Credentialing Application Checklist

IN ORDER TO PROCEED CONTRACT COORDINATORS MUST HAVE THE FOLLOWING COMPLETED DOCUMENTS

If provider is in CAQH please submit per practitioner:

- ❑ Completed W-9, at least one if all practitioners share same tax ID
- ❑ CAQH Provider Data Form, FULLY COMPLETED
- ❑ Schedule C Participating Provider Attestation (in the Agreement/Contract)
- ❑ Completed and signed Ownership and Disclosure Form
- ❑ Copy of Current General Liability coverage (document showing the amounts and dates of coverage)

Please send all completed materials to:

Mail:
Centurion
c/o Lisa Rossics
Centene Plaza
7700 Forsyth Blvd
Clayton, MO 63105

Fax:
844-614-1177

Email:
lrossics@centene.com

CAQH Provider Data Form

For Credentialing Purposes

Date:			Are you registered with CAQH? Yes No
If Yes, CAQH Provider ID:			Individual NPI:
Last Name:	First Name:		Middle Initial:
Date of Birth:	Social Security:		Medicaid ID #:
Provider Type (MD, DO, PhD, LCSW, LPC, etc.):	Are you a hospital based only provider not practicing in an office setting? Yes No		
Tax ID:	Group Billing NPI:		
Practice Name:			E-Mail Address:
Primary Office Street Address:			Suite #:
Primary Office City:	State:	County:	Zip:
Primary Telephone:			Primary Fax:
Credentialing Contact Information:			
Specialty:	Applying As: ❑ Specialist ❑ Primary Care Physician		
If PCP, are you accepting new patients? ❑ Yes ❑ No ❑ Yes, existing patients only	What gender or age restrictions do you have? Gender: ❑ No Restrictions ❑ Female Only ❑ Male Only Age: ❑ No Restrictions ❑ Age Limits: Lowest Age ____ Highest Age ____		
Are you board certified? Yes No	If Yes, board name:		Exp. Date:
Please list any medical related organizations you have ownership with, e.g., laboratory, home health agency, radiology facility, mobile testing, MRI, etc.:			
If you provide direct laboratory services, please indicate the TIN utilized and provide Clinical Laboratory Information Act (CLIA) information. Attach a copy of your CLIA certificate or waiver if you have one**.**			
Do you have a CLIA Certificate? Yes No	Do you have a CLIA waiver? Yes No	Type of Service Provided:	
Certificate Number: Certificate Expiration Date:			CLIA Name: Tax ID #:

Note: If you have already completed your application with CAQH, please ensure that you have authorized Centurion to access your data. This can be done by calling CAQH at (888) 599-1771 or by logging into your account and adding Centurion to your list of authorized plans. Using the CAQH Universal Credentialing DataSource does not grant participation or constitute applying for participation with Centurion.

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Disclosure of Ownership and Control Interest Statement

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to managed care organizations that contract with the state Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. If there are any changes to the information disclosed on this form, an updated form should be completed and submitted to Centurion within 30 days of the change. Please attach a separate sheet if necessary to provide complete information.

Practice Information

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Disclosing Entity:
DBA Name:
Address:
Federal Tax Identification Number: Provider CAQH #:

Section I

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater.

List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. Please attach a separate sheet if necessary. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent, child). (42 CFR 455.104)

Names	Type of relation

Section III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

Section IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX program? ☐ Yes ☐ No (verify through IUIS-OIG Website)

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

Section V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more that $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).
Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

Section VI

Have you identified your status (under Practice Information 1) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

I certify that the information provided herein, is true and accurate. Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Signature _____ Title (or indicate if authorized Agent) _____

Name (please print) _____ Date _____

Please return the form by fax or by mail to:

Centurion
c/o Lisa Rossics
Centene Plaza
7700 Forsyth Blvd
Clayton, MO
Fax: 844-614-1177
lrossics@centene.com