Hospital/Facility Provider Application

Instructions: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each Legal Entity/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following to the completed application:

- State Operational License
- Professional/Facility Liability Insurance (Certificate showing amounts and dates of coverage)
- Other applicable State/Federal Licensures (e.g., CLIA, DEA, Pharmacy or Department of Health)
- Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO/CARF/COA/or AOA) Accreditation letter with dates of accreditation
- If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency
- W-9
- Ownership and Disclosure Form

Disability Access Definitions:

- Parking (P): Parking spaces, including van-accessible space(s), are accessible. Pathways have curb ramps between the parking lot, office and at drop-off locations.
- Exterior Building (EB): There is an accessible ramp to the building. Curb ramps and other ramps to the building are wide enough for a wheelchair/scooter. Handrails are provided on both sides of the ramp. Doors are wide enough to allow entrance for a wheelchair/scooter and the doors have handles that are easily opened
- Interior Building (IB): Doors are wide enough for a wheelchair/scooter and have handles that are easily opened. There are interior ramps available and the ramps have handrails. If an elevator is present, it must be available for use by the public and members. The elevator has easy-to-hear sounds and Braille buttons within reach. The elevator is large enough for a wheelchair/scooter to turn around. If a chair lift is present, it can be utilized without help.
- Programmatic Access (PA): Programmatic access includes, but is not limited to: methods of communicating with member for the provision of individual medical information and general health information; appointment scheduling procedures and time slots; and system-wide coordination and flexibility to enable access.

☐ **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:	☐ Hospital; NPI:
☐ Hospital (Substance Abuse); NPI:		
☐ Adult Day Care Center; NPI:	☐ Clinic - School Based Health Center (SBHC) NPI:	☐ Orthotics and Prosthetics; NPI:
☐ Adult Living Facility/Assisted Living Facility; NPI:	☐ Community Mental Health Center (CMHC); NPI:	☐ Outpatient Clinic; NPI:
☐ Agency (Dept. of Health, State Health); NPI:	☐ Core Service Agency; NPI:	☐ Outpatient Infusion / Chemotherapy; NPI:
☐ Ambulance; NPI:	☐ Critical Care Services – Intensive Care Units (ICU); NPI:	☐ Physical Therapy; NPI:
☐ Assisted Long-Term Care Facility; NPI:	☐ Diagnostic Imaging Center; NPI:	☐ Pediatric Day Health Care Facilities (PDHC) ; NPI:
☐ Ambulatory Surgical Center ; NPI:	☐ Dialysis; NPI:	☐ Personal Care Assistant Facilities (PCAs); NPI:
☐ Autism Facility ; NPI:	☐ Durable Medical Equipment; NPI:	☐ Residential Treatment Center; NPI:
☐ Behavioral Health Agency/Child Placing Agency ; NPI:	☐ Family Planning Clinics; NPI:	☐ Rehabilitation Facility (Outside of Hospitals); NPI:
☐ Board of Health ; NPI:	☐ Home & Community Based Services (HCBS); NPI:	☐ Skilled Nursing Facility; NPI:
☐ Cardiac Surgery Program; NPI:	☐ Home Health Agency; NPI:	☐ Sleep Diagnostic; NPI:
☐ Cardiac Catheterization Services; NPI:	☐ Hospice; NPI:	☐ Speech Therapy; NPI:
☐ Chemical Dependency /Substance Abuse; NPI:	☐ Inpatient Psychiatric Services; NPI:	☐ Surgical Services (OP or ASC); NPI:
☐ Clinic –Federally Qualified Health Center (FQHC); NPI:	☐ Intensive Family Intervention; NPI:	☐ Telemedicine; NPI:
☐ Clinic – Indian Health (IHC); NPI:	☐ Laboratory; NPI:	Transplant: ☐ Heart ☐ Lung ☐ Heart/Lung ☐ Kidney ☐ Liver ☐ Pancreas
☐ Clinic – Rural Health Center (RHC); NPI:	☐ Mammography; NPI:	☐ Urgent Care (Attached to Hospital); NPI:
	☐ Occupational Therapy; NPI:	☐ Urgent Care (Free Standing); NPI:

Taxonomy:

Contact Information:

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

Credentialing Contact Information: ☐ Same as Contact Information

If 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)

Carrier:	**Amount of Coverage:**	**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:**

LTSS/HCBS/Home Health Agencies Servicing 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:**
Servicing County 9:	**Servicing County 10:**	**Servicing County 11:**	**Servicing County 12:**

Complete for each Service Location that is part of this application.

Service Location 1 of ____		
Group or Facility Name (to be displayed in the Directory)		
Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID # (Group/Type 2):**
State License Number:	**Medicaid ID #:**	**Medicare Number:**
Service Location Address: ☐**Same as Legal Entity**		
Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**
Website:		

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8 – 5**

Hospital Services Offered (Check all that apply).	**Service Location Accepting New Patients?**
☐ **Emergency Setting** ☐ **Post Stabilization Services** ☐ **Primary Care Team**	☐**Yes** ☐ **No**

Disability Access? (Check all that apply). Are you in compliance with Centene's minimum standard of disability access related to Parking, Exterior and Interior Building, and Programmatic access?
For a list of minimum standards, contact 1-855-688-6589.

Parking ☐**Yes** ☐**No** **Exterior Building** ☐**Yes** ☐**No**
Interior Building ☐**Yes** ☐**No** **Programmatic Access** ☐**Yes** ☐**No**
If you check "Yes", you certify you meet **all** of the minimum standards.

Are you located on a Public Transportation route? ☐**Yes** ☐ **No**

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

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 _____**

Does this location provide Early and Periodic, Diagnostic and Treatment (EPSDT) for members under 21? ☐ **Yes** ☐ **No**	**Does this location provide a Patient Centered Medical Home?** ☐ **Yes** ☐ **No**

Behavioral Health Services Provided for Service Location 1 of _____: (check all that apply)

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

LTSS/HCBS Services Provided for Service Location 1 of _____: (check all that apply)

- ☐ **Adult Daily Living**
- ☐ **Assistive Technology**
- ☐ **Benefits Counseling**
- ☐ **Career Assessment**
- ☐ **Community Integration**
- ☐ **Community Transition Services**
- ☐ **Durable Medical Equipment**
- ☐ **Education Support**
- ☐ **Employment Skills Development**
- ☐ **Exceptional DME**
- ☐ **Family Support Services**
- ☐ **Financial Management Services**
- ☐ **Home Adaptations**
- ☐ **Home Delivered Meals**
- ☐ **Home Health Aide Services**
- ☐ **I & A: Service Coordinators/Care Managers**
- ☐ **Job Coaching**
- ☐ **Job Finding**
- ☐ **Non-Medical/Non-Emergency Transportation**
- ☐ **Nursing Facility Services**
- ☐ **Nursing Services**
- ☐ **Nutritional Counseling/SNAP**
- ☐ **Other _____**
- ☐ **Occupational Therapy**
- ☐ **Participant-Directed Community Support**
- ☐ **Participant-Directed Goods and Services**
- ☐ **Personal Assistance Services**
- ☐ **Personal Care Service Agencies (PCS) - Delegated**
- ☐ **Personal Care Service Agencies (PCS) - Directed**
- ☐ **Personal Emergency Response System (PERS)**
- ☐ **Pest Eradication**
- ☐ **Physical Therapy**
- ☐ **Prevocational Services**
- ☐ **Residential Habilitation**
- ☐ **Respite**
- ☐ **Special Diet Preparation**
- ☐ **Specialized Medical Equipment and Sales**
- ☐ **Speech Therapy**
- ☐ **Structured Day Habilitation**
- ☐ **Supported Employment**
- ☐ **Telecare Services**
- ☐ **Temporary Crisis Services**
- ☐ **Therapeutic and Counseling Services**
- ☐ **Transportation**
- ☐ **Vehicle Modifications**
- ☐ **Other _____**

Billing Information for Service Location 1 of _____ :		
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:**

Insurance Information for Service Location 1 of _____:		
☐ **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** **Alaskan Native ☐Yes ☐ No Hispanic/Latino ☐Yes ☐ No** **American Indian ☐Yes ☐ No Pacific Islander ☐Yes ☐ No** **Other_____ ☐Yes ☐ No**		

Service Location 1 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

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)			
Pharmacy			

State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 1 of _____ – Sanctions ☐ **Same as Legal Entity** *If 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 DEA 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**

Complete for each Service Location that is part of this application.

Service Location 2 of ____		
Group or Facility Name (to be displayed in the Directory)		
Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID # (Group/Type 2):**
State License Number:	**Medicaid ID #:**	**Medicare Number:**
Service Location Address: ☐**Same as Legal Entity**		
Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**
Website:		

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8 – 5**

Hospital Services Offered (Check all that apply).	**Service Location Accepting New Patients?**
☐ **Emergency Setting** ☐ **Post Stabilization Services** ☐ **Primary Care Team**	☐**Yes** ☐ **No**

Disability Access? (Check all that apply). Are you in compliance with Centene's minimum standard of disability access related to Parking, Exterior and Interior Building, and Programmatic access?
For a list of minimum standards, contact 1-855-688-6589.

Parking ☐**Yes** ☐**No** **Exterior Building** ☐**Yes** ☐**No**
Interior Building ☐**Yes** ☐**No** **Programmatic Access** ☐**Yes** ☐**No**
If you check "Yes", you certify you meet **all** of the minimum standards.

Are you located on a Public Transportation route? ☐**Yes** ☐ **No**

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

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 _____**

Does this location provide Early and Periodic, Diagnostic and Treatment (EPSDT) for members under 21? ☐ **Yes** ☐ **No**	**Does this location provide a Patient Centered Medical Home?** ☐ **Yes** ☐ **No**

Behavioral Health Services Provided for Service Location 2 of _____: (check all that apply)

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

LTSS/HCBS Services Provided for Service Location 2 of _____: (check all that apply)

- ☐ **Adult Daily Living**
- ☐ **Assistive Technology**
- ☐ **Benefits Counseling**
- ☐ **Career Assessment**
- ☐ **Community Integration**
- ☐ **Community Transition Services**
- ☐ **Durable Medical Equipment**
- ☐ **Education Support**
- ☐ **Employment Skills Development**
- ☐ **Exceptional DME**
- ☐ **Family Support Services**
- ☐ **Financial Management Services**
- ☐ **Home Adaptations**
- ☐ **Home Delivered Meals**
- ☐ **Home Health Aide Services**
- ☐ **I & A: Service Coordinators/Care Managers**
- ☐ **Job Coaching**
- ☐ **Job Finding**
- ☐ **Non-Medical/Non-Emergency Transportation**
- ☐ **Nursing Facility Services**
- ☐ **Nursing Services**
- ☐ **Nutritional Counseling/SNAP**
- ☐ **Other _____**
- ☐ **Occupational Therapy**
- ☐ **Participant-Directed Community Support**
- ☐ **Participant-Directed Goods and Services**
- ☐ **Personal Assistance Services**
- ☐ **Personal Care Service Agencies (PCS) - Delegated**
- ☐ **Personal Care Service Agencies (PCS) - Directed**
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- ☐ **Pest Eradication**
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- ☐ **Temporary Crisis Services**
- ☐ **Therapeutic and Counseling Services**
- ☐ **Transportation**
- ☐ **Vehicle Modifications**
- ☐ **Other _____**

Billing Information for Service Location 2 of _____ :		
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:**

Insurance Information for Service Location 2 of _____:		
☐ **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** **Alaskan Native ☐Yes ☐ No Hispanic/Latino ☐Yes ☐ No** **American Indian ☐Yes ☐ No Pacific Islander ☐Yes ☐ No** **Other_____ ☐Yes ☐ No**		

Service Location 2 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

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)			
Pharmacy			

State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 2 of _____ – Sanctions ☐ **Same as Legal Entity** *If 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 DEA 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 New Mexico Western Sky Community 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 New Mexico Western Sky Community Care Health Plan Credentials Committee for their review and approval, and, absent such affirmative approval, New Mexico Western Sky Community 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 New Mexico Western Sky Community 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 New Mexico Western Sky Community 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 New Mexico Western Sky Community 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 photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ **Date:** _____

Print or type name

_____

Signature of Provider or Authorizing Representative **Title**

A stamp signature is not acceptable