Facility/Ancillary Provider Application

Instructions: For the application to be considered complete:

1. All information must be legible. Please print clearly or type all information.
2. A separate application must be completed for **each Legal Entity/TIN**.
3. The application must be signed and dated. *Application expires one year after signature date.*
4. If necessary, use a separate sheet of paper to provide additional information.
5. Fill in the Tax ID Number at the bottom of every page for reference purposes.
6. If your entity provides any HCBS services, you will need to complete an Iowa Total Care HCBS Waiver Provider Application instead of this application for those services.

Provide the following information with the completed application when applicable:

- ☐ **State Operational License.**
- ☐ **Any other applicable State/Federal Licensures** (e.g., CLIA, DEA, Pharmacy or Department of Health).
- ☐ **Accreditation Certificate(s)** or **Accreditation letter with dates of accreditation.** (By a nationally-recognized accrediting body, e.g., TJC/JCAHO/CARF/COA or AOA).
- ☐ **Site Evaluation Results:** If not accredited by a nationally-recognized accrediting body, attach the Site Evaluation Results from a governmental agency.
- ☐ **W-9** signed and dated.
- ☐ **Professional/General Liability Insurance**. Attach a current copy of the Certificate of Insurance (COI) detail with amounts and coverages listed. *Minimum requirement: $1M per occurrence /$3M per aggregate.*
- ☐ **Provider Accessibility Initiative (PAI) Survey.** The PAI Survey must be submitted for each service location and can be found at the following link: https://www.iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html

Please return this form along with any supporting documentation to Iowa Total Care:

- By email: NetworkManagement@IowaTotalCare.com
- By fax: 1-833-208-1397
- By mail: Iowa Total Care
  Attn: Network Management
  1080 Jordan Creek Parkway, Suite 100S
  West Des Moines, IA 50266

Please keep your set of originals for reference.

Reason for Application:

- **Initial Credentialing/Assessment**
- **Re-Credentialing/Re-Assessment**
- **Addition of new site to current contract**

Legal Entity/TIN: _____

This application applies to the following **Provider Types:** *(Choose all that apply.)*

☐ Hospital (Critical Access) NPI:	☐ Hospital (Swing Bed) NPI:	☐ Hospital (General Acute Care) NPI:
☐ Hospital (Rehabilitation) NPI:	☐ Hospital (Psychiatric) NPI:	☐ Maternal Health Center NPI:
☐ Community Mental Health Center (CMHC) NPI:	☐ Clinic – Federally Qualified Health Center (FQHC) NPI:	☐ Clinic – Rural Health Center (RHC) NPI:
☐ Birthing Center NPI:	☐ Clinic – Indian Health (IHC) NPI:	☐ Hearing Aid Dealer (Ancillary) NPI:
☐ Nursing Facility – Mentally Ill NPI:	☐ Clinic – County or State Health Department NPI:	☐ Outpatient Infusion / Chemotherapy NPI:
☐ Public Health Agency NPI:	☐ Diagnostic Imaging Center; High Tech and Low Tech (Freestanding) NPI:	☐ Orthotics and Prosthetics NPI:
☐ Ambulance NPI:	☐ Dialysis (ESRD) Clinic NPI:	☐ Behavioral Health Center (Ancillary) NPI:
☐ Assertive Community Treatment (ACT) NPI:	☐ Durable Medical Equipment (DME) NPI:	☐ Hospice NPI:
☐ Ambulatory Surgical Center NPI:	☐ Family Planning Clinic NPI:	☐ Residential Treatment Center (Behavioral Health/SUDs) NPI:
☐ Chronic Condition Health Home (CCHH) NPI:	☐ Maternal Screening Center/ Pediatric Screening Center (Title V/X) NPI:	☐ Rehabilitation Facility (Outside of Hospital) NPI:
☐ Behavioral Health Agency/ Child Placing Agency NPI:	☐ Home Health Agency (HHA) NPI:	☐ Skilled Nursing Facility (SNF) NPI:
☐ Integrated Health Home (IHH) NPI:	☐ Laboratory (Freestanding) NPI:	☐ Psych Medical Inst. Children (PMIC) NPI:
☐ Crisis Response Services NPI:	☐ Subacute Mental Health Services NPI:	Transplant ☐ Heart ☐ Kidney ☐ Pancreas ☐ Liver ☐ Lung NPI:
☐ Sleep Diagnostic Center NPI:	☐ Occupational Therapy (OT) Rehab Agency NPI:	☐ Urgent Care (Attached to Hospital) NPI:
☐ Chemical Dependency/ Substance Abuse Facility NPI:	☐ Physical Therapy (PT) Rehab Agency NPI:	☐ Urgent Care (Free Standing) NPI:
☐ Telehealth/Telemedicine NPI:	☐ Speech Therapy (ST) Rehab Agency NPI:	☐ Mammography (Free Standing/Mobile) NPI:
☐ Intermediate Care Facility (ICF) NPI:	☐ Community-Based ICF/ID NPI:	☐ Behavioral Health Intervention Services (BHIS) NPI:
☐ Other (Please Specify) NPI:	☐ Other (Please Specify) NPI:	☐ Other (Please Specify) NPI:

Taxonomies associated with this Tax Identification Number:

Contact Information

For questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**

Credentialing Contact Information

For questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**

Legal Entity Information *(Name on Income Tax Return)*

Tax ID Holder Name:	**Federal Tax ID Number:**	☐ **Profit** ☐ **Non-Profit**
Legal/Tax Address *(where you want the 1099 sent)*:		

Insurance Information *(Both facility general and professional liability if required; minimum coverage requirement is $1 million per occurrence and $3 million aggregate.)*
Note: Please attach your COI *(Certificate of Insurance).*

Carrier:	**Amount of Coverage, Per Occurrence:**	**Amount of Coverage, Per Aggregate:**
Policy Number:	**Coverage Dates:**	

Billing Information

Pay To Name (Issue check to): *(Note: May be different than name on the 1099.)*		
Pay To Address (Send remittance to):	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Entity Servicing Which Counties *(If needed, attach an additional sheet.)*

Servicing County 1:	**Servicing County 2:**	**Servicing County 3:**	**Servicing County 4:**
Servicing County 5:	**Servicing County 6:**	**Servicing County 7:**	**Servicing County 8:**

Please complete Service Location pages for each NPI listed on page 2 of this application.
If an NPI has more than one location, please complete service location pages for each location.

Service Location 1 of ____

Facility Name (to be displayed in the Directory) ☐ **Check box if this should be excluded from the Directory.**

Tax ID Number:	**Provider Type:**	**NPI:**
State License Number:	**Medicaid ID Number:**	**Medicare Number:**

Service Location Address:	**Requested Effective Date of Enrollment:** *(This date cannot be prior to the IME enrollment date or contract effective date.)*

Physical Street Address:	**City, State, Zip:**	**County:**
Main Phone Number:	**Location Fax Number:**	**Email:**

Website:

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8–5, Monday–Friday**

Hospital Services Offered *(Check all that apply.)*
☐ **Emergency Setting** ☐ **Post Stabilization Services**

Service Location Accepting New Patients?
☐ **Yes** ☐ **No**

Was the Provider Accessibility Initiative (PAI) Survey submitted for this location? ☐ **Yes** ☐ **No**

The Provider Accessibility Initiative (PAI) Survey can be found at the following link:
https://www.iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html

Crisis Intervention/ Emergency Services Offered? ☐ **Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐ **M** ☐ **F** ☐ **Both**

Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:

Do you provide services to any of the following special needs population? *(Check all that apply.)*
☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental Disability**
☐ **Other (Please specify: _____)**

Is your practice limited to certain ages? ☐ **Yes** ☐ **No**
If yes, specify age restrictions: ☐ **None** ☐ **0-2 years** ☐ **0-6 years** ☐ **0-12 years** ☐ **0-17 years** ☐ **0-20 years**
☐ **6-12 years** ☐ **13+ years** ☐ **13-17 years** ☐ **13-20 years** ☐ **3+ years** ☐ **17+ years** ☐ **21+ years**
☐ **65+ years** ☐ **Other_____**

Behavioral Health Services Provided for Service Location 1 of _____ *(Check all that apply.)*

☐ **Inpatient Mental Health**	☐ **Inpatient – Eating Disorder**
☐ **Inpatient Substance Abuse**	☐ **Electroconvulsive Therapy (ECT) – Inpatient**
☐ **Day Treatment – Mental Health**	☐ **Electroconvulsive Therapy (ECT) – Outpatient**
☐ **Day Treatment – Substance Abuse**	☐ **Partial Hospitalization Program (PHP) – Mental Health**
☐ **Intensive Outpatient Program (IOP) – Mental Health**	☐ **Partial Hospitalization Program (PHP) – Substance Abuse**
☐ **Intensive Outpatient Program – Substance**	☐ **Residential Treatment – Chemical Dependency**
☐ **Abuse Observation**	☐ **Community-Based Services**
☐ **Residential Treatment – Mental Health (PRTF)**	☐ **Targeted Case Management**
☐ **OP Treatment Services – Mental Health**	☐ **Crisis Stabilization**
☐ **OP Treatment Services – Substance Abuse**	☐ **Detox; Ages Served:** _____
	☐ **Other (please specify):** _____

Insurance Information for Service Location

☐ **Same as indicated on page 3** *(If different, complete below.)*

Professional Carrier:	**Amount of Coverage:** _____ **Per Occurrence:** _____ **Per Aggregate:**	**Coverage Dates:**
Worker's Compensation Carrier:		**Coverage Dates:**

Has the Provider Office completed Cultural Training? ☐ **Yes** ☐ **No**

If yes, did the training include the following?

African American	☐ **Yes**	☐ **No**	**Asian**	☐ **Yes**	☐ **No**	**Other** _____	☐ **Yes**	☐ **No**
Alaskan Native	☐ **Yes**	☐ **No**	**Hispanic/Latino**	☐ **Yes**	☐ **No**			
American Indian	☐ **Yes**	☐ **No**	**Pacific Islander**	☐ **Yes**	☐ **No**			

Accreditation/Certification Type

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC [aka JCAHO])			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			

Service Location 1 of ____: Accreditation/Certification Type (Continued)

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation Commission for Health Care, Inc. (URAC)			
Others (please list):			

Service Location 1 of ____: Sanctions

If response is yes to any question below, please explain on a separate sheet of paper.

Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐**No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐**Yes** ☐**No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐**Yes** ☐**No**
Has the facility's DE! Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?	☐**Yes** ☐**No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐**No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐**Yes** ☐**No**

Please complete Service Location pages for each NPI listed on page 2 of this application.
If an NPI has more than one location, please complete service location pages for each location.

Service Location 2 of ____

Facility Name (to be displayed in the Directory) ☐ **Check box if this should be excluded from the Directory.**

Tax ID Number:	**Provider Type:**	**NPI:**
State License Number:	**Medicaid ID Number:**	**Medicare Number:**

Service Location Address:	**Requested Effective Date of Enrollment:** *(This date cannot be prior to the IME enrollment date or contract effective date.)*

Physical Street Address:	**City, State, Zip:**	**County:**
Main Phone Number:	**Location Fax Number:**	**Email:**

Website:

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8–5, Monday–Friday**

Hospital Services Offered *(Check all that apply.)*
☐ **Emergency Setting** ☐ **Post Stabilization Services**

Service Location Accepting New Patients?
☐ **Yes** ☐ **No**

Was the Provider Accessibility Initiative (PAI) Survey submitted for this location? ☐ **Yes** ☐ **No**

The Provider Accessibility Initiative (PAI) Survey can be found at the following link:
https://www.iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html

Crisis Intervention/ Emergency Services Offered? ☐ **Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐ **M** ☐ **F** ☐ **Both**

Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:

Do you provide services to any of the following special needs population? *(Check all that apply.)*
☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental Disability**
☐ **Other (Please specify: _____)**

Is your practice limited to certain ages? ☐ **Yes** ☐ **No**
If yes, specify age restrictions: ☐ **None** ☐ **0-2 years** ☐ **0-6 years** ☐ **0-12 years** ☐ **0-17 years** ☐ **0-20 years**
☐ **6-12 years** ☐ **13+ years** ☐ **13-17 years** ☐ **13-20 years** ☐ **3+ years** ☐ **17+ years** ☐ **21+ years**
☐ **65+ years** ☐ **Other_____**

Behavioral Health Services Provided for Service Location 2 of _____ *(Check all that apply.)*

☐ **Inpatient Mental Health**	☐ **Inpatient – Eating Disorder**
☐ **Inpatient Substance Abuse**	☐ **Electroconvulsive Therapy (ECT) – Inpatient**
☐ **Day Treatment – Mental Health**	☐ **Electroconvulsive Therapy (ECT) – Outpatient**
☐ **Day Treatment – Substance Abuse**	☐ **Partial Hospitalization Program (PHP) – Mental Health**
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☐ **Intensive Outpatient Program – Substance**	☐ **Residential Treatment – Chemical Dependency**
☐ **Abuse Observation**	☐ **Community-Based Services**
☐ **Residential Treatment – Mental Health (PRTF)**	☐ **Targeted Case Management**
☐ **OP Treatment Services – Mental Health**	☐ **Crisis Stabilization**
☐ **OP Treatment Services – Substance Abuse**	☐ **Detox; Ages Served:** _____
	☐ **Other (please specify):** _____

Insurance Information for Service Location

☐ **Same as indicated on page 3** *(If different, complete below.)*

Professional Carrier:	**Amount of Coverage:** _____ **Per Occurrence:** _____ **Per Aggregate:**	**Coverage Dates:**
Worker's Compensation Carrier:		**Coverage Dates:**

Has the Provider Office completed Cultural Training? ☐ **Yes** ☐ **No**

If yes, did the training include the following?

African American	☐ **Yes**	☐ **No**	**Asian**	☐ **Yes**	☐ **No**	**Other** _____	☐ **Yes**	☐ **No**
Alaskan Native	☐ **Yes**	☐ **No**	**Hispanic/Latino**	☐ **Yes**	☐ **No**			
American Indian	☐ **Yes**	☐ **No**	**Pacific Islander**	☐ **Yes**	☐ **No**			

Accreditation/Certification Type

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC [aka JCAHO])			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			

Service Location 2 of ____: Accreditation/Certification Type (Continued)

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation Commission for Health Care, Inc. (URAC)			
Others (please list):			

Service Location 2 of ____: Sanctions

If response is yes to any question below, please explain on a separate sheet of paper.

Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐**No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐**Yes** ☐**No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐**Yes** ☐**No**
Has the facility's DE! Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?	☐**Yes** ☐**No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐**No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐**Yes** ☐**No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Iowa Total Care Health Plan provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Iowa Total Care Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, Iowa Total Care Health Plan members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Iowa Total Care Health Plan. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Iowa Total Care Health Plan in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Iowa Total Care Health Plan credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need-to-know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photocopy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photocopy shall have the same force and effect as the signed original.

Name of Entity: _____ **Date:** _____
Print or type name.

Signature of Authorized Representative: _____ **Title:** _____
A stamp signature is not acceptable.