**Participating Provider Application**

**Provider Name:**

 **please include parent company and dba name (if applicable)**

**Mailing address:**

**Contact Person:**

**Telephone:**

**Fax:**

**Email:**

**If different from above: Please complete a separate application for each facility.**

**FACILITY CONTACT INFORMATION: (if applicable)**

**Contact Person:**

**Mailing Address:**

**Telephone:**

**Fax: (for authorizations)**

**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” Day/Hours**

**PROVIDER BILLING INFORMATION**

**Billing Name:**

**Tax ID:**

**NPI Number:**

**Contact Person:**

**Billing Address:**

**Telephone:**

**Fax: (for authorizations)**

**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 |
|  |  |  | **Credentialing Requirements** |
|  | **Services Provided** | **Services Provided** | State and other applicable license | Evidence of applicable accreditation | If not accredited, submit State survey |
|  | Adult Day Health Care Program |  |  |  |  |
|  | Audiology |  |  |  |  |
|  | Assistive Technology |  |  |  |  |
|  | Community Transitional Services (CTS) |  |  |  |  |
|  | Consumer Directed Personal Assistance Services |  |  |  |  |
|  | Dentistry |  |  |  |  |
|  | Durable Medical Equipment |  |  |  |  |
|  | Environmental Modification (E-Mod) |  |  |  |  |
|  | Hearing Aid Dispenser |  |  |  |  |
|  | Home Health Care (Certified) |  |  |  |  |
|  | Home Health Care *(*LHCSA*)* |  |  |  |  |
|  | Meals – Congregate Dining |  |  |  |  |
|  | Meals – Home Delivered |  |  |  |  |
|  | Medical Social Worker |  |  |  |  |
|  | Moving Assistance (MA) |  |  |  |  |
|  | 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 |  |  |  |  |
|  | Skill Acquisition Maintenance & Enhancement (SAME) |  |  |  |  |
|  | Social Day Care |  |  |  |  |
|  | Speech Therapy |  |  |  |  |
|  | Vehicle Modification (V-Mod) |  |  |  |  |

**Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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

|  |  |
| --- | --- |
| **Albany □**  | **Fulton □ Oneida □ Schenectady □**  |
| **Cattaraugus □**  | **Herkimer □ Onondaga □ St. Lawrence □**  |
| **Cayuga □**  | **Madison □ Orleans □ Warren □**  |
| **Chautauqua □**  | **Monroe □ Ontario □ Wayne □**  |
| **Erie □**  | **Montgomery □ Rensselaer □ Wyoming □**  |
| **Genesee □**  | **Niagara □ Saratoga □**  |

**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: \_\_\_\_\_\_\_\_\_\_\_

**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 DEA Certificate (prescribing practitioners) |  |  |
| 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 to:

**Elderwood Health Plan**

**Contract Administration Department**

**500 Seneca, Suite 100**

**Buffalo, NY 14204**

**Attention: Stephanie Thompson**

OR return a copy via Fax or Email to:

**SThompson@Elderwood.com**

**Fax: 716-568-8378**