Gateway Health Plan®
Organizational Provider Participation Application

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable or not available and reason. Attach additional sheets when necessary. Separate forms may be required for each practice location and provider type.

Business Information

Facility/Ancillary Classification:			**Federal Tax Identification Number:**	
Legal Name of Applicant:				
Doing Business As (DBA):				
Primary Office Address:				
City:	**State:**	**Zip Code:**	**County:**	
Primary Phone:	**Primary Fax:**	**Web Address:**		
Mailing Address (if different from Primary)		**City**	**State**	**Zip Code**
Billing Address:		**City:**	**State:**	**Zip Code:**
Billing Phone:	**Billing Fax:**	**Email Address:**		
Credentialing Address:		**City:**	**State:**	**Zip Code:**
Credentialing Contact:	**Credentialing Phone:**	**Credentialing Fax:**	**Credentialing Email Address:**	
Ownership: ☐ **Privately Owned** ☐ **Publicly Owned** ☐ **Government Owned** **Status:** ☐ **For Profit** ☐ **Not For Profit**				
Part of a Multi-Facility Chain? ☐ **Yes** ☐ **No**		**If Yes, Name of Parent Company:**		
Is the organization classified as: ☐ **Yes** ☐ **No** **FQHC, CBHC, RHC or Urgent Care Center**		**If Yes, Please Specify:**		
If facility is classified as FQHC – is the facility registered with HRSA - http://findahealthcenter.hrsa.gov/ ☐ **Yes** ☐ **No** **Note: Gateway uses the registration with the HRSA website as evidence of facility's participation as a FQHC.**				

Business Staff Contacts

Chief Executive Office:	**Phone:**
Chief Financial Officer:	**Phone:**
Medical Officer:	**Phone:**
Billing Contact:	**Phone:**

Licensure/Certification

Please complete the following information as applicable to your facility/ancillary service. Submit a current copy of each certificate. For facilities with several locations, please complete the Site Specific Information section for each location within this questionnaire.

State Licensure/Registration Number:		**Expiration Date:**
Master Provider Index Number (MPI):	**Medicare Provider Number:**	**National Provider Identifier Number (NPI):**
Therapy Providers, Please Indicate Medicare Certification: ☐ **CORF** ☐ **ORF** ☐ **OPT**		

Accreditation

Please indicate all organizations that have accredited your facility, e.g., JOINT COMMISSION, CARF, AAPH, ACR, AAAHC, CHAP, ABC, etc. Please attach a copy of each certificate of accreditation. If Facility/Ancillary is not accredited by an appropriate accrediting body, submit your last state survey.

NOTE-Gateway Health Plan® may also complete a site visit for adequate assessment of quality.

Accreditation Body:			
Accreditation Status:	**Expiration Date:**	**Recent Survey:**	**Expected Next Survey:**

Non-Accredited Facilities

Last Survey Date: ☐ **Compliant**	☐ **Deficiencies Found (Attach Documentation Detailing Deficiencies)**
Date Corrective Action Plan Submitted:	**** Submit copies of Recent State Survey, Corrective Action Plans and Revisit Reports**

Liability and Insurance Information

Please attach a copy of the declaration page (face sheet) of each insurance policy indicating current status, coverage effective dates and coverage amounts.

Type of Coverage	Policy Effective Dates	Policy End Date	Limit Per Claim	Aggregate Limit	Umbrella Limit
Professional Liability			$	$	$
General Liability			$	$	$

Policy Number(s): _____

Name of Professional Carrier: _____

Name of General Carrier: _____

Liability Information/Disclosure Questions

If you answer "YES" to any of the following questions, please provide details on a separate sheet of paper.

1. Has your facility/ancillary service been disciplined by any state licensing or other authorizing agency, or have you ever been reprimanded, or fined by any state agency that disciplines healthcare facilities of ancillary services within the last five years?	☐ Yes ☐ NO
2. Has your facility/ancillary service been reprimanded, censured, excluded, suspended, or disqualified by the Medicare, Medicaid, or CLIA programs within the last five years?	☐ Yes ☐ NO
3. Has the pharmacy license been suspended or otherwise limited for your facility/ancillary service within the last five years?	☐ Yes ☐ NO ☐ N/A
4. Have any malpractice suits, arbitrations or other proceedings been instituted against your facility/ancillary service in the last five years? If yes, please indicate the number of open cases and the number of settled cases.	☐ Yes ☐ NO
5. Has your facility/ancillary service been canceled, non-reviewed, or restricted by an insurance carrier within the last five years?	☐ Yes ☐ NO
6. Has your facility/ancillary service had membership in a professional organization revoked, reduced, denied, or suspended within the last five years?	☐ Yes ☐ NO

Release of Liability and Attestation of Truth

The facility/ancillary consents to the review of records and documents that may be material to any evaluation of the facility's competence. Facility/ancillary releases from liability individuals and organizations that provide information, including otherwise privileged or confidential information to Gateway Health Plan® representatives in good faith and without malice concerning the facility's competence.

Facility/ancillary certifies that all the information in this application is correct and complete. Any information in this application that is later determined to be false may result in contract termination. Facility/ancillary is aware that review of the information in this application will form the basis for the Gateway Health Plan® credentialing assessment process regarding facility/ancillary's participation in the Gateway Health Plan® network.

Facility/ancillary certifies that all the information in this application is correct and complete for all sites listed on this application. If necessary attach a separate disclosure and attestation for additional sites, as applicable.

Printed Name of Facility/Ancillary Representative	Signature
Title	Date

Site Specific Information

Duplicate this page as necessary and complete the following for each location operated by your facility/ancillary service. Please include copies of all site -specific documentation as listed below.

Facility Classification:			**Federal Tax Identification Number:**	
Legal Name of Applicant:				
Doing Business As (DBA):				
Primary Office Address:				
City:	**State:**	**Zip Code:**	**County:**	
Mailing Address (if different from Business):		**City:**	**State:**	**Zip Code:**
Primary Phone:	**Primary Fax:**		**Web Address:**	

Licensure/Certification

Please complete the following information as applicable to your facility/ancillary service. Submit a current copy of each certificate.

State Licensure/Registration Number:		**Expiration Date:**
Master Provider Index Number (MPI):	**Medicare Provider Number:**	**National Provider Identifier Number (NPI):**
Therapy Providers, Please Indicate Medicare Certification: ☐ **CORF** ☐ **ORF** ☐ **OPT**		

Accreditation

Please indicate all organizations that have accredited your facility, e.g., attach a copy of each certificate of accreditation and the report from the last survey.

Accreditation Body:			
Accreditation Status:	**Expiration Date:**	**Recent Survey:**	**Expected Next Survey:**

Non-Accredited Facilities

Last Survey Date:	☐ **Compliant** ☐ **Deficiencies Found (Attach Documentation Detailing Deficiencies)**
Date Corrective Action Plan Submitted:	**** Submit copies of Recent State Survey, Corrective Action Plans and Revisit Reports**

The below fields must be completed for all of the following provider types that practice within the facility: Audiology (AUD), Physical/Occupational /Speech Therapy (PT/OT/SP), FQHC, RHC, CBHC, Urgent Care *.
Practitioners practicing at an Ambulatory Surgery Center – ONLY if billing on a HCFA 1500 form.
Please include a copy of current license for each provider listed.

Name of Group: _____ **Panel Size:** _____ **Age Limit**: _____

Group Tax ID #: _____

1. How do you bill? _____Professional Only _____Technical Only _____Professional & Technical
2. Will Gateway Health Plan® receive a separate bill from the physician for professional services? _____Yes _____No
3. On what form do you bill? _____HCFA 1500 _____UB 92

***All required fields, as applicable.**

Physician Listing OR attach a full roster of practitioners which, at a minimum, includes the information below.

First Name	M.I.	Last Name	Degree	Specialty	PCP or Specialist	NPI#	Medicare ID#	Medicaid ID#	State License#

Please be sure to include all practitioners on this list. If you have additional practitioners, please include their information on a separate page.

Facility/Ancillary Services Check List

Gateway Health Plan® would like to know what specific services you provide. Please check all boxes that apply. Also please indicate your service area.

Ambulance:
- ☐ Advanced Life Support (ALS)
- ☐ Basic Life Support (BLS)
- ☐ Wheelchair Van

Audiology:
- ☐ Hearing Aids
- ☐ Speech Therapy

Durable Medical Equipment:
- ☐ Bedside Commodes
  - o Specialty
  - o Standard
- ☐ Breast Pumps
- ☐ Breast Prosthesis/Bras
- ☐ Catheters
- ☐ Crutches
- ☐ Enteral Supply (oral)
- ☐ Hospital Beds
- ☐ Hoyer Lifts (non-standard lifts)
- ☐ Incontinence Supplies
  - o Diapers
  - o Pull-Ups
- ☐ Insulin Pumps
- ☐ Molded Shoes
- ☐ Ostomy Supplies
- ☐ Respiratory Equipment
  - o Bi-PAP
  - o C-PAP
- ☐ Rifton Equipment
- ☐ Specialty Mattresses
- ☐ Splints/braces
- ☐ Support Stockings
- ☐ TENS Units
- ☐ Walkers
  - o Specialty
  - o Standard
- ☐ Wheelchairs
  - o Customized
  - o Standard
- ☐ Wound Care Supplies

Home Health:
- ☐ Home Health Aides
- ☐ Hospice
- ☐ Mom/Baby Maternity Visits
  - o Prenatal
  - o Postpartum
- ☐ Ostomy Nurse
- ☐ Private Duty
  - o Home Health Aides
  - o RN, LPN care
- ☐ Psychiatric Visits
- ☐ Social Worker
- ☐ Therapy Home Visits
  - o Adult OT
  - o Adult PT
  - o Adult ST
  - o Pediatric OT
  - o Pediatric PT
  - o Pediatric ST

Skilled Nursing Facility:
- ☐ TPN
- ☐ Tracheostomy
- ☐ Ventilator Dependent Patients
- ☐ Wound-Vac Care

Rehabilitation Hospital/Free-Standing Therapy:
- ☐ Adult Occupational Therapy
- ☐ Adult Physical Therapy
  - o Aquatic Therapy
- ☐ Adult Speech Therapy
- ☐ Pediatric Occupation Therapy (<21 years)
  - o Autism Services
- ☐ Pediatric Physical Therapy (<21 years)
  - o Autism Services
- ☐ Pediatric Speech Therapy (<21 years)
  - o Autism Services

Please list the counties the Facility/Ancillary will be servicing: