AmeriHealth Caritas Florida

Professional Credentialing Application

11631 Kew Gardens Avenue, Suite 200
Palm Beach Gardens, FL 33410

Attention: Provider Network Management

Professional Credentialing Application

AmeriHealth Caritas Florida

Requirements

Please submit all of the following items to expedite the credentialing process.
You can choose one of two ways to apply with AmeriHealth Caritas Florida:

1. Apply through the Council for Affordable Quality Healthcare (CAQH).

If you are enrolled with CAQH, please provide AmeriHealth Caritas Florida access to your application and submit your name and CAQH ID to us via email at **credentialingsupport@amerihealthcaritasfl.com.**

If you are interested in joining CAQH, please contact CAQH at **1-888-599-1771** or register at **proview.caqh.org.** Once you have registered with CAQH, please grant AmeriHealth Caritas Florida access to your application. Please complete the application and submit your name and CAQH ID to us via email at credentialingsupport@amerihealthcaritasfl.com or fax to **1-866-930-4632**.

2. Apply with the Professional Credentialing Application.

- ☐ AmeriHealth Caritas Florida Professional Credentialing Application (page 3).
- ☐ Primary care providers **only** — Patient Load Attestation Statement (page 5).
- ☐ Professional Historical Disclosure Questionnaire, signed and dated (page 6). **All** questions must be answered either "Yes" or "No." Do not use correction fluid. If a correction must be made, cross out the incorrect answer, **initial** next to the change, and indicate the correct answer.
- ☐ Attestation, Consent, and Release, signed and dated (page 7).
- ☐ At least two professional peer references (page 8).
- ☐ Advanced registered nurse practitioners (ARNPs) **only** — Collaborative Practice Agreement (page 9).

Additional required documents

All of the following must be provided, where applicable:

- ☐ Copy of current medical license.
- ☐ Copy of Drug Enforcement Administration (DEA) certificate.
- ☐ Copy of current professional liability insurance.
- ☐ Copy of current Clinical Laboratory Improvement Amendments (CLIA) certificate.
- ☐ Copy of W-9.
- ☐ **Nine-digit** individual Medicaid number and **nine-digit** group Medicaid number (both must be active) or a copy of Medicaid application or Medicaid application tracking number (ATN).

  Per Florida requirements, to receive Medicaid reimbursement, a provider must be enrolled in Medicaid and meet all provider requirements at the time services are rendered. Any entity that bills Medicaid for Medicaid-compensable services provided to Medicaid recipients or that provides billing services of any kind to Medicaid providers must enroll as a Medicaid provider.
- ☐ **Ten-digit** individual NPI and **10-digit** group NPI.
- ☐ Current résumé or curriculum vitae listing all work and educational history with dates in month/year format. All gaps in education and employment of more than six months must be accompanied by a written explanation.
- ☐ Professional reference forms are included with this application. It will greatly expedite the process if these can be completed by your references and sent back to AmeriHealth Caritas Florida. Current colleagues are acceptable.
- ☐ Any answers marked "Yes" on the Professional Disclosure Questionnaire page must be accompanied by a written explanation of the event indicated. This explanation should include dates, a description of events, outcomes, and any settlements or payments made by the provider or on his or her behalf.

If you have questions or comments about any of the items detailed in this document, you may contact us by email at **credentialingsupport@amerihealthcaritasfl.com** or by phone at **1-800-617-5727**, option 6.

Are you applying as a ☐ primary care provider (PCP) or ☐ specialist provider?		Specialty being contracted for:	
Professional demographics			
Last name:	First name:	Middle:	Degree:
Maiden name:		Place of birth:	
Languages spoken: ☐ English ☐ Spanish ☐ French ☐ Creole ☐ Other:			
Gender: ☐ Male ☐ Female	Date of birth:	Social Security number:	
Are you part of or affiliated with an American Indian tribe? ☐ Yes ☐ No			
Individual NPI:		Individual Medicaid number:	
Medical license number:		Drug Enforcement Administration (DEA) license number:	
Credentialing contact name:			
Credentialing contact phone:		Credentialing contact fax:	
Credentialing contact email:			
Billing pay name:			
Billing mailing address:			
Billing phone:		Billing fax:	

Professional locations and office hours (Attach a separate sheet for additional locations.)	
Primary practice location	**Secondary practice location**
Name:	Name:
County:	County:
Street address:	Street address:
City, state, ZIP:	City, state, ZIP:
Office phone:	Office phone:
Office fax:	Office fax:
Office tax ID number:	Office tax ID number:
Office NPI:	Office NPI:
Office Medicaid number:	Office Medicaid number:
CLIA certificate number:	CLIA certificate number:
Age range of patients seen:	Age range of patients seen:
Genders of patients seen:	Genders of patients seen:
Monday hours:	Monday hours:
Tuesday hours:	Tuesday hours:
Wednesday hours:	Wednesday hours:
Thursday hours:	Thursday hours:
Friday hours:	Friday hours:
Saturday hours:	Saturday hours:
Sunday hours:	Sunday hours:

*Note: Pediatric medicine ages are 0 – 21 years. General medicine may be ages 16 and older.

List all providers and other professionals providing services at the above locations (include advanced registered nurse practitioners [ARNPs], physician assistants, and certified nurse midwives).

Primary practice location	Secondary practice location

Please indicate below either general practice or specialty for which you're board trained (BT) or board certified (BC).

Primary specialty:	☐ BT ☐ BC
Subspecialty:	☐ BT ☐ BC

If you are not BC (select one):

☐ I have taken an exam and results are pending for the specialty type of:

☐ I intend to sit for an exam on this date:

☐ I do not intend to take a certifying board exam. (Be sure to complete the continuing medical education (CME) portion below.)

CME Only non-board certified professionals should complete the following.

1. Have you completed the necessary number of CME credits to meet your licensing requirements? ☐ Yes ☐ No

2. How many CME credits have you obtained over the past three years?

3. In what specialty have you obtained CME credits?

Education and training

Institution name	Address	Degree	Year
Medical school:			
Internship:			
Residency:			
Fellowship:			

Work history and practice experience Please list in month/year format covering the last five years. Any gap of six months or more requires a brief explanation.

Employer name	Address	From	To

Six-month gap explanation (if applicable)

Hospital privileges
Hospitals at which you have active medical staff privileges.

Hospital name	Location	Category	Status

Professional references
Please identify a minimum of two co-professionals. Include complete name, title, and phone number for each.

Complete name	Title	Phone	Fax

PCPs only
Please complete the following:

Every PCP must arrange for coverage 24 hours a day, 365 days a year. It is strongly preferred that your call-coverage physicians be participating providers. However, if they are not, necessary services performed for patients in your absence are subject to the terms of the Participating Physician's Agreement, and the covering physician must be fully credentialed with the plan.

Name of covering physician:	
Specialty of covering physician:	
Office location:	
Office phone:	

PCP — Patient load attestation
PCPs only: please check appropriate box.

The total active patient load (patients who access your services three or more times in a 12-month period) from all populations, including, but not limited to, Medicaid, Medicare, KidCare, and commercial coverage:

☐ Less than or equal to 3,000 patients.

☐ More than 3,000 patients.

Professional Historical Disclosure Questionnaire

If you answer "Yes" to any of the questions below, please provide a letter of explanation with clinical details, settlement or payment amount (if applicable), and dates with this application. Please answer all questions listed below. If any changes must be made, please cross out the error, initial, and fill in the correct response.

1. Have there ever been any actions or investigations relating to your professional license(s) in any jurisdiction?	☐ Yes ☐ No
2. Have you ever voluntarily or involuntarily surrendered your license?	☐ Yes ☐ No
3. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state or federal agency that disciplines physicians or allied health professionals?	☐ Yes ☐ No
4. Has there ever been any disciplinary action, suspension, probation, formal reprimand or request to voluntarily or involuntarily resign during your education, internship, residency, fellowship, preceptorship, or additional applicable training — or is any such action pending?	☐ Yes ☐ No
5. Have there ever been any actions against or investigations relating to your hospital, health maintenance organization (HMO), and/or health care plan or managed care plan privileges?	☐ Yes ☐ No
6. Have you ever voluntarily or involuntarily surrendered your hospital, HMO, and/or health care plan or managed care plan privileges?	☐ Yes ☐ No
7. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has such a denial or limitation been recommended by a medical staff or peer review committee to a governing board?	☐ Yes ☐ No
8. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other health care facility or military agency; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or health care facility or any military agency?	☐ Yes ☐ No
9. Are any professional liability (malpractice) suits, actions, or claims currently pending against you?	☐ Yes ☐ No
10. Have any judgments ever been made against you in professional liability (malpractice) cases or claims, or have you ever entered into any settlements?	☐ Yes ☐ No
11. Does your current liability malpractice insurance coverage exclude any specific procedures?	☐ Yes ☐ No
12. Have you been without malpractice insurance coverage in the past five consecutive years?	☐ Yes ☐ No
13. Has your professional liability insurance coverage ever been denied, suspended, restricted, limited, modified, canceled, or not renewed by the action of any insurance company?	☐ Yes ☐ No
14. To your knowledge, has any information pertaining to you ever been reported to the National Practitioner Data Bank?	☐ Yes ☐ No
16. Have you ever been convicted of a felony, including, but not limited to, fraud, narcotics, or crimes involving children? (Misdemeanors do not need to be reported.) This statement is being answered under the penalty of perjury, subject to applicable federal punishment for perjury. If yes, please include the disposition of the case and explain all such occurrences in an attachment.	☐ Yes ☐ No
17. Have you ever been named as a defendant in any past or pending criminal proceedings, including misdemeanors (excluding traffic violations)?	☐ Yes ☐ No
18. Have you ever been sanctioned or otherwise disciplined by a professional organization or association?	☐ Yes ☐ No
19. Have you ever voluntarily or involuntarily surrendered membership in a professional organization or association?	☐ Yes ☐ No
20. Has there ever been any action against or investigation related to your board certification (e.g., medical professional board or society) or have you voluntarily or involuntarily surrendered any board certifications?	☐ Yes ☐ No
21. Has an adverse action been filed against you, or have you received any disciplinary procedures regarding your participation in any private, state, or federal insurance program, including Office of Personnel Management, Medicare, Medicaid, or TRICARE?	☐ Yes ☐ No
22. Is there anything that would prevent you from being able to competently perform essential job-related functions without risk to patient safety or health, with or without reasonable accommodation?	☐ Yes ☐ No
23. Are you currently using any illegal substances, or are you chemically dependent on alcohol, drugs, or illegal substances?	☐ Yes ☐ No
24. During the last three years, have you ever been under the influence of alcohol during work hours, or have you used drugs illegally?	☐ Yes ☐ No
25. Are you currently participating in or under the supervision of a physician or recovery network or applicable recovery program? If yes, provide the program name, address, and phone number.	☐ Yes ☐ No
26. Do you, your business entity, or any family member have an ownership greater than 5 percent in any medical enterprise or business? If yes, please complete Attachment A in accordance with Federal Regulations 42C.F.R. §455.104.	☐ Yes ☐ No

Attestation, Consent, and Release

I hereby give permission to "AmeriHealth Caritas Florida," directly and/or through its designee, to request information regarding my professional credentials and qualifications from educational facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, Federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers. I agree that the plans operated by the following companies may use the information that I have provided with this application, including this Attestation, Consent & Release, for credentialing purposes: Florida True Health, Inc. d/b/a Prestige Health Choice, Blue Cross and Blue Shield of Florida d/b/a/ Florida Blue and/or Health Options, Inc. (the "Plans").

The information requested may include otherwise privileged or confidential material relative to my professional qualifications, credentials, claims history, clinical and/or professional competence, character, ethics, or any other matter applicable to the credentialing procedure. I release and agree to hold harmless the Plans, and their designee and their respective officers, directors, representatives, employees and agents from any and all liability for any damages, costs and expenses which may result from the gathering or good faith use of the information gathered during the credentialing process.

I hereby authorizer the education facilities, the hospital(s) in which I currently have or formerly have had staff privileges, professional certification boards, federal and state regulatory and licensing departments, professional liability insurance carriers, other professional monitoring entities, and present and past employers to submit information requested by the Plans, directly and/or through its designee, including otherwise privileged or confidential material relative to my professional qualifications, credentials, past and present malpractice coverage, claims and lawsuit information, clinical and/or professional competence, character, ethics, or any other matter having bearing on the credentialing procedure. If applicable, I hereby authorize the Physician Recovery Network or applicable recovery program to release to the Plans, information regarding my health status and participation status in any treatment program(s). I hereby further release and agree to hold harmless all such entities referenced in the previous sentence, their representative, employees, and agents from any and all liability for any damages which may result from providing this information as long as such release of information is done in good faith and without malice.

I agree that a photocopy or facsimile of this document with my signature may be accepted by any person or entity from which such information is sought with the same authority as the original, and I specifically waive written notice from any such entities or individual who may provide information based upon this authorized request.

I understand that a condition of this application is that any misrepresentation, misstatement or omission from this application, whether intentional or not, is a cause for automatic and immediate rejection of this application by any of the Plans, and may result in denial of my application or termination of my participation in any of the Plans. I further understand that any representation, misstatement or omission from this application, if discovered after network participation has been awarded to me, may lead to immediate suspension or termination of such participation. I agree to use my best efforts to inform the Plans, in writing, within 15 days if there is any change in the information provided or the answers to questions on the application as a result of developments subsequent to my signing this application.

I warrant that I have the authority to sign this application, on my behalf and on behalf of any entity or organization for which I am signing in a representative capacity. I agree that submission of the application does not constitute approval or acceptance as a participating provider.

If I am accepted for participation, I consent to the inspection of my patient records for Plan Members as necessary for peer review and utilization review purposes and agree to be bound by the participation agreement, credentialing plan and provider manual.

I understand that I have the right to review and correct erroneous information obtained by the Plans, to evaluate my credentialing application. This includes information obtained from primary sources (e.g., malpractice insurance carriers, state licensing boards, National Practitioner Data Bank). The review must take place within 6 months of this application. Any corrections must be made in writing within 30 days of the review. This does not require the Plans to allow a provider to review references or recommendations or other information that is peer-review protected.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, that the Plans may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

I represent the information provided in or attached to this application is accurate and complete. I attest to either having adequate current malpractice insurance or proof of meeting the State's financial responsibility requirements. I certify that I hold a full, unrestricted license to practice in the state in which I reside or have indicated on this application the limitations and/or restrictions imposed. I agree that I have reported any loss or limitation of hospital privileges or any disciplinary activity to the Plans, or its designee. I attest that I will continue to maintain active admitting and staff privileges at a network participating hospital or as I have otherwise indicated on this application. Primary Care Providers only, the patient load information provided in this application is accurate as of the date of this certification.

I understand and agree that the information submitted by me on this form and the information provided to the Plans and their designee may be used:

I. To evaluate my credentials for initial provider status; and

II. To re-evaluate my credentials at any time during my provider relationship with the Plans.

I hereby acknowledge that this Consent and Release form will be valid for a period of three (3) years from the date it is signed by me. Your signature and the date **are required** to complete this application. Stamped signatures **are not acceptable**.

Print name:	Signature:	Date:

Professional peer references

(Minimum of two references)

Date:	
To:	
Re:	
Specialty:	

The above health care provider has given us your name as a professional reference. As part of AmeriHealth Caritas Florida's credentialing process, please answer the following questions, taking into consideration the quality of care, utilization, and demeanor of this health care provider. If you have any questions, please contact the Credentialing department.

Phone: **1-800-617-5727**, option 6

Fax: **1-866-930-0432**

Years of acquaintance:	Level of acquaintance (e.g., professional or personal):

	Above average	Average	Below average
Clinical knowledge			
Clinical competence			
Emotional stability			
Work habits			
Committee activities			
Relationship with peers			
Relationship with patients			
Ability to work with others			
Physical and mental condition			
Compliance with policies and regulations			

Please indicate and explain any restrictions, concerns, and recommendations concerning the performance of this applicant:	
Signature	Date
Print name	Title

Collaborative practice information **Allied professional dependent practitioners** A copy of the protocol submitted to the state licensing body may be substituted for this form.		
Last name:	First name:	Middle:
License type:	Specialty:	
Location where member services are provided		
Type of member services to be provided		
Please provide name, address, and phone number of the practitioner with whom you have a collaborative agreement, if applicable. (This section must be completed by those practitioners whose state license requires a protocol be entered into with a state-licensed physician.)		
Name of collaborating physician (please print):	Specialty:	
Address:	City:	State:	ZIP code:
Phone:	Fax:	
Signature of collaborating physician:		Date:
Collaborating physician is a plan participating provider? ☐ Yes ☐ No		

Behavioral Health Subspecialty Checklist

(completed for *each* Behavioral Health practitioner to ensure appropriate referrals)

Ages treated (check all that apply):
☐ children (0 – 12 years) ☐ adolescents (13 – 18 years) ☐ adults (19 – 64 years) ☐ seniors (65+ years)

Please check all the areas where you have clinical training and experience AND are currently accepting referrals.

- ☐ Abuse (physical, sexual, emotional)
- ☐ Adoption issues
- ☐ Anger management
- ☐ Anxiety and panic disorders
- ☐ Attention deficit disorders (ADHD)
- ☐ Bariatric/gastric bypass evaluation
- ☐ Behavior modification
- ☐ Behavioral issues/ oppositional defiant disorder
- ☐ Biofeedback
- ☐ Bipolar (manic-depressive) disorder
- ☐ Christian counseling
- ☐ Compulsive gambling
- ☐ Depression and mood disorders
- ☐ Developmental disabilities
- ☐ Dialectical behavioral therapy
- ☐ Disability evaluation
- ☐ Dissociative disorders
- ☐ Divorce/blended family issues
- ☐ Domestic violence
- ☐ Eating disorders (anorexia/bulimia)
- ☐ Electroconvulsive therapy (ECT)
- ☐ Eye movement desensitization and reprocessing (EMDR)
- ☐ Family therapy
- ☐ Feeding and eating disorders
- ☐ Fetal alcohol syndrome
- ☐ Foster care issues
- ☐ Group therapy
- ☐ Lesbian/gay/bisexual/ transgender/queer (LGBTQ) issues
- ☐ Grief/bereavement
- ☐ Health and behavior assessment
- ☐ Hearing impaired
- ☐ HIV/AIDS/ARC
- ☐ Hypnosis
- ☐ Infertility issues
- ☐ Learning disabilities
- ☐ Long-acting injectable (LAI) administration
- ☐ Medication assisted treatment (MAT): buprenorphine, suboxone, naltrexone injectable, etc. (submit DEA registration with the DATA 2000 prescribing identification number)
- ☐ Medicaid office-based opioid treatment program (OBOT)
- ☐ Men's issues
- ☐ Methadone maintenance
- ☐ Medication management
- ☐ Military/veterans' issues
- ☐ Native American traditional healing systems
- ☐ Neuropsychological testing
- ☐ Nursing home visits
- ☐ Obsessive-compulsive disorder
- ☐ Pain management
- ☐ Parent support and training
- ☐ Parent-child evaluation
- ☐ Personality disorders
- ☐ Phobias
- ☐ Physical disabilities
- ☐ Play therapy
- ☐ Postpartum depression
- ☐ Post-traumatic stress disorder (PTSD)
- ☐ Psychological testing
- ☐ Psychotic/schizophrenic disorders
- ☐ Rape issues
- ☐ Substance use and abuse issues
- ☐ Relaxation techniques
- ☐ Sexual dysfunction
- ☐ Sleep-wake disorders
- ☐ Somatoform disorders
- ☐ Spravato™ (esketamine) (prescribers only)
- ☐ Stress management
- ☐ Telehealth (Telehealth Provider Attestation must be signed)
- ☐ Transcranial magnetic stimulation (TMS)
- ☐ Trauma therapy
- ☐ Women's issues
- ☐ Other: _____

I hereby attest that all of the information above is true and accurate to the best of my knowledge. I understand that any information provided pursuant to this attestation that is subsequently found to be untrue and/or incorrect could result in my termination from the network.

Print name of applicant:	Signature of applicant:	Date:

Telehealth Provider Attestation

Provider Name: _____ Provider Tax ID Number (TIN):_____

AmeriHealth Caritas Florida provides coverage for services provided through telemedicine, when appropriate, for services covered under the Agency for Health Care Administration (AHCA) contract. Signing this attestation signifies your compliance with the requirements set forth by AHCA.

When treating AmeriHealth Caritas Florida members, be sure to include all of the following items in your documentation for services provided through telehealth:

- ☐ Medical records documentation, including a brief explanation of the use of telehealth in each progress note.
- ☐ Documentation of telehealth equipment used for the particular covered services provided.
- ☐ A signed statement from the patient or his/her authorized representative indicating their choice to receive services through telehealth. This statement may be for a set period of treatment or one-time visit, as applicable to the service(s) provided. Remember to bill telehealth services using the GT modifier, or other subsequent billing indicator as required by AHCA.

1. Provider type and specialty: Medical provider: Behavioral health provider:	
2. Our equipment and processes for providing telemedicine services are in compliance with the Health Insurance Portability and Accountability Act, other state and federal laws pertaining to patient privacy, technical standards required by 45 CFR §164.312, and Rule 59G-1.057 F.A.C.	☐ Yes ☐ No
3. We use two-way, real-time interactive communication between the patient and the physician at the distant site.	☐ Yes ☐ No
4. We use audio and video interaction with patient.	☐ Yes ☐ No
5. We educate the patient on the use of telemedicine and obtain consent.	☐ Yes ☐ No
6. We provide recipients the choice of whether to access services through a face-to-face or telemedicine visit with us.	☐ Yes ☐ No
7. We document the choice for telemedicine in the patient's medical record.	☐ Yes ☐ No
8. We will provide services to the same extent that services would be covered if provided through a face-to-face (in person) encounter with a practitioner.	☐ Yes ☐ No
9. We are responsible for all equipment required to provide telemedicine services.	☐ Yes ☐ No
10. We have protocols to prevent fraud and abuse and have protocols that address: (a) Authentication and authorization of users. (b) Authentication of the origin of the information. (c) The prevention of unauthorized access to the system or information. (d) System security, including the integrity of information that is collected, program integrity, and system integrity. (e) Maintenance of documentation about system and information usage.	☐ Yes ☐ No

I will follow the guidance provided by AHCA regarding any temporary or permanent changes to the requirements for the provision of telehealth services, to be in compliance with any changes made by AHCA.

I attest that I represent the practice under "Provider Name" above. I further attest that I am able to provide telehealth services to AmeriHealth Caritas Florida members and to the statements and answers above.

Printed name:	Title:	
Phone number:	Signature:	Date:

Please return to: **PNM_Inquiries@amerihealthcaritasfl.com**