435 N Whittington Pkwy, Suite 275
Louisville, KY 40223

Aetna Better Health® of Kentucky

Facility, HealthCare Delivery Organizations (HDO), Long Term Special Services Credentialing and Recredentialing Application Instructions

Please submit all applicable documents from the list below with your completed and signed application. Failure to provide this information will prohibit completion of your credentialing and/or contracting process. Please submit enclosures for each location.

- Copy of all federal, state and/or local licenses required to operate as a healthcare facility (by location)
- Copy of all accreditation certificate(s) or letter(s).
- Copy of most recent CMS or state survey, including your corrective action plan if deficiencies were cited
- Copy of CLIA certificate for each location, as applicable
- Copy of current DEA certificate (if applicable);
- Professional/Malpractice liability declaration sheet or certificate of Insurance
- Copy of W9

Please submit completed application, along with all required documentation

If any of your locations has a unique NPI, a unique Tax ID number, or a unique license, a separate credentialing event and application is Required

Provider Identification

Legal business name:	
Doing business as (if applicable):	
TIN:	NPI:

Primary Office/Service Address to be credentialed

Practice location name:			
Medicaid Number:		Medicare Number:	
Address line 1:			
Address line 2:			
City:	State:	Zip+4 (Preferred):	County:
Phone:	Fax:	Primary Contact:	
Administrator (full name):			
Pay To Address:			
City:	State:	ZIP+4 (Optional):	Phone:

Credentialing Address (Verisys will send credentialing correspondence to this address)

Credentialing Contact Name:		
Address line 1:		
Address line 2:		
City:	State:	ZIP+4 (Optional):
Email:	Phone:	Fax:

ADA Requirements

Access & Availability ☐ Yes ☐ No	Appropriate Equipment Available ☐ Yes ☐ No

Provider Types

Please check the applicable provider type below:

- ☐ Adaptive Aids/Medical Equipment (LTSS)
- ☐ Adult Day Care
- ☐ Adult Foster Care
- ☐ Ambulance Service/Transportation Company
- ☐ Ambulatory Surgical Center
- ☐ Assisted Living
- ☐ Behavioral Health Facility
- ☐ Behavioral Health Unit
- ☐ Birthing Center
- ☐ Cardiac Rehab Center
- ☐ Case Management
- ☐ Certified Community Behavioral Health Clinic
- ☐ Chemical Dependency Treatment Facility (CDTF)
- ☐ Clinic/Group Practice
- ☐ Community Mental Health Center
- ☐ Comprehensive Outpatient Rehab Facility (CORF)
- ☐ Day Habilitation (LTSS)
- ☐ Durable Medical Equipment
- ☐ Early Childhood Intervention (ECI)
- ☐ Emergency Response Service/System
- ☐ End Stage Renal Disease Facility (ESRD)
- ☐ Endoscopy Facility
- ☐ Family Planning Clinic
- ☐ Federal Qualified Health Center (FQHC)
- ☐ Financial Management Service Agency
- ☐ Home Health Agency
- ☐ Home Infusion
- ☐ Home Modification/Minor Home Modification
- ☐ Hospice
- ☐ Hospital
- ☐ Hospital, Behavioral Health
- ☐ Infusion Therapy Clinic
- ☐ Laboratory
- ☐ Magnetic Resonance Imaging (MRI)
- ☐ Meals, Home Delivered Meals
- ☐ Mobile X-Ray/Mobile Diagnostic Provider
- ☐ Non-Emergent Transportation Services
- ☐ Nursing Home
- ☐ Nursing/Healthcare Staffing Service
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Rehab Facility (ORF)
- ☐ Pediatric Day Health Care
- ☐ Personal Assistance Services Agency
- ☐ Personal Care Services
- ☐ Pharmacy
- ☐ Pharmacy-Home Health IV LTC
- ☐ Physical Rehabilitation Distinct Part Unit
- ☐ Physiological-Independent Diagnostic Testing (IDTF)
- ☐ Public Health Agency
- ☐ Radiation/Cancer Treatment Centers
- ☐ Rehab Behavioral Hlth Serv
- ☐ Assisted Long-Term Care
- ☐ Residential-Based Supported Community Living Serv
- ☐ Rural Health Clinic
- ☐ Skilled Nursing Distinct Part Unit
- ☐ Skilled Nursing Facility (SNF)
- ☐ Sleep Medicine Center
- ☐ Transition Assistance Services (LTSS)
- ☐ Urgent Care Center
- ☐ Vehicle Modification (LTSS)

Licensure & Certificates (attach a copy of current licensure and Clinical Laboratory Improvements Amendment [CLIA] certification, if applicable)			
Type of License:_____ State:_____	License issuance date: _____	License number: _____	Expiration date: _____
Type of License:_____ State:_____	License issuance date: _____	License number: _____	Expiration date: _____
Type of License:_____ State:_____	License issuance date: _____	License number: _____	Expiration date: _____
Radiology Certificate #: _____		Radiology Expiration Date:_____	
CLIA Certificate #: _____		CLIA Expiration Date: _____	

Accreditation/Certification (attached a copy of current accreditation, certificate or survey, if applicable)

- American Association of Blood Banks (AABB)
- Accreditation Association of Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care (ACHC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Board for Certification in Orthotics & Prosthetics (ABC)
- American College of Radiology (ACR)
- American Society for Histocompatibility and Immunogenetics
- American Association for Laboratory Accreditation (A2LA)
- Board Certification/Accreditation International (BOC)
- Center for Improvement in Healthcare Quality (CIHQ)
- Clinical Laboratory Improvement Amendments (CLIA)
- CMS Certification
- College of American Pathologists (CAP)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Commission on Office Laboratory Accreditation (COLA)
- Community Health Accreditation Partner (CHAP)
- Det Norske Veritas Healthcare GL (DNV GL)
- Healthcare Facility Accreditations Program (HFAP)
- Healthcare Quality Association on Accreditation (HQAA)
- Intersocietal Accreditation Commission (IAC)
- National Association of Boards of Pharmacy (NABP)
- National Dialysis Accreditation Commission (NDAC)
- The Compliance Team (TCT)
- The Joint Commission (TJC)
- RadSite
- Utilization Review Accreditation Commission (URAC)
- Public Health Accreditation Board (PHAB)

Unaccredited Organizations:

Site Survey — Visit May Be Required

Non-Accredited providers must provide a copy of:

- Most recent government agency survey (may not be older than 36 months),
- Corrective action plan (if deficiencies were cited) and attach the proof from the government agency stating the facility is in substantial compliance with most recent survey standards.

Facilities that don't meet the requirements above require an onsite visit before network status may be granted. Failure to provide documentation or complete the onsite survey may delay your ability to become a participating provider.

- Has a site survey been completed by CMS or a state agency?
  - ☐ Yes, If Yes: Date of Most Recent Full Survey
  - ☐ No
- Is accreditation being pursued?
  - ☐ Yes, If Yes: Expected Date of Accreditation (MM/DD/YYYY) _____
  - ☐ No

General liability insurance

General liability coverage - Please submit a copy of your certificate of insurance	
Current carrier name:	
Policy number:	Coverage type: ☐ Occurrence-based ☐ Claims-based
Effective date:	Expiration date:
Per incident: $	Aggregate: $

Professional Disclosure Questions

1. Has your organization or any of its authorized representatives ever been convicted of, pled guilty to, or pled nolo contendere to any legal actions (excluding medical malpractice and misdemeanors)?

   ☐ No ☐ Yes (provide an explanation): _____

2. Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?

   ☐ No ☐ Yes (provide an explanation): _____

3. Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military and State Department of Health programs?

   ☐ No ☐ Yes (provide an explanation): _____

4. At any time, has any license or certification held by the organization ever been revoked, denied or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which may lead to one of these outcomes?

   ☐ No ☐ Yes (provide an explanation): _____

5. Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?

   ☐ No ☐ Yes (provide an explanation): _____

6. At any time, has any third-party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management or quality of care issues?

   ☐ No ☐ Yes (provide an explanation): _____

7. Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?

   ☐ No ☐ Yes (provide an explanation): _____

Attestation/Consent and Release

I, the undersigned authorized agent, hereby attest that the information submitted in, or in support of this application is true, accurate and complete to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of privileges, employment or participating practitioner agreement.

I release from liability, Aetna Better Health of Kentucky(ABHKY) participating plans and all representatives of ABHKY provided to ABHKY. I hereby authorize ABHKY to review and inspect all documents and information bearing the organization's qualifications, and consent to the release and authorize the exchange of information relating to any claims, disciplinary actions, suspensions, restrictions, or termination of professional associations to ABHKY.

A photocopy of this document shall be as effective as the original.

Preparer's Name: _____ Title: _____

Signature: _____ Date: _____