elderwood health plan

Participating Provider Application

Provider Name: ______________________________

Mailing address: ______________________________

____

Billing address: ______________________________

____

Facility/practice address: (if different from above): Please complete a separate application for each facility.

____

____

Parent company (if applicable):

____

Contact Person: ______________________________

Telephone: ______________________________

Fax: ______________________________

E-mail address: ______________________________

Hours of Operation/Hours at Site:

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
9-5	9-5	9-5	9-5	9-5	9-5	9-5

"On-Call": ______________________________

PROVIDER BILLING INFORMATION

Billing Name: ______________________________

Tax ID: ______________________________

NPI Number: ______________________________

Contact Person: ______________________________

Billing Address: ______________________________

Telephone: ______________________________

Fax: ______________________________

E-mail address: ______________________________

SERVICES: Under "Services Provided", please identify the services you are seeking to provide to members; the documentation listed under "Credentialing Requirements" for each service type you are seeking to provide must be submitted with this application

Services Provided	Services Provided	Credentialing Requirements		
		State and other applicable license	Evidence of applicable accreditation	If not accredited, submit State survey
Adult Day Health Care Program				
Audiology				
Consumer Directed Personal Assistance Services				
Dentistry				
Durable Medical Equipment				
Hearing Aid Dispenser				
Home Health Care (Certified)				
Home Health Care (LHCSA)				
Long Term/Rehab				
Meals – Congregate Dining				
Meals – Home Delivered				
Medical Social Worker				
Non-Emergent Transportation				
Nutrition				
Occupational Therapy				
Optometry/Eyeglasses				
Orthotics and Prosthetics				
Outpatient Rehab Services				
Personal Emergency Response System				
Physical Therapy				
Podiatry				
Private Duty Nursing				
Respiratory Therapy				
Skilled Nursing Facility				
Social Day Care				
Speech Therapy				

Other:

____

____

____

____

7 Limestone Drive, Williamsville, NY 14221 | phone 716-631-1327 toll-free 1-866-843-7526
www.elderwoodhealthplan.com | fax 716-633-1153 TTY NY Relay Dial 7-1-1

SERVICE AREA: Please check the appropriate box(es).

Erie		Orleans	
Niagara		Monroe	
Genesee		Wyoming	

LANGUAGES Spoken in the Office/Agency:

Alternate communication systems in place:

Hearing Impaired/Deaf	Ex. TTD/TTY Phone/Computer	Yes _____ No _____
Vision Impaired/Blind	Ex. Raised Symbols/Braille/Large Print/Audio	Yes _____ No _____
Non-English Speaking	Ex. Interpreter/Translation	Yes _____ No _____

LICENSURE: Please submit copies of each certificate

State License/Registration #: _________________ **Expiration date:**_ _/_ _/_ _ _ _

Medicare Billing #: _________________ **Expiration date:**_ _/_ _/_ _ _ _

Medicaid Billing #: _________________ **Expiration date:**_ _/_ _/_ _ _ _

NY Pharmacy License #: _________________ **Expiration date:**_ _/_ _/_ _ _ _

ACCREDITATION: Please attach a copy of certificates of accreditation and the most recent survey report (e.g., JACHO). If you have accreditation for different services, please attach them to this application.

Accrediting organization: ____

Accreditation status and term: ____

INSURANCE: Please attach a declaration page (face sheet) for each insurance policy indicating current status and coverage amounts.

Carrier Name: ____________________________________ **Effective date:** ____________

General liability limit: ______________________________ **Professional liability:** ____________

Are you self-insured? Yes No If yes, please document the status of the plan: ____________

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KEY CONTACTS:

	NAME	PHONE and EMAIL
Chief Executive Officer		
Chief Operating Officer		
Chief Financial Officer		
Compliance officer		
Director Clinical Compliance		
Director of Patient Services		
QI and Utilization Review		
Intake		
Patient Accounts		

In addition to the information on this application, please enclose copies of the following:

	Enclosed	**Not Applicable**
Current Valid State License or Operation Certificate, Business Registration, or Certificate of Occupancy (if applicable)		
Current General and Professional Liability Insurance Certificate		
Current Proof of Workers' Compensation Insurance		
Malpractice/Liability Face Sheet ($1M/3M minimum required)		
Most Recent Accreditation Report		
Current W-9		
Proof of NPI		
Copy of Patient Satisfaction Survey		

The undersigned hereby certifies that the above information requested by Niagara Advantage Health Plan LLC, dba Elderwood Health Plan is truthful, correct and complete in all respects, and the undersigned further understands that the intentional submission of false or misleading information, or withholding of relevant information is grounds for termination as a participating provider with Elderwood Health Plan. The undersigned hereby agrees to notify Elderwood Health Plan of any changes in the above information.

Provider Name/Organization: ____

Signature: ____ **Date:** _________________________

Name (print): ____

Please Mail the original to:

Elderwood Health Plan
Contract Administration Department
7 Limestone Drive
Williamsville NY 14221
Attention: Heather Clark

Please complete and return a copy via Fax or Email to:

HClark@elderwood.com
Fax: 716-633-1153