Facilities Application Packet

Thank you for your interest in becoming part of StayWell's Provider Network. Prior to beginning your service with StayWell Insurance, you must complete our credentialing process for your facility and be approved in our Network.

We will make every effort to process your application in a timely and efficient manner.

Credentialing is a five-step process:

1. Respective representative of facility will receive application packet.

2. Respective representative will return the completed application along with requested documents within 30 days from the date application was signed directly to the StayWell Provider Relations Department at 520 Route 8 Maite Guam 96910 or email: provider.relations@staywellguam.com or jmqcoronel@staywellguam.com

3. The application will be reviewed by StayWell's Provider Relations Department to make sure all information is complete and accurate.

4. The completed and verified application packet will be forwarded to the Credentialing Committee for approval.

5. The respective representative will be notified of the approving authority's decision.

The credentialing process may take up to 90 to 180 days to verify, review, and obtain final approval. To expedite the process, application should be without blanks or missing requested documents. If in the event application is incomplete, the applicant will be notified in writing by the StayWell Provider Relations Department of the deficiency no later than 45 days following receipt of application.

If you should have any questions, please contact the StayWell Provider Relations Department:
Edna Carbonell – Contracts & Provider Relations Manager at (671) 477-5091 ext 1181
Jan Marie Coronel – Provider Network Credentialing Specialist at (671) 477-5091 ext 1189

Facilities Application Packet

Instructions:

1. Information must be typed or legibly printed.

2. All questions must be answered and forms must be signed where indicated. Incomplete applications will result in a delay in the Credentialing Process.

3. Please initial the bottom of each page of this application.

4. Please attach the following documents with your application:
   - Letter of Intent
   - Copy of current state(s) license
   - Copy of signed W-9
   - Copy of Accreditation to include accreditation status and level, Center for Medicare & Medicaid Services (CMS) confirmation of participation or other Certification(s) (if applicable)
     * Note: Any hospital or ancillary facility that is not accredited or does not have a CMS confirmation of participation, must submit credentialing procedures and quality improvement procedures. Your facility may require a plan site evaluation.
   - Provide Roster (include practitioner name, specialty and individual NPI)
   - Proposed Fee Schedule
   - Current Drug Enforcement Administration (DEA) License (if applicable)
   - Copy of current general liability insurance certificate (if applicable)
   - Copy of current professional liability insurance certificate covering all employees (if applicable)

Section 1 – Facility Type:

Please check one:

- ☐ Hospitals, including critical care access hospitals, acute rehabilitation hospitals, mental health hospitals
- ☐ Ambulance
- ☐ Behavioral health facilities providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting
- ☐ Cardiac rehabilitation services, Cardiac Lab
- ☐ Rural Health Clinic (RHC)/Federally Qualified Healthcare Center (FQHC), Public Health Agency, Urgent Care Centers
- ☐ Comprehensive Outpatient Rehab Facility (CORF)
- ☐ Durable medical equipment vendors (DME), including cardiac monitoring, INR
- ☐ End stage renal disease treatment facility (ESRD) (e.g., Dialysis Centers)
- ☐ Free-standing surgical center (to include family planning and assisted reproductive technology)
- ☐ Rehab agency/PT/OT/ST (functional therapy groups)
- ☐ Audiology
- ☐ Home health care & home infusion provider
- ☐ IV Infusion Therapy
- ☐ Hospice
- ☐ Hyperbaric centers
- ☐ Independent laboratory, including general outpatient labs, genetic labs, sleep labs
- ☐ Radiology, including independent diagnostic testing facility, supplier or portable x-ray services
- ☐ Nursing Homes
- ☐ Skilled nursing facility (SNF)
- ☐ Supplier- Diabetes Prevention, Outpatient Diabetes Management
- ☐ Orthotic/Prosthetic Supplier
- ☐ Birthing Centers
- ☐ Other (please indicate):

Section 2 – Facility Identification:

Legal business name: (as reported to the Internal Revenue Service [IRS])	
Doing business as (DBA) name: (if applicable)	
Tax identification number (TIN):	
National Provider Identifier (NPI) Number:	
Medicaid Number:	
Medicare Number:	

APPLICANT INITIALS:

Section 3 – Facility Information:			
Physical Address:	City	State	Zip Code
Mailing Address: ☐ Same as Physical Address	City	State	Zip Code
Phone Number:	Fax Number:		
Email Address: ☐ None	Website Address: ☐ None		

Section 4 – Facility Point of Contact Information:	
Name (First, Middle Initial, Last):	Title:
Direct Phone Number and Extension Number:	Direct Fax Number: ☐ None
Email Address:	

Section 5 – General Hours:		
Day	Start (HH:MM)	End (HH:MM)
Sunday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM
Monday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM
Tuesday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM
Wednesday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM
Thursday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM
Friday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM
Saturday ☐ Closed	☐ AM ☐ PM	☐ AM ☐ PM

Section 6 - Services at this location:	
Americans with Disabilities Act (ADA) accessibility requirements:	☐ Yes ☐ No
Handicap accessibility:	☐ Yes ☐ No

APPLICANT INITIALS:

Section 6 - Services at this location:	
24/7 phone coverage:	☐ Yes ☐ No
Answering service:	☐ Yes ☐ No
Any interpreters available?	☐ Yes ☐ No If Yes, please specify languages interpreted and/or any services you use:
Section 7 - Open Practice Status:	
Total number of licensed beds?	
Accepts walk-ins?	☐ Yes ☐ No
Accepts new patients with Medicaid Coverage?	☐ Yes ☐ No
Accepts new patients with Medicare Coverage?	☐ Yes ☐ No
Are there any Practice Limitations?	☐ Yes ☐ No If Yes, please specify limitations:

Section 8 – Billing Company Information: ☐ Not Applicable			
Name of Billing Company:			
Mailing Address:	City	State	Zip Code
Phone Number:	Fax Number:		
Contact Person Name (First, Middle Initial, Last):			
Title:	Email Address:		

APPLICANT INITIALS:

Section 9 - Payment and Remittance:	
Preferred Payment Delivery Method:	☐ Mailed to Facility ☐ Mailed to Billing Company
	☐ Pick-up by Authorized Personnel Note: Authorized Personnel Listing must be accompanied with this application.
Electronic Billing Capabilities?	☐ Yes ☐ No ☐ Not at this time If Yes, do you have a clearing house? ☐ Yes ☐ No
If you answered "Yes" to both of the above, please complete the next section below:	
Name of Clearing House:	
Point of Contact Name (First, Middle Initial, Last):	Title:
Point of Contact Phone Number:	Point of Contact Email Address:

Section 10 – Healthcare Licensure: ☐ **Not Applicable** Please provide a copy of each facility license. Do not submit provider licenses.	
Licensure Number:	State/City:
Licensing Agency:	Initial Issued Date (mm/dd/yyyy):
Renewal Date (mm/dd/yyyy):	Expiration Date (mm/dd/yyyy):

Section 11 - Medicare Status:		
Is this facility participating in the Medicare program?	☐ Yes ☐ No ☐ Pending	
	If Yes, provide Medicare Number:	
Is this facility certified by the Centers for Medicare & Medicaid Services (CMS)? ☐ Check here if facility is not eligible for CMS certification	☐ Yes ☐ No ☐ Pending	
	If Yes, please provide the following below:	
	Date of initial CMS certification (mm/dd/yyyy):	Medicare certification number:

APPLICANT INITIALS:

Section 12 – Accreditation: ☐ **Not Applicable**

Please select accrediting agency from the list below and attach a copy of current accreditation certificate.

☐ Accreditation Canada	☐ Joint Commission International
☐ Accreditation Commission for Health Care (ACHC)	☐ The Joint Commission Home Care Accreditation Program
☐ American Academy of Sleep Medicine (AASM)	
☐ American College of Radiology (ACR)	
☐ Australian Council on Health Care Standards	Other:
☐ Centers for Medicare & Medicaid Services (CMS)	
☐ Clinical Laboratory Improvement Amendment (CLIA)	
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)	
☐ Hong Kong Laboratory Accreditations Scheme (HOKLAS)	
☐ Joint Commission (JC) - formally known as JCAHO (Joint Commission on Accreditation of Healthcare Organizations)	

Section 17 – Disclosure Questions

Please answer "Yes" or "No" to the following questions.
If you answered "Yes" to any of the following, please provide full details/information on a separate sheet.

1.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been convicted of any health care-related criminal offense, had adjudication withheld on any health care-related criminal offense, pleaded no contest to any health care-related criminal offense, or entered into a pre-trial agreement for any health care-related criminal offense?	☐ Yes ☐ No
2.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
3.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had disciplinary action taken against any business or professional license held in this or any other state?	☐ Yes ☐ No
4.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had his or her license to practice restricted, reduced, or revoked in this or any other state; or been previously found by a licensing, certifying, or professional standards board or agency to have violated the standards or conditions relating to licensure or certification or the quality of services provided; or entered into a consent order issued by a licensing, certifying, or professional standards board or agency?	☐ Yes ☐ No
5.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been denied enrollment, suspended, excluded, terminated, or involuntarily withdrawn from Medicare, Medicaid, or any other government or private health care or health insurance program in any state?	☐ Yes ☐ No
6.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been suspended or excluded from participation in, or had any sanction imposed by, a federal or state health care program, or been disbarred from participation in any federal executive branch procurement or non-procurement program?	☐ Yes ☐ No
7.	Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had payments suspended by Medicare or Medicaid in any state under any Medicare or Medicaid billing number?	☐ Yes ☐ No

APPLICANT INITIALS:

Section 17 – Disclosure Questions

Please answer "Yes" or "No" to the following questions.
If you answered "Yes" to any of the following, please provide full details/information on a separate sheet.

8. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had civil monetary penalties levied by Medicare, Medicaid, or other state or federal agency or program, even if the fines have been paid in full?	☐ Yes ☐ No
9. Has Medicare or Medicaid in any state ever taken recoupment actions against any entity, agent, owner, or managing employee of the facility, under any current or former name or business identity?	☐ Yes ☐ No
10. Does the facility or any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, owe money to Medicare or Medicaid that has not been paid in full?	☐ Yes ☐ No
11. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the neglect or abuse of a patient in connection with the delivery of any health care item or service?	☐ Yes ☐ No
12. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to the delivery of an item or service under Medicare or state health care program?	☐ Yes ☐ No
13. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law of a criminal offense related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
14. Has any entity, agent, owner, or managing employee of this facility, under any current or former name or business identity, ever been found to have violated federal or state laws, rules or regulations in any program established under Medicare, any other state's Medicaid program, Title XX, or any other publicly funded federal or state health care or health insurance program?	☐ Yes ☐ No

Section 18 – Testimonial and Release

PLEASE READ AND UNDERSTAND THE FOLLOWING BEFORE SIGNING THIS APPLICATION:

1. I fully understand that any significant misstatement in or omissions from this application constitute cause for denial.
2. All information submitted by me in this application is true to my best knowledge and belief.
3. I agree that StayWell Insurance, its affiliates and the employees, agents and representative thereof have permission to obtain information about the facilities licensing, competence, ethics, and other qualifications.
4. I consent to the release of such information, whether in the form of records, tapes, letters, photocopies/duplications of any of the foregoing, or verbal statements, state licensing boards, or regulatory bodies, clinics, or other individuals or organization who or which possess information about the facility. Such information may be released to StayWell Insurance, its affiliates and the employees, agents and representatives.
5. I hereby release from any liability all representatives of StayWell Insurance for acts performed in good faith in connection with evaluating the application and credentials and I release from liability all individuals and organizations which, in good faith, provide information to StayWell Insurance in response to such inquiries.
6. I understand that StayWell Insurance will rely upon the information given on this application form during the processing of my application to be a Participating Facility Site. A fully completed and signed application, and copies of necessary documents are essential for consideration.
7. I agree that I will immediately inform StayWell Insurance of any change or modification to the information provided herein, so that at all times, StayWell Insurance will have accurate and current information.

AUTHORIZED SIGNATURE: DATE:

PRINTED NAME: TITLE:

Please list the name of the individual completing application or the person to be contacted if clarifying information is needed about this application.	

STAYWELL CREDENTIALING COMMITTEE:		
CHAIRMAN	DATE	☐ APPROVED ☐ NOT RECOMMENDED ☐ DEFERRED
STAYWELL ADMINISTRATOR:		
ADMINISTRATOR	DATE	☐ APPROVED ☐ NOT RECOMMENDED ☐ DEFERRED
REMARKS:		