HCS HEALTHCARE CREDENTIALING SERVICES LLC

MedNetOne HEALTH SOLUTIONS

PROVIDER ENROLLMENT & CREDENTIALING APPLICATION

Please complete all sections of the MNO and MichCare Provider Enrollment & Credentialing Application. If you are enrolling a new group practice, please complete and submit the Group Practice Enrollment Form. Completed Applications can be emailed to enrollment@hcscredentialing.com or faxed to (248) 436-4758.

PERSONAL INFORMATION			
Last Name:	**First:**	**Middle:**	**Suffix:**
Degree:	**NPI:**	**DOB:**	
CAQH ID:	**ECFMG Number (If applicable):**	**Gender:**	

PRACTICE AS		
☐ **Primary Care Provider**	☐ **Specialist**	☐ **Hospital Based**
☐ **Hospitalist**	☐ **Behavioral Health**	☐ **Pharmacist**

PHYSICIAN ORGANIZATION	
☐ **Medical Network One (MNO)**	☐ **MichCare Organized System of Care**

LICENSE INFORMATION		
State License Number:	**Issuing State:**	**Expiration Date:**
State License Number:	**Issuing State:**	**Expiration Date:**

SPECIALTY & BOARD INFORMATION				
Primary Specialty:			**Taxonomy:**	**Certificate # (if applicable):**
Board Certified:	**Yes** ☐	**No** ☐	**Board Name:**	
Additional Specialty:			**Taxonomy:**	**Certificate # (if applicable):**
Board Certified:	**Yes** ☐	**No** ☐	**Board Name:**	
Additional Specialty:			**Taxonomy:**	**Certificate # (if applicable):**
Board Certified:	**Yes** ☐	**No** ☐	**Board Name:**	

SERVICES			
Family Practitioners – Do you offer Obstetric Services?		**Yes** ☐	**No** ☐
D.O. Physicians – Do you offer OMT Services?		**Yes** ☐	**No** ☐
Specialized Training & Experience in Treating (If yes, complete Attachment A):		**Yes** ☐	**No** ☐
OB/GYNs – Do you offer Obstetrics & Gynecology Services?	**OB/GYN** ☐	**GYN only** ☐	**OB only** ☐
Psychologists – Do you treat the following patient populations?	**Adult** ☐	**Adolescent** ☐	**Pediatric** ☐

BILLING INFORMATION (Please attach a copy of W-9 or SS4)							
Tax ID Name (As it appears on W-9 or SS4):				**Tax ID Number:**			
DBA (If applicable):							
Remittance Address:							
City:	**State:**		**Zip:**				
Phone:		**Fax:**					
Billing Contact Name:		**Email:**					

PRIMARY PRACTICE LOCATION INFORMATION							
Primary Practice Location Name:				**Group NPI:**			
Address:							
City:	**State:**		**Zip:**				
Office Phone:			**Office Fax:**				
Office/Practice Website:			**Office Email:**				
Office Manager Name:	**Office Manager Phone:**		**Office Manager Email:**				
Credentialing Contact Name:	**Credentialing Contact Phone:**		**Credentialing Contact Email:**				
List Location in the Directory:			**Yes** ☐	**No** ☐			
Appointment Phone (If Different than Office Phone):			**After Hours Phone (If Different Than Office Number):**				
Does this Practice Utilize Electronic Medical Records?			**Yes** ☐	**No** ☐			
EMR Name and Version:							
Does this Location offer Telemedicine Services?			**Yes** ☐	**No** ☐			
Does this Location Have E Prescribing Capabilities?			**Yes** ☐	**No** ☐			
Is this Practice PCMH Certified? (if yes please attach a copy)			**Yes** ☐	**No** ☐			
NCQA PCMH Certification Level:	**Level 1** ☐	**Level 2** ☐	**Level 3** ☐	**Effective Date:**	**End Date:**		

PROVIDER OFFICE HOURS (Hours which the providers see patients)						
Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
AM	**AM**	**AM**	**AM**	**AM**	**AM**	**AM**
PM	**PM**	**PM**	**PM**	**PM**	**PM**	**PM**

PROVIDER PATIENT POPULATION INFORMATION								
Accepting Patients at this location?	**Accepting New** ☐		**Not Accepting** ☐		**Existing Patients Only** ☐			
Genders Accepted?	**Both** ☐		**Males Only** ☐		**Females Only** ☐			
Accepts Medicaid at this Location?	**Yes** ☐		**No** ☐		**Managed Medicaid** ☐			
Age Restrictions:	**Yes** ☐	**No** ☐	**Minimum Age:**		**Maximum Age:**			
Practice Capacity Restrictions:	**Yes** ☐	**No** ☐	**Minimum:**		**Maximum:**			

MAILING ADDRESS (If different than Primary Location)		
Address:		
City:	**State:**	**Zip:**

PRACTICE LOCATION RESTRICTIONS		
Hospital Based Location Only:	**Yes** ☐	**No** ☐
In Home Services Only:	**Yes** ☐	**No** ☐
Indian Health Services Only:	**Yes** ☐	**No** ☐
Minute Clinic Services Only:	**Yes** ☐	**No** ☐
Nursing Home Services Only	**Yes** ☐	**No** ☐
Skilled Nursing Services Only:	**Yes** ☐	**No** ☐
Telemedicine Services Only:	**Yes** ☐	**No** ☐
Urgent Care Location Only:	**Yes** ☐	**No** ☐
Veteran Affairs Location Only:	**Yes** ☐	**No** ☐

ANNUAL TRAINING COMPLETION		
Have you completed annual CMS Certified FWA Training?	**Yes** ☐	**No** ☐
Have you completed annual Cultural Competency Training?	**Yes** ☐	**No** ☐
Have you completed annual Model of Care Training?	**Yes** ☐	**No** ☐
Have you completed annual Dual Eligible Training?	**Yes** ☐	**No** ☐
Have you completed annual HIPAA Training?	**Yes** ☐	**No** ☐

COLLABORATING PROVIDER INFORMATION

For Practitioners which require Collaborating Providers please include a current copy of your Collaboration Agreement

Collaborating Provider Last Name:	**Collaborating Provider First Name:**
Collaborating Provider Degree:	**Collaborating Provider NPI:**

APPLICATION CHECK LIST

Completed Application and W-9
Copy of a current government issued ID (Drivers License, State ID, Passport or Military ID)
CAQH attested to within the last 120 Days (Ensure all applicable attachments are updated in CAQH including Licenses, Curriculum Vitae, DEA, CDS, Malpractice Face sheet)
Practitioners which require Collaborating Providers - include a copy of your current Collaboration Agreement with each Collaborating Provider
Nurse Practitioners please include a current copy of your applicable Nursing Board Certificate
Completed Attachment A – Specialized Training & Experience in Treating (if applicable)
Completed Group Practice Application

CONSENT TO RELEASE OF INFORMATION FORM

Applicant agrees to participate in the credentialing/re-credentialing and interviewing program as established by Healthcare Credentialing Services LLC. Applicant consents to the release of information for the purpose of proper evaluation of his/her professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

Applicant agrees that the decision of the Healthcare Credentialing Services, LLC shall be final and binding, and to release the plan and its shareholders, respective officers, trustees, agents, employees and all members of the committees of the plan from any and all liability. Applicant further agrees to release from any and all liability any physician, hospital or other person or entity providing information which, but for such waiver, would be privileged and confidential.

Applicant understands that any and all information submitted on or with this form and/or the CAQH Universal Provider Datasource that is found to be false or intentionally misleading may result in rejection or termination with Healthcare Credentialing Services LLC and its Client Networks.

Furthermore, a copy of these statements shall be as binding as the original. Applicant also understands that all information submitted on or with this form and/or the CAQH Universal Provider Datasource is subject to investigation and review by Healthcare Credentialing Services LLC and its Client Networks.

Notice: The National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB) will be queried. If you are not credentialed/re-credentialed for reasons relating to professional conduct or professional competence, the rejection may be reported to the NPDB and/or HIPDB. Applicant understands and agrees that he/she has the burden of producing information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

Applicant further understands that it is his/her responsibility to notify Healthcare Credentialing Services in writing within fifteen (15) calendar days of any changes or additions to the information submitted on or with this form and/or the CAQH Universal Provider Datasource.

Practitioner Rights Applicant understands that he/she has the right to:

1) Review information obtained through primary source verification for credentialing purposes. This includes information from malpractice insurance carriers and state licensing boards. This does not include information collected from references, recommendations and other peer-review protected information.
2) Be notified if any credentialing information is received that varies substantially from application information submitted by the practitioner.
3) The practitioner will be notified of any of the following types of variances: (e.g., actions on license, malpractice claim history, suspension or termination of hospital privileges or board certification decisions except for references, recommendations or other peer-review protected information).
4) The practitioner will have the right to correct erroneous information if the credentialing information received varies substantially from the information that was submitted on his/her application.
5) (Upon request) be informed of the status of their application. If the application is current and complete the applicant can be informed of the tentative date that his/her application will be presented to the Credentialing Committee for approval.

I certify that all information included in my application and the accompanying documents are correct and complete to the best of my knowledge.

Each submission requires an original signature and current date. Rubber stamped and electronic signatures are not acceptable.

Provider Signature:	
Printed Name:	**Date:**

ADDITIONAL PRACTICE LOCATION INFORMATION

Practice Location Name:		**Group NPI:**
Address:		
City:	**State:**	**Zip:**
Office Phone:		**Office Fax:**
Office/Practice Website:		**Office Email:**
Office Manager Name:	**Office Manager Phone:**	**Office Manager Email:**
Credentialing Contact Name:	**Credentialing Contact Phone:**	**Credentialing Contact Email:**

List Location in the Directory:	**Yes** ☐	**No** ☐
Appointment Phone (If Different than Office Phone):	**After Hours Phone (If Different Than Office Number):**	
Does this Practice Utilize Electronic Medical Records?	**Yes** ☐	**No** ☐
EMR Name and Version:		
Does this Location offer Telemedicine Services?	**Yes** ☐	**No** ☐
Does this Location Have E Prescribing Capabilities?	**Yes** ☐	**No** ☐
Is this Practice PCMH Certified? (if yes please attach a copy)	**Yes** ☐	**No** ☐

NCQA PCMH Certification Level:	**Level 1** ☐	**Level 2** ☐	**Level 3** ☐	**Effective Date:**	**End Date:**

PROVIDER OFFICE HOURS (Hours which the providers see patients)

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
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PM	PM	PM	PM	PM	PM	PM

PROVIDER PATIENT POPULATION INFORMATION

Accepting Patients at this location?	**Accepting New** ☐	**Not Accepting** ☐	**Existing Patients Only** ☐
Genders Accepted?	**Both** ☐	**Males Only** ☐	**Females Only** ☐
Accepts Medicaid at this Location?	**Yes** ☐	**No** ☐	**Managed Medicaid** ☐

Age Restrictions:	**Yes** ☐	**No** ☐	**Minimum Age:**	**Maximum Age:**
Practice Capacity Restrictions:	**Yes** ☐	**No** ☐	**Minimum:**	**Maximum:**

MAILING ADDRESS (If different than Practice Location)

Address:		
City:	**State:**	**Zip:**

PRACTICE LOCATION RESTRICTIONS		
Hospital Based Location Only:	**Yes** ☐	**No** ☐
In Home Services Only:	**Yes** ☐	**No** ☐
Indian Health Services Only:	**Yes** ☐	**No** ☐
Minute Clinic Services Only:	**Yes** ☐	**No** ☐
Nursing Home Services Only	**Yes** ☐	**No** ☐
Skilled Nursing Services Only:	**Yes** ☐	**No** ☐
Telemedicine Services Only:	**Yes** ☐	**No** ☐
Urgent Care Location Only:	**Yes** ☐	**No** ☐
Veteran Affairs Location Only:	**Yes** ☐	**No** ☐
ANNUAL TRAINING COMPLETION		
Have you completed annual CMS Certified FWA Training?	**Yes** ☐	**No** ☐
Have you completed annual Cultural Competency Training?	**Yes** ☐	**No** ☐
Have you completed annual Model of Care Training?	**Yes** ☐	**No** ☐
Have you completed annual Dual Eligible Training?	**Yes** ☐	**No** ☐
Have you completed annual HIPAA Training?	**Yes** ☐	**No** ☐

COLLABORATING PROVIDER INFORMATION **For Practitioners which require Collaborating Providers please include a current copy of your Collaboration Agreement**	
Collaborating Provider Last Name:	**Collaborating Provider First Name:**
Collaborating Provider Degree:	**Collaborating Provider NPI:**

ATTACHMENT A (please indicate "X")

Area	Yes	Area	Yes	Area	Yes	Area	Yes
Abuse - Adults		Cognitive Therapy		Heart Disease		Play Therapy	
Abuse - Children		Community Based Services		Heart Failure		Post-Partum Disorder	
Abuse - Elder		Community Support Program		Hernia Surgery		Psychodynamic Therapy	
Addictive Disorders		Community Support for the Homeless		High Blood Pressure		Psychological Testing	
Addictive Medicine		Congestive Heart Failure		High Cholesterol		Psychopharmacology	
Adjustment Disorder		Co-occurring Disorders		High Risk Pregnancies		PTSD	
Adolescent Behavior Disorders		COPD		Hip Dysplasia		Pulmonary Therapy	
Adolescent Psychiatry		Corneal Disease		HIV/AIDS		Radiation Treatment	
Adolescent Psychotherapy		Couples Therapy		Homelessness		Rationale Emotive Therapy	
Adolescents		Criminal Offenders		Hypertension		Reactive Attachment Disorder	
Adoption Issues		Crisis Intervention/Stabilization		Hypnosis		Relapse Prevention	
Alzheimer's Disease		Critical Incident Debriefing		Immunizations		Relationship Disorders	
Anger Management		Cultural Issues		Impulse Disorders		Respiratory Therapy	
Anxiety/Panic Disorder		Cystic Fibrosis		In Home or Homebound Services		Retina Disorders	
Applied Behavior Analysis		Deafness or Hard of Hearing		Individual Therapy		Rheumatic Diseases	
Art Therapy		Dementia Disorders		Infertility		Robotic Surgery	
Arthritis		Depression		Intake Assessment		Schizophrenia	
Asthma		Developmental Disorder		Intellectual and Developmental Disabilities		Self-Injury	
Atrial Fibrillation		Developmental Evaluation		Intensive Family Intervention		Sensory Processing/Integration	
Attachment Disorder		Diabetes		Interventional Cardiology Procedures		Separation/Divorce	
Attachment Therapy		Diabetic Foot Care		Ischemic Heart Disease		Serious Emotional Disturbance	
Attention Deficit Disorder (ADD)		Diabetic Retinopathy		IVIG Therapy		Serious Mental Illness	
Attention Deficit/Hyperactivity Disorder		Diabetic Wound Care		IV-Infusion		Severe Persistent Mentally Ill	
Autism Spectrum Screening & Treatment Adults		Dialectical Behavioral Therapy		Kidney Disease		Sex Therapy	
Autism Spectrum Screening & Treatment Child		Disruptive Behavior		Knee and Hip Replacement		Sexual Abuse/Incest	
Autism/Asperger's		Dissociative Disorder		LGBTQ+		Sexual Compulsions/Addictions	
Bariatric Surgery		Domestic Violence		Liver Disease		Sexual Disorders	
Behavioral Therapy		Drug and Alcohol Counseling		Marital Issues		Sexual Dysfunction	
Biofeedback		Eating Disorders		Medication Management		Sexual Offender	
Bipolar Disorder		Electroconvulsive Therapy		Men Issues		Sexual/Physical Abuse Adults	

Blindness or Visual Impairment		Electromyography		Mental Health Disorders		Sexual/Physical Abuse Children	
Blood Disorders		Electrophysiology Procedures		Methadone Treatment		Skin, Nail and Hair Diseases	
Bone Health		EMDR Therapy		Mobile Crisis		Sleep Disorders	
Breast Cancer		Emotionally Disturbed		Mood Disorders		Spinal Disorders	
Breast Surgery		Empowerment Therapy		Neuro-Linguistic Programming		Spinal Surgery	
Brief Therapy		Endocrine Disorders		Neurological Disorders		Step/Blended Families	
Burn Injuries		Endoscopy Procedures		Neuropsychology Testing		Stress Management	
Cancer Treatment		Equine Assisted Therapies		Nutritional Counseling - Adults		Stroke Rehabilitation	
Cardiovascular Disease		Eye Surgery		Nutritional Counseling - Children		Suboxone Treatment Program	
Cataract Surgery		Eyelid Surgery		Obsessive Compulsive Disorder		Substance Abuse	
Cerebral Palsy		Family Therapy		Oppositional Defiant Disorder		Telemedicine	
Chemical Dependency		Feeding Disorders		Organic Mental Disorder		Tobacco Cessation	
Child Parent Psychotherapy		Gender Identity Issues		Osteopathic Manipulation Treatment		Transesophageal Echocardiogram Procedures	
Child Psychiatry		Genetics Counseling		Outcomes Oriented Therapy		Trauma Focused Cognitive Behavioral Therapy	
Child Psychological Testing		Geriatric Psychiatry		Pain Management		Trauma Informed Care	
Child/Parent Bonding		Geriatrics		Panic Disorder		Trust Based Relational Intervention	
Chiropractic Sports Treatment		Glaucoma		Parent Child Interaction Therapy		Varicose Veins	
Christian Counseling		Grief/Loss/Bereavement		Parenting Issues		Weight Management	
Chronic Kidney Disease		Group Therapy		Personality Disorders		Women's Health	
Chronic Pain Management		Hand Surgery		Phobias		Work Related Problems	
Client Centered Therapy		Head Trauma		Physical Abuse		Wound Care	
Cognitive Disorder		Heart Catheterization		Physical Disabilities		Other:	