FACILITY/ ANCILLARY/ LONG-TERM CARE APPLICATION

Please circle all states which apply:
☐**GA** ☐**MD** ☐**NE** ☐ **NJ** ☐**NV** ☐**NY** ☐**OH** ☐**TN** ☐**TX** ☐**VA**

PROVIDER IDENTIFICATION

Legal Business Name:	
Doing Business As: (if applicable)	
Contact Person:	Email:
Tax ID #1:	Tax ID #2:
Medicaid #1:	Medicare #1:
Medicaid #2:	Medicare #2:
Long-Term Care Vendor #:	

PROVIDER TYPE

FACILITY:

__Ambulatory Surgery Center (ZS)
__Birthing Center (Z1)
__Hospital (99)
__Inpatient Mental Health/ Substance Abuse Facility (Z9)
__Inpatient Rehab Hospital (YD)
__Nursing Home (NH)
__Organ Transplant Facility (ZT)
__Psychiatric hospital (BH)
__Skilled Nursing Facility (ZJ)
__Sub acute/ Intermediate Care Facility (YQ)
__Trauma Center (ZV)

Facilities must provide a copy of a recent CMS or state survey/review (current within 36 months). Please see the ENCLOSURES section for a list of other required documents. Failure to provide these documents will delay or prohibit your ability to become a participating provider with AMERIGROUP.

ANCILLARY:

__Ambulance (ZO)
__Audiology Services (AU)
__Dialysis (Z2)**
__Dietician/ Nutritional Services (Y6)
__Durable Medical Equipment & Supplies (Z3)
__Early Childhood Intervention (EC)
__Family Planning Services (ZF)
__Federally Qualified Health Center (Y8)**
__Fetal Monitoring Services (Z4)
__Genetic Services (GE)
__Hearing Aids (ZM)
__Hemophilia Center (ZU)
__Home Health Agency (Z5)**
__Home Infusion Therapy (Z6)**
__Hospice Care- Outpatient (Z7)**
__Hospice Facility (HO)**
__Imaging Facility (IF)**
__Interpreter Service (YE)
__Laboratory (ZA)**
__Lithotripsy Services (ZB)
__Occupational Therapy Services (YH)
__Orthotics & Prosthetics (ZE)
__Outpatient Rehab Center (RC)**
__Personal Assistance Services (AZ)
__Physical Therapy Services (AZ)
__Radiology Facility ZG)**
__Radiology- Mobile Unit (RM)**
__Respite Care (YN)
__ Rural Health Clinic (YO)**
__Sleep Disorder Clinic (SD)
__Speech Therapy Services (ST)
__ Urgent Care Center (ZK)
__ Walk-In Clinic

Behavioral Health Ancillaries:
__Methadone Maintenance Clinic (MC)**
__Outpatient Mental Health/ Substance Abuse Facility (ZC)**
__Residential Treatment Center (TC)**

**** These providers must submit a copy of their appropriate accreditation or provide a copy of a recent HCFA/CMS or state survey/review (current within 36 months), if not accredited. If documents are not available, a site visit will need to be scheduled.**

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LONG-TERM CARE:

__Adult Foster Home (Y2)	__Home Health Agency (Z5)**	__Hospice Facility (HO)**	__Pest Control (YK)
__Day Activity/ Health Services (Y5)	__Home Infusion Therapy (Z6)**	__Music Therapy (YG)	__Residential Care/Assisted Living Facility (RT)
__Emergency Response Systems (Y7)	__Home Modification/ Repair (YF)	__Nursing Home (NH)**	__Respite Care (YN)
__Home Delivered Meals (Y9)	__Hospice Care- Outpatient (Z7)**	__Personal Assistance Services (AZ)	

****These providers must submit a copy of their appropriate accreditation or provide a copy of a recent HCFA/ CMS or state survey/ review (current within 36 months), if not accredited. If documents are not available, a site visit will need to be scheduled.**

PRIMARY OFFICE /SERVICE ADDRESS			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Contact:	
Administrator (Full Name):			
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			
BILLING INFORMATION			
Name (Billing Name)			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	Phone:

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SECONDARY OFFICE /SERVICE ADDRESS			
Practice Location Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Contact:	
Administrator (Full Name):			
Does Provider bill from this address? ☐ Yes ☐ No			
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply: Handicap Accessible: ☐ Building ☐ Parking ☐ Restroom Services for Disabled: ☐ Text Telephone ☐American Sign Language ☐ Mental/Physical Impairment Accessible by Public Transportation: ☐ Bus ☐ Subway ☐ Regional Train			

BILLING INFORMATION			
Name (Billing Name)			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	Phone:

If there are additional office/service locations, please attach a separate sheet indicating the address, phone/fax numbers.

NATIONAL PROVIDER IDENTIFIER	
Name:	
Service Address:	
Tax ID/EIN:	NPI#:
Taxonomy Code(s):	
Name:	
Service Address:	
Tax ID/EIN:	NPI#:
Taxonomy Code(s):	

Note: If you are a DME provider, please submit NPI and Taxonomy for each location. If more space is needed, please attach a separate sheet with Name, Service Address, Tax ID/EIN, NPI# and Taxonomy Code(S).

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LICENSURE **(Attach a copy of current licensure and CLIA certification, if applicable.)**			
State:	Date of License:	License Number:	Expiration Date:
State:	Date of License:	License Number:	Expiration Date:
CLIA#:			

ACCREDITATION/CERTIFICATION **(Attach a copy of current Accreditation certificate or survey.)**

☐ AAAHC ☐ AAAASF ☐ ACHC ☐ ACR ☐ AOA ☐ CAP ☐ CARF ☐ CCAC ☐ CHAP ☐ COA
☐ HCU ☐ HFAP ☐ JCAHO ☐ **NOT ACCREDITED**

Date of initial accreditation: _____/_____/_____

Date of last survey: _____/_____/_____

Has provider had an on-site survey by a State agency? ☐ Yes ☐ No Date of last State survey: _____/_____/_____

Is provider participating in the Medicare program? ☐ Yes ☐ No Date of last CMS survey: _____/_____/_____

INSURANCE **(Attach a copy of liability insurance face sheet indicating general & professional coverage.)**

General Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

Professional Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ☐ Occurrence Based ☐ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information			
Name of Entity			
Business Address			
City	State	Zip	Telephone No.

II. Answer the following questions by checking "Yes" or "No". If any of the questions are answered "Yes", list names and addresses of individuals or corporations under Remarks on Page 7. Indentify each item number to be continued.

a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5% or more in the institution, organizations, or agency that have been convicted or a criminal offense related to the involvement of such persons, or organization in any of the programs established by Titles XVIII, XIX, or XX?	☐ Yes ☐ No
b) Are there any directors, officers, agents, or managing employees of the institution, agency, or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?	☐ Yes ☐ No
c) Are there any individuals currently employed by the institution, agency or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only.)	☐ Yes ☐ No

III. (a) List names, addresses for individuals or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. List any additional names and addresses under "Remarks" on Page 7. If more than one individual is reported and any of these persons are related to each other, this must be reported under "Remark on Page 7.

NAME	ADDRESS	EIN

(b) Type of Entity

☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other (Specify) _____

(c) If the disclosing entity is a corporation, list names, addresses of the Directors and EINS for corporations under Remarks.

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers. ☐ Yes ☐ No

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

NAME	ADDRESS	PROVIDER NUMBER

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ ☐ Yes ☐ No

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ ☐ Yes ☐ No

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ ☐ Yes ☐ No

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations_____ ☐ Yes ☐ No

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year? ☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
☐ Yes ☐ No

Name _____ EIN _____

Address _____

(b) If the answer to Question VII. (a) is No, was the facility ever affiliated with a chain?
If yes, list Name, Address of Corporation, and EIN)
☐ Yes ☐ No

Name _____ EIN _____

Address _____

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years? ☐ Yes ☐ No
If yes, give year of change _____ Current beds _____ Prior beds _____

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates. A termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed)	Title
Signature	Date

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

Remarks

ENCLOSURES:

Please submit all applicable documents, from the list below, with your completed and signed application. Failure to provide this information will prohibit AMERIGROUP from completing your credentialing and/ or contracting process.

1. A copy of you state license for each location and/ or specialty.
2. A copy of your Liability Insurance Policy face sheet with effective and expiration dates, including the coverage amounts for each location. Professional Liability limits as outlined in the Participating Provider Agreement; General Liability with limits of at least $1M/$3M.
3. As noted above (**), a copy of your accreditation for each location or recent, within the last 36 months, HCFA/CMS or state review for each location if not accredited. If none of these are available an on-site review conducted by AMERIGROUP will be required.
4. Laboratories only: A copy of your current CLIA Certificate for each location.
5. Radiology and Imaging Facilities: A copy of your Certificate of Registration for Equipment.
6. A copy of your W-9 Form(s).

Form Completed by:

_____ _____

Printed Name of Authorized Representative | Signature of Authorized Representative

_____ _____

Authorized Representative's Title | Date Signed