# 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 where possible.

**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**

**Required:** 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**

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

☐ **W9**

**Return completed applications using the following option:**

**Email the Practitioner and Provider Quality Assurance Department at:**

ppqa-mas@kp.org

# Organizational Credentialing Application

**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
- ☐ Free-standing Diagnostic Testing Center (e.g. Radiology, Audiology)
- ☐ Home and Community Based Services (HCBS)
- ☐ Home Health/Home Visiting Agency
- ☐ Hospice
- ☐ Long-Term Services and Supports (LTSS)
- ☐ Outpatient Diabetes Self-Management Program
- ☐ Physical Therapy Facility
- ☐ Portable X-Ray Supplier
- ☐ Skilled Nursing Facility/Nursing Home
- ☐ Speech Pathology Facility
- ☐ Urgent Care Facility

# Organizational Credentialing Application

**Facility Location(s)**

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: _____

# Organizational 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: _____

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

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:

_____

**Accreditation**

Virginia 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

# Organizational 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: