural Health Clinic
- ☐ Free-Standing Ambulatory Surgery Center
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Hospital
- ☐ Physical Therapy Facility
- ☐ Portable X-Ray Supplier
- ☐ Skilled Nursing Facility/Nursing Home
- ☐ Speech Pathology Facility
- ☐ Urgent Care Facility

Provider Credentialing Application

Demographics

Address 1:

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

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

Contact Name: _____

Contact's Title: _____

Contact's Phone: _____

Contact Email Address: _____

Contact Address (if different from above):

Address: _____

City: _____ State: _____ ZIP: _____

Address 2:

Facility Name: _____

Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ FAX: _____

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

Contact Name: _____

Contact's Title: _____

Contact's Phone: _____

Contact Email Address: _____

Contact Address (if different from above):

Address: _____

City: _____ State: _____ ZIP: _____

Provider Credentialing Application

Licensure

License Type: _____

License Number: _____ License Expiration Date: ____ / _____ / _____
MM / DD / YYYY

Have you ever had any action taken against your license? ☐ Yes ☐ No
If YES, provide relevant details below:

_____

_____

_____

Medicare Certification

Do you participate with Medicare? ☐ Yes ☐ No
Is your facility Medicare certified? ☐ Yes ☐ No
If YES, provide your Medicare Certification Number: _____

Is your Medicare certification in good standing? ☐ Yes ☐ No
If NO, provide relevant details below:

_____

Has your participation in Medicare ever been suspended or denied? ☐ Yes ☐ No
If YES, provide relevant details below:

_____

Last Medicare Survey Date: ____ / _____ / _____
MM / DD / YYYY

Accreditation

ARTS Provider? ☐ Yes ☐ No
If YES, provide your ASAM Level: _____

Joint Commission Accreditation? ☐ Yes ☐ No
If YES, provide your last survey date: ____ / _____ / _____
MM / DD / YYYY

Other Accreditation? ☐ Yes ☐ No
If YES, name of accrediting agency: _____
If YES, provide your last survey date: ____ / _____ / _____
MM / DD / YYYY

(Note: If not accredited, include a copy of your last state or Medicare survey. The survey must include identified deficiencies and corrective plans, if applicable. If a state or Medicare survey has not been completed, Kaiser Permanente will contact you to conduct a site visit).

Insurance/Claims

Professional Liability Insurance Carrier Name: _____

Policy Number: _____

Level of Coverage: $ _____ Occurrence / $ _____ Aggregate

Coverage Dates: ____ / _____ / _____ TO ____ / _____ / _____
MM / DD / YYYY MM / DD / YYYY

Provider Credentialing Application

General Liability Insurance Carrier Name: _____

Policy Number: _____

Level of Coverage: $ _____ Occurrence / $ _____ Aggregate

Coverage Dates: ____ / _____ / _____ TO ____ / _____ / _____
MM / DD / YYYY MM / DD / YYYY

(Note: Minimum coverage requirements by organization type are specified on application instructions sheet).

AUTHORIZATION/ATTESTATION:

I hereby submit this application for credentialing/re-credentialing into the provider network administered by Kaiser Permanente of the Mid-Atlantic States (KPMAS) and understand that this application will be reviewed based on the information I have provided. I certify that the information and documentation provided is true and correct, and that this facility is in good standing with all applicable state, federal and other regulatory agencies.

I understand that any information found to be false could result in denial or subsequent termination of this facility's membership in the KPMAS network. I am an officer of the above named organization with the authority to provide KPMAS the requested information, documentation and to execute this attestation.

By the signature below, I hereby attest to the accuracy, validity and completeness of the information and documentation.

Printed Name and Title:

Signature:

Date:

KAISER PERMANENTE®

Provider (Group/Facility/Individual) Information Form

Section 1: Provider Demographic Information

Legal Entity Information	
Legal Entity Name:	
Legal Entity Tax ID:	
Legal Entity NPI:	
Legal Entity Medicare ID:	
Legal Entity VA Medicaid ID:	
Legal Entity MD Medicaid ID:	

Primary Contact/Correspondence Information	
Primary Contact Name:	
Job Title:	
Street Address, Suite/Floor:	
City, State, Zip:	
Phone Number:	
Email:	

Billing Information	
Billing Contact Name:	
Job Title:	
Street Address, Suite/Floor:	
City, State, Zip:	
Phone Number:	
Email:	

Claims Payment Address	
Claims Payment Contact Name:	
Job Title:	
Street Address, Suite/Floor:	
City, State, Zip:	
Phone Number:	
Email:	

Section 2: Virginia and Maryland Medicaid and Medicare Enrollment

Medicaid / Medicare Enrollment		
Indicate if you wish to participate in the Medicare Advantage line of business	Yes ☐	No ☐
Indicate if you wish to participate in either Virginia Medicaid	Yes ☐	No ☐
VA Medicaid – is Group, Facility and/or Individual Providers (as applicable), enrolled in the Provider Services Solutions Portal (PRSS)?	Yes ☐	No ☐
Indicate if you wish to Participate in Maryland Medicaid	Yes ☐	No ☐
MD Medicaid – is Group, Facility and/or Individual Providers (as applicable), enrolled in the Electronic provider Revalidation and Enrollment Portal (EPrep)?	Yes ☐	No ☐

**Enrollment is required for all Groups, Facilities and/or Individuals in the systems above in order to have these lines of business added to your Agreement.*

Section 3: Practice Location Adds

Location 1			
Practice Name:			
Street Address, Suite/Floor:			
City, State, Zip:			
Location Tax ID:			
Location Billing NPI/CCN Number:	Location Billing NPI	CCN Number (Skilled Nursing Facility Only)	
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#
Practice Location Phone Numbers:	Voice	Fax	
Contact Name/ Email:			
Email:			

Location 2			
Practice Name:			
Street Address, Suite/Floor:			
City, State, Zip:			
Location Tax ID:			
Location Billing NPI/CCN Number:	Location Billing NPI	CCN Number (Skilled Nursing Facility Only)	
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#
Practice Location Phone Numbers:	Voice	Fax	
Contact Name:			
Email:			

Location 3			
Practice Name:			
Street Address, Suite/Floor:			
City, State, Zip:			
Location Tax ID:			
Location Billing NPI/CCN Number:	Location Billing NPI	CCN Number (Skilled Nursing Facility Only)	
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#
Practice Location Phone Numbers:	Voice	Fax	
Contact Name:			
Email:			

Location 4			
Practice Name:			
Street Address, Suite/Floor:			
City, State, Zip:			
Location Tax ID:			
Location Billing NPI/ CCN Number:	Location Billing NPI	CCN Number (Skilled Nursing Facility Only)	
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#
Practice Location Phone Numbers:	Voice	Fax	
Contact Name:			
Email:			

**For additional Location adds, please replicate this section for as many additional locations as are needed*

Section 4: Provider Adds

Provider 1				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				
Provider 2				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				
Provider 3				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
Telehealth, EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				

Provider 4				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				
Provider 5				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				
Provider 6				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				

Provider 7				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				
Provider 8				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				
Provider 9				
Provider Name and Title:	First	Middle	Last	Title
Gender, Languages	Gender	Foreign Languages Spoken		
Social Security, CAQH, License NPI #:	Social Security	CAQH#	License#	Individual NPI
Medicare/Medicaid Numbers:	Medicare Advantage ID#	Virginia Medicaid ID#	Maryland Medicaid ID#	
Medicaid Enrollment (if applicable)	Maryland Medicaid – enrolled in "EPrep"?		Virginia Medicaid – Enrolled in "PRSS"?	
	Yes ☐ No ☐		Yes ☐ No ☐	
Specialty(ies):				
EPSDT, New Patients		EPSDT Certified (if applicable)	Accepting New Patients?	
		Yes ☐ No ☐ N/A ☐	Yes ☐ No ☐	
Hospital Affiliation:				
Practice Locations (indicate by using Practice Location #):				
Billing NPI:				

For additional Provider adds, replicate this section for as many additional providers as needed.

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****