Medicaid Provider Validation Application

Samaritan Health Plans

This application is the first step in validating Medicaid-eligible, contracted providers who don't otherwise qualify for full credentialing. Samaritan Health Plans requires you to complete this form and provide supporting documentation in order to be validated prior to reimbursement for Medicaid claims. This validation process is required at least every three years to remain as a participating Medicaid provider with Samaritan Health Plans.

Note to providers licensed under supervision (such as licensed interns): Should a license to practice independently be obtained, full initial credentialing will be required to maintain participation status with Samaritan Health Plans/Intercommunity Health Network-CCO and to request additional contracted lines of business

1. Provider information

Last name_____ First name_____ Middle name _____

Other names used_____

Credentials/certification (check all that apply for the current contract)

- ☐ Addictions Counselor (CADC I, II, III)
- ☐ Addictions Counselor, Registrant (CADC-R)
- ☐ Birth Doula (THW)
- ☐ Community Health Worker (THW)
- ☐ Professional Counselor Associate (LPC-A)
- ☐ Family Support Specialist (THW)
- ☐ Interpreter (HCI)
- ☐ Licensed Psychologist Associate (LPA) Supervised
- ☐ Marriage/Family Therapist Associate (LMFT-A)
- ☐ Mental Health Associate (QMHA)
- ☐ Mental Health Associate Registrant (QMHA-R)
- ☐ Mental Health Professional (QMHP)
- ☐ Mental Health Professional Registrant (QMHP-R)
- ☐ Peer Support Specialist (THW)
- ☐ Peer Wellness Specialist (THW)
- ☐ Personal Health Navigator (THW)
- ☐ Psychologist Associate Resident (PhD)
- ☐ Psychologist Associate Resident (PsyD)
- ☐ Social Work Associate (CSWA)
- ☐ Youth Support Specialist (THW)

☐ Other (specify) _____

Area(s) of interest _____

Certification number (if applicable) _____

Date of birth_____ Social Security number _____

Individual (type I) NPI number_____ Gender identity _____

Race/ethnicity_____ Personal email address _____

Individual Medicaid number_____ Home address _____

Language(s) spoken by the provider _____

Note: Samaritan Health Plans does not discriminate or base credentialing decisions on an applicant's race, ethnicity or language and that providing the information is optional.

Supervisor information

For providers whose credential requires them to be clinically supervised for licensure or certification requirements (provider listed must meet the requirements for supervision by the appropriate licensing/certifying board):

Supervisor name:_____ Supervisor license/certification no._____

Providers licensed under supervision (such as board-registered interns/associates) who obtain a license to practice independently will be required to complete full credentialing via submission of an Oregon Practitioner Credentialing Application to maintain participation status with Samaritan Health Plans.

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2. Practice information

Name of practice/clinic _____ Tax ID no. _____

Location and accessibility (please attach separate documents for additional locations)

Effective date at location _____

Street address _____

City _____ State _____ ZIP _____

Phone (the number you want members to call) _____ Fax _____ Group NPI (type II) no. _____

Office manager name _____ Email address _____

Group Medicare no. _____ Group Medicaid no. _____

Languages fluently spoken by office personnel _____

Please check all that apply ☐ Accepting new patients ☐ Office is wheelchair accessible

Practice limitations (e.g., age, gender) ☐ Yes ☐ No If yes, specify _____

Office Hours of Operation (Open – Close)

Mon _____ Tues _____ Wed _____ Thurs _____

Fri _____ Sat _____ Sun _____

Do you provide 24-hour call coverage? Yes ☐ No ☐

If no, please explain how your patients obtain advice and care after hours: _____

Credentialing information | Contact information where validation materials and correspondence can be sent.

☐ Same as the "Location and accessibility" contact information above

Contact name _____ Contact email _____

Mailing address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Billing information

☐ Same as the "Location and accessibility" contact information above ☐ Same as the credentialing contact information

Mailing address _____

City _____ State _____ ZIP _____

Phone _____ Fax _____

Email _____

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3. Qualifications and competencies

Please provide information of all education and training programs relevant to obtaining your current/future credential/ certification only. Qualifications and competencies must meet the OHA and state standards for certification and/or licensure. (Please attach separate sheets for additional relevant training programs.)

☐ Check here to indicate that you were granted an exception to certification without professional education/training program.

Professional education/training program

School/program name_____ Degree/certification received_____

From date (MM/YY)_____ To date (MM/YY)_____ Study/major _____

☐ Check here to indicate that you completed the program.

☐ Check here if your training is in process of being completed (please indicate your future graduation date above).

Additional education

School/program name_____ Degree/certification received_____

From date (MM/YY)_____ To date (MM/YY)_____ Study/major _____

☐ Check here to indicate that you completed the program.

☐ Check here if your training is in process of being completed (please indicate your future graduation date above).

Mental health experience

This section needs to be completed for a qualified mental health professional unless certified or registered.

☐ N/A - Check here to indicate you meet **all** criteria outlined in OAR Chapter 309.

Mental health work experience			
Position/title	Employer/location	Start/end date	Hours per week

4. Professional liability insurance

Please attest to current professional liability insurance or provide a copy of the insurance certificate. Contractually, all participating providers are required to hold at least $1,000,000 per claim and at least $3,000,000 aggregate amount. If these limits are not able to be met, please provide an explanation on a separate sheet.

Carrier name_____ Policy no._____

Month/day/year effective_____ Month/day/year expiration_____

Month/day/year retroactive date (if applicable)_____

Per claim limit_____ Aggregate amount_____

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5. Documentation

Please complete/provide the following documentation:

☐ Pleasecomplete theattachedAttestation Questions,Authorizationand Release of Information,andAttachmentAformsfromthe Oregon Practitioner Credentialing Application (OPCA)

NOTE: Anyyesanswers to theAttestationQuestionsmustinclude anexplanationfromtheprovider, witha fullsignature and date.

☐ Evidence of most recent Criminal Background Check
Acceptable evidence may alsoinclude active registration/certification with theMental Health and Addiction Certification Board of Oregon (MHACBO), the Traditional Health Worker (THW) Registry, a state licensing board; or a copy of the Final Fitness Determination Letter if nocurrent registration/certificationexists.

☐ If the backgroundcheck is olderthantwo (2)years,checkhere to confirmit wasthe lastcriminalbackgroundcheck run.

☐ Copy of licensureandcertification(s)(ifapplicable)

☐ Professional Liability Insurance (PLI) certificate

Email or fax this form and your supporting documentation to our credentialing team:

Email: SHSCredentialingHealthPlansOperation@samhealth.org
Fax: 541-768-9771

**Please note any information that varies substantially from the information verified during the validation process may require follow-up and clarification to proceed with the application process.*

XXI. Attestation Questions – This section to be completed by the Practitioner.

Modification to the wording or format of these Attestation Questions will invalidate the application.

Please answer the following questions "yes" or "no". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet**. Please sign and date each additional sheet.** NOTE: Answering "yes" to Question L does not require any further details.

A.	Has your license, certification, or registration to practice your profession, Drug Enforcement Administration (DEA) registration, or narcotic registration/certificate in any jurisdiction **ever been** denied, limited, suspended, revoked, not renewed, voluntarily or involuntarily relinquished, or subject to stipulated or probationary conditions, had a corrective action, or have you **ever been** fined or received a letter of reprimand or is any such action pending or under review?	YES	NO
B.	Have you **ever been** suspended, fined, disciplined, or otherwise sanctioned, restricted or excluded for any reasons, by Medicare, Medicaid, or any public program or is any such action pending or under review?	YES	NO
C.	Have you **ever been** denied clinical privileges, membership, or contractual participation by any health care related organization*, or have clinical privileges, membership, participation or employment at any such organization **ever been** placed on probation, suspended, restricted, revoked, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
D.	Have you **ever** surrendered clinical privileges, accepted restrictions on privileges, terminated contractual participation or employment, taken a leave of absence, committed to retraining, or resigned from any health care related organization* while under investigation or potential review?	YES	NO
E.	Has an application for clinical privileges, appointment, membership, employment or participation in any health care related organization* **ever been** withdrawn on your request prior to the organization's final action?	YES	NO
F.	Has your membership or fellowship in any local, county, state, regional, national, or international professional organization **ever been** revoked, denied, limited, voluntarily relinquished while under investigation, not renewed while under investigation, involuntarily relinquished, or is any such action pending or under review?	YES	NO
G.	Have you **ever** voluntarily or involuntarily left or been discharged from any education or training programs related to your current licensure or certification?	YES	NO
H.	Have you **ever** had board certification revoked?	YES	NO
I.	Have you **ever been** the subject of any reports to a state or federal data bank or state licensing or disciplinary entity?	YES	NO
J.	Have you ever been charged with a criminal violation (*felony or misdemeanor*)?	YES	NO
K.	Do you presently use any illegal drugs?	YES	NO
L.	We recognize that providers encounter health conditions, including those involving physical and mental health and substance use disorders, just as their patients do. It is imperative that providers address their health concerns for their own well-being, as well as for patient safety. Do you attest to no current physical, mental health, or chemical dependency conditions (alcohol or other substances) that currently affect your ability to practice, with or without reasonable accommodation? Please disclose any current conditions that require employer-provided accommodations on a separate sheet.	YES	NO
M.	Are you **unable** to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/ hospital appointment, with or without reasonable accommodation, according to accepted standards of professional performance?	YES	NO
N.	Have any professional liability claims or lawsuits **ever been** closed and/or filed against you? If yes, please complete **Attachment A, Professional Liability Action Detail,** for **each** past or current claim and/or lawsuit.	YES	NO
O.	Has your professional liability insurance **ever been** terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you **ever been** denied professional liability insurance?	YES	NO

e.g.** ***hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, health care faculty position or other health delivery entity or system

I certify the information in this entire application is complete, current, correct, and not misleading. I understand and acknowledge that any misstatements in, or omissions from this application will constitute cause for denial of my application or summary dismissal or termination of my clinical privileges, membership or practitioner participation agreement. A photocopy of this application, including this attestation, the authorization and release and any or all attachments has the same force and effect as the original. I have reviewed this information on the most recent date indicated below and it continues to be true and complete. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.

I agree to provide continuous care for my patients, until the practitioner/patient relationship has been properly terminated by either party, or in accordance with contract provisions.

Signature:	**Date:**

OREGON PRACTITIONER CREDENTIALING APPLICATION

AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this application, I understand and agree to the following:

1. I understand and acknowledge that, as an applicant for medical staff membership at the designated hospital(s) and/or participation status with the health care related organization(s) [*e.g. hospital, medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), physician hospital organization (PHO), medical society, professional association, medical school faculty position or other health delivery entity or system*] indicated on this application , I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and other qualifications. In this application, I have provided information on my qualifications, professional training and experience, prior and current licensure, Drug Enforcement Agency registration and history, and applicable certifications. I have provided peer references familiar with my professional competence and ethical character, if requested. I have disclosed and explained any past or pending professional corrective action, licensure limitations or related matter, if any. I have reported my malpractice claims history, if any, and have attached or will provide a copy of a current certificate of professional liability coverage.
2. I further understand and acknowledge that the health care related organization(s) or designated agent would investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the health care related organization(s) as a part of the verification and Credentialing process.
3. I authorize all individuals, institutions, entities of other hospitals or institutions with which I have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status, to consult with the designated health care related organization(s), their staffs and agents.
4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges/services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews, if required or requested.
5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the health care related organization(s) or their respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.
6. I understand and agree that the authorizations and releases given by me herein shall be valid so long as I am an applicant for or have medical staff membership and/or clinical privileges/participation status at the health care related organization(s) designated herein, unless revoked by me in writing.
7. For hospital or medical staff membership/clinical privileges, I acknowledge that I have been informed of, and hereby agree to abide by, the medical staff bylaws, rules, regulations and policies.
8. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the health care related organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.
9. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

Printed name:	
Signature:	**Date:**

I grant permission for the release of the credentials information contained in this practitioner application to the following health care related organization(s):

Modification to the wording or format of the Oregon Practitioner Credentialing Application will invalidate the application.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact Jon McElfresh at jonathan.p.mcelfresh@oha.oregon.gov or 503-385-3075 (voice). We accept all relay calls.

Attachment A

Professional Liability Action Detail — Confidential

Please list any past or current professional liability claim or lawsuit, which has been filed against you. **Photocopy this page as needed and submit a separate page for EACH professional liability claim/lawsuit.** It is not acceptable to simply submit court documents in lieu of completing this document. Please complete each field. Please attach additional sheet(s), if necessary.

Practitioner's name *(print or type)*:

Month/day/year of the incident: - - and clinical details:

Your role and specific responsibilities in the incident:

Subsequent events, including patient's clinical outcome:

Month/day/year the suit or claim was filed: - -

Was this claim reported to any state or federal agency? YES ☐ NO ☐
If yes, please state which agency:

Name and address of insurance carrier/professional liability provider that handled the claim:

Your status in the legal action *(primary defendant, co-defendant, other)*:

Current status of suit or other action:

Month/day /year of settlement, judgment, or dismissal: - -

If case was settled out-of-court, or with a judgment, settlement amount attributed to you:

I verify the information contained in this form is correct and complete to the best of my knowledge.

Signature: Date:

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