Ancillary Recredentialing Application

Thank you for your participating in Horizon Managed Care Network and Horizon PPO Network or the Horizon NJ Health Networks. Per the guidelines of our Credentialing and Recredentialing Policy for Ancillary and Managed Long Term Support Service (MLTSS) Providers this application must be completed for Organizations due for recredentialing.

Instructions

- Complete a separate application for each service location.
- Complete this application in its entirety. Missing information/documentation will delay application processing.
- Email your completed application(s), along with all supporting documents, to support@andros.co or fax this information to **1-877-656-9455**.

Ancillary Information

Provider DBA Name: _____

Corporate Name (*if different than above*) _____

Tax ID Number (TIN) _____

NPI Number _____

Medicare Number _____

Medicaid Number _____

Specialty _____

Location Information

Primary Service Location _____

Phone Number _____

Fax Number _____

Service Area _____

License Number _____

Accreditation _____

Billing Address _____

Billing Phone _____

Languages (other than English) spoken by staff _____

Credentialing Contact Information

Contact Name _____

Contact Phone _____

Contact Email _____

(*Continues*)

General Disclosure Questions

Please complete the required general disclosure questions below. Incomplete disclosures may result in delays in our recredentialing process.

1. Does your organization have any pending, settled, dropped or dismissed liability cases?
   - ☐ Yes
   - ☐ No

   If you answered "Yes" above, please attach an explanation of each case which should include the date(s) of each incident and the final outcome.

2. Has your organization (or any owner controlling 10 percent or more of your organization) ever been subjected to or is currently undergoing any of the following:

   Government disciplinary action such as, but not limited to revocation of license or Medicare/Medicaid provider status?
   - ☐ Yes
   - ☐ No

   Medicare and/or Medicaid sanction within the last five years?
   - ☐ Yes
   - ☐ No

   Criminal or ethical investigation or conviction?
   - ☐ Yes
   - ☐ No

   Bankruptcy, insolvency or assignment for the benefit or creditor proceedings?
   - ☐ Yes
   - ☐ No

   Received any member complaints in the past 12 months?
   - ☐ Yes
   - ☐ No

   If you answered "Yes" above, please attach an explanation of each case which should include the date(s) of each incident and the final outcome.

Affirmation of Information

All information submitted by me on behalf of _____ an ancillary provider (the "provider") is true and correct to the best of my knowledge and belief. I understand that as an authorized representative of the provider, I have the right to review the information submitted in support of the provider's application. I understand that if any of this information is subsequently found to be false, misleading or incomplete, it could result in denial of the provider's application or termination of participation in the Horizon Blue Cross Blue Shield of New Jersey provider network, or any of its subsidiary or affiliate provider networks (hereafter collectively referred to as "Horizon BCBSNJ").

I understand and agree that I have the responsibility for producing adequate and accurate information for proper evaluation of the qualifications of the provider and for resolving any doubts about such qualifications. I also agree to provide information on an ongoing basis as requested and in accordance with any specific future request that is relevant to Horizon BCBSNJ's evaluation of the provider's application, credentials or qualifications, and that this statement in its entirety shall also apply then.

(*Continues*)

I hereby authorize and consent to Horizon BCBSNJ's acquisition of information from any person or organization, as long as such acquisition is done in good faith and without malice in connection with Horizon BCBSNJ's evaluation of the provider's application, credentials and qualifications.

I hereby release from liability Horizon BCBSNJ, its agents or designees, and any and all persons or organizations that provide information to Horizon BCBSNJ, its agents or designees, for any and all actions taken in good faith and without malice in connection with Horizon BCBSNJ's review of the provider's application, credentials and qualifications.

I attest that to the best of my knowledge the information provided in response to the questions on the Recredentialing Update Form have been answered correctly.

Name _____

Title _____

Entity Name _____

Signature _____

Date _____

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