Provider Application for Credentialing or Re-Credentialing

Legal Entity Name: _____

DBA name: _____

Tax ID: _____

NPI: _____

License/operating certificate: _____

Medicaid ID: _____

Medicare ID: _____

Facility Information:

Facility Address: _____

Facility Phone: _____

Facility Fax: _____

Preferred method to receive authorizations:
- ○ Fax: _____
- ○ Email: _____

Office Manager/Director Name: _____

Office Manager Phone: _____

Officer Manager Email: _____

Mailing Information:

Mailing Address: _____

City State Zip _____

Billing Information:

Remittance Billing Address: _____

City State Zip _____

Billing Contact Name: _____

Billing Contact Phone: _____

Billing Contact Email: _____

500 Seneca Street, Suite 100, Buffalo, NY 14204
www.elderwoodhealthplan.com
phone 716-631-1327
fax 716-568-8378
toll-free 1-866-843-7526
TTY NY Relay Dial 7-1-1

Contact List:

Contact List	Name	Email	Signing contract (X)
Chief Executive Officer:			
Chief Finance officer:			
President:			
Compliance:			
Provider Relations:			
Contracts:			
Outreach:			
Additional			

Office Hours:

Office Hours on Site (Please indicate hours if different than noted):						
Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	9:00am-5:00pm	9:00am-5:00pm	9:00am-5:00pm	9:00am-5:00pm	9:00am-5:00pm	
On Call Hours:						

Servicing Counties:

Check off each participating county	
	Erie
	Niagara
	Orleans
	Genesee
	Wyoming
	Monroe

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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.

(X)	Services Provided	Additional Details	Credentialing Required:
	Adult Day Health Program		Operating Certificate
	Audiology		Provider License
	Consumer Directed Personal Assistance Services (CDPAS)		
	Durable Medical Equipment	o Prosthetics/Orthotics o Respiratory Therapy	Accreditation
	Certified Home Health Agency (CHHA)	o In-Home Physical Therapy o In-Home Occupational Therapy o In-Home Speech Therapy o Medical Social Services o Nutrition o In-home Respiratory Therapy	Operating Certificate
	Licensed Home Health Services Agency (LHCSA)	o Private Duty Nursing	State License
	Meals	o Meals on Wheels o Congregate Meals o Home Delivered Meals	
	Non-Emergent Transportation		DOT certificate (if applicable)
	Optometry/Eyeglasses		Provider License
	Personal Emergency Response System (PERS)		
	Podiatry		Provider License
	Private Duty Nursing		State License
	Skilled Nursing Facility		Operating Certificate
	Social Day Care		OMIG certificate
	Social and Environmental Supports		
	Physical Therapy		Provider License
	Occupational Therapy		Provider License
	Speech Therapy		Provider License
	Respiratory Therapy		Provider License
	Other:		

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Accessibility:

Languages spoken by office staff

	Spanish		Polish
	American Sign Language		Russian
	Chinese		French
	Bengali		Korean
	Japanese		Yiddish
	Other_____		Other_____
	Other_____		Other_____

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 _____
Language Line Services	Ex. Interpreter/Translation	Yes _____ No _____

In addition to the application please include the following credentialing documents (as applicable).

- Copy of Federal, State Operating certification or License
- Accreditation Certificate
- Copy of Certificate of Insurance with General Liability Coverage minimum amount $1M/$2M with current coverage dates and Elderwood Health Plan listed as the insured.
- Professional Liability $1M/$3M
- Proof of enrollment in New York State Medicaid
- W-9: Please sign and date the form with the IRS registered legal entity name and billing address.
- Copy of Worker's Compensation coverage
- DOT certificate
- Patient Satisfaction Survey

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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): _____

Title: _____

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