Dear Provider:

This application is intended to be used by participating groups with new locations or a group who has been recruited for participation by the Network Development. Unsolicited applications will not be processed and maybe discarded. An executed contract is required to be considered a participating Virginia Premier Network Provider.

Attached is the organizational enrollment application and supplemental enrollment form that Virginia Premier Health Plan, Inc. (VPHP) is requesting that you complete and return along with the credentialing documents. Please carefully review the supplemental enrollment form section(s) entitled ***Company Ownership/Control Interest Statement and Disclosure of Business Transactions***. This is new to the credentialing process. All providers are required to complete this section in accordance with federal regulations 42 CFR 455.105 and 42 CFR 455.106. The form must be submitted with the application and signed by the owner otherwise; your participation process may be delayed.

Under federal regulations, providers entering into or renewing a provider agreement must disclose to the Department of Health and Human Services Secretary/Department, State Medicaid Agency and/or VPHP, on request, the identity of any excluded individual with an ownership or controlling interest in the provider entity. VPHP is contracted with the Department of Medical Assistance Services (DMAS), as a Medicaid Managed Care Health Plan. It is required to obtain this information from providers, in addition to the names of all individuals/entities having a five percent (5%) or more direct or indirect ownership or a controlling interest in the entity.

Below are practitioner rights in accordance to the National Committee for Quality Assurance (NCQA). Practitioners have the right to:

- Review information submitted to support their credentialing application.
- Correct erroneous information.
- Receive the status of their credentialing or re-credentialing application, upon request.
- Receive notification of these rights

Please use the application check-off list to ensure all items have been completed and included in your application. The process generally can take up to 180 days to complete. Incomplete information will certainly delay this process. If you have questions, please call your Contracting Specialists at **(800) 727-7536**.

Sincerely,

Jamie McPherson	Patrick McMahon
Vice-President, (Quality) & Accreditation	Vice-President, Network Development

REV043010

P.O. Box 5307 • Richmond, VA 23220-0307 • (804) 819-5151 (O) • (804) 819-5171 (F)

ORGANIZATIONAL ENROLLMENT APPLICATION

FOR OFFICE USE ONLY:

Date Application Mailed:	Initials:	Date Application Mailed:	Initials:

This application should not be submitted unless, you have received a letter from VPHP of itøs intent to recruit you as a participating provider. VPHPøs on-line application is intended to be used for providers who do not have a completed application through the CAQH website. A completed application should be submitted along with two (2) signed agreement and **current** copies of the following information, within 30 days to:

Virginia Premier Health Plan, Inc.
Attn: Network Development
P.O. Box 5307
Richmond, VA 23220-0307

Please check all that is applicable and provide copies of supporting documents:

- ☐ CMS Certified Letter (if applicable)
- ☐ Recent CMS Site Survey
- ☐ Certificate of Insurance (Malpractice and General Liability)
- ☐ Current Business License
- ☐ State License (if applicable)
- ☐ Official Letter from Internal Revenue Service
- ☐ Accreditation certificate (if applicable)

SECTION 1: PROVIDER TYPE

NOTE: Check all that apply.

- ☐ Ambulatory Surgery Center (ASC)
- ☐ Audiology
- ☐ Dialysis Center
- ☐ Durable Medical Equipment Supplier
- ☐ Communication Device Supplier
- ☐ Community Services Board
- ☐ Health Department
- ☐ Hearing Center
- ☐ Home Infusion Provider
- ☐ Hospital
- ☐ Interpreter/Translation Services
- ☐ Orthotics
- ☐ Orthotics/Prosthetics
- ☐ Private Duty Nursing
- ☐ Prosthetics
- ☐ Power Mobility Devices (PMD)
  - ☐ Power Operated Vehicles (scooters)
  - ☐ Power Wheelchairs
- ☐ Rehabilitation Center (PT/OT/SP)
- ☐ Respiratory Supplier
- ☐ Skilled Care Provider (check all applicable)
  - ☐ RN
  - ☐ HHA
  - ☐ Registered Dietician
  - ☐ Physical Therapy
  - ☐ Occupational Therapy
  - ☐ Speech Therapy
  - ☐ Medical Social Worker
- ☐ Skilled Nursing Facility
- ☐ Transportation Vendor
- ☐ Wheelchairs Supplieró Manual
- ☐ Wound Care Services
- ☐ Other (Specify): ______________________________

SECTION 2: NAME AND ADDRESS

Legal Business Name as Reported to the IRS:					Tax Identification Number:
Business Location Name *(NOT your billing agent, staffing company, or managing organization)*					
Primary Business Location Address Line 1:					
City/Town		State	ZIP Code +4		
Telephone Number	Fax Number *(if applicable)*			E-mail Address *(if applicable)*	
Date this business Started at this Location *(mm/dd/yyyy)*		Date this Business Terminated at this Location *(if applicable)(mm/dd/yyyy)*			
Mailing/Correspondence Address, if different from Location(s):					
Business Location Name *(NOT your billing agent, staffing company, or managing organization)*					
Secondary Business Location Address Line 2:					
Remittance Location (if different from main and secondary location).					
City/Town		State	ZIP Code +4		
Telephone Number	Fax Number *(if applicable)*			E-mail Address *(if applicable)*	
Date this business Started at this Location *(mm/dd/yyyy)*		Date this Business Terminated at this Location *(if applicable)(mm/dd/yyyy)*			
Office Primary Contact:		Phone Number			

INCORPORA TION INFORMATION

Identify the type of organizational structure for this supplier (Check one):

- ☐ Corporation (regardless of whether supplier is õfor-profitö or õnon-profitö)
- ☐ Partnership (õgeneralö or õlimitedö)
- ☐ Sole Proprietor/sole Proprietorship
- ☐ Other (Specify)

Is the entity currently enrolled in the Medicare program?

☐ YES ☐ NO

If yes, please provide the following:

Medicare Contractor Name	Medicare Billing Number	NPI

SECTION 3: INSURANCE INFORMATION		
Name of Insurance Company		
Insurance Policy Number	Date Policy Issued *(mm/dd/yyyy)*	Expiration Date of Policy (*mm/dd/yyyy)*

Insurance Agentøs First Name	Middle Initial	Last Name	Jr., Sr., etc.
Underwriterøs Agentøs First Name	Middle Initial	Last name	Jr., Sr., etc.

Agentøs Telephone Number	Agentøs Fax Number *(if applicable)*	Agentøs E-mail address *(if applicable)*
Underwriterøs Telephone Number	Underwriterøs Fax Number *(if applicable)*	Underwriterøs E-mail address *(if applicable)*

Is the insurance agent also the underwriter for this policy?

☐ Yes (Submit written proof from the insurance company attesting the agent is also the underwriter.)

☐ No

SECTION 4: ACCREDITATION INFORMATION

NOTE: Attach additional sheet if more than one accreditation needs to be reported.

☐ The enrolling provider is not accredited.

☐ The enrolling provider is accredited.

Name of Accrediting Organization	
Contact Person for the Accrediting Organization	Telephone Number of Contact Person
Date of Last Accreditation	Expiration of Current Accreditation
☐ The enrolling provider, including the business location in Section 1, is in the process of obtaining accreditation.	
Name of Accrediting Organization	
Date Applied for Accreditation	

SECTION 5: OWNERSHIP/CONTROL INTEREST STATEMENT

NOTE: Please copy this page if more information provided.

Please list names, addresses, and Social Security Numbers (SSN) for individuals and Employer Identification Numbers (EIN) for organizations having 5% or more direct or indirect ownership or a controlling interest in the entity or practice. Please provide a separate sheet with required information if necessary.

Individual/Organization	SSN/EIN
Address	
Individual/Organization	SSN/EIN
Address	
Individual/Organization	SSN/EIN
Address	
Individual/Organization	SSN/EIN
Address	

Are there any individuals/organizations having a 5% or more direct or indirect ownership or control interest in the entity or practice that have ever been debarred, suspended or otherwise excluded from federal or state health care programs (Medicare, Medicaid), or been convicted of a criminal offense related to their involvement in any Medicare, Medicaid or Title XX program? ☐ Yes ☐ No If yes, please provide the following information.

Name	Date	SSN
Name	Date	SSN

Please list all officers, directors and managing employees. Please provide a separate sheet with the required information if necessary.

Name	Position	SSN
Name	Position	SSN
Name	Position	SSN
Name	Position	SSN

Are there any directors, officers, agents, or managing employees of the entity or practice that have ever been debarred, suspended or otherwise excluded from federal or state health care programs (Medicare, Medicaid), or been convicted of a criminal offense related to their involvement in any Medicare, Medicaid or Title XX program? If yes, please provide the following information. ☐ Yes ☐ No

Name	Date	SSN
Name	Date	SSN

SECTION 6: DISCLOSURE OF BUSINESS TRANSACTION

Please describe any business transactions during the past 12 months totaling more that $25,000 between you and any subcontractor owned by you or your company. Please include the name of the subcontractor and the nature of the business transaction.

____

____

____

____

Please describe any significant business transactions during the past 5 years between you and any wholly owned supplier or between you and any **SUBCONTRACTOR**. Please include the name of the supplier or subcontractor and the nature of the business transactions.

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____

____

____

SECTION 7: SERVICE AREA

Please indicate all Counties and Independent Cities for which you provide services.

☐ Statewide

COUNTIES

☐ Accomack
☐ Albemarle
☐ Alleghany
☐ Amelia
☐ Amherst
☐ Augusta
☐ Bath
☐ Bedford
☐ Bland
☐ Botetourt
☐ Brunswick
☐ Buchanan
☐ Buckingham
☐ Campbell
☐ Caroline
☐ Carroll
☐ Charles City
☐ Charlotte
☐ Chesterfield
☐ Clarke
☐ Craig
☐ Culpeper
☐ Cumberland
☐ Dickenson
☐ Dinwiddie
☐ Essex
☐ Fairfax
☐ Fauquier
☐ Floyd
☐ Fluvanna
☐ Franklin
☐ Frederick
☐ Giles
☐ Gloucester
☐ Goochland
☐ Grayson
☐ Greene
☐ Greensville
☐ Halifax
☐ Hanover
☐ Henrico
☐ Henry
☐ Highland
☐ Isle of Wright
☐ James City
☐ King and Queen
☐ King George
☐ King William
☐ Lancaster
☐ Lee
☐ Loudoun
☐ Louisa
☐ Lunenburg
☐ Madison
☐ Mathews
☐ Mecklenburg
☐ Middlesex
☐ Montgomery
☐ Nelson
☐ New Kent
☐ Northampton
☐ Northumberland
☐ Nottoway
☐ Orange
☐ Page
☐ Patrick
☐ Pittsylvania
☐ Powhatan
☐ Prince Edward
☐ Prince George's
☐ Prince William
☐ Pulaski
☐ Rappahannock
☐ Richmond
☐ Roanoke
☐ Rockbridge
☐ Rockingham
☐ Russell
☐ Scott
☐ Shenandoah
☐ Smyth
☐ Southampton
☐ Spotsylvania
☐ Stafford
☐ Surry
☐ Sussex
☐ Tazewell
☐ Warren
☐ Washington
☐ Westmoreland
☐ Wise
☐ Wythe
☐ York

INDEPENDENT CITIES

☐ Alexandria
☐ Bedford
☐ Bristol
☐ Buena Vista
☐ Charlottesville
☐ Chesapeake
☐ Clifton Forge
☐ Colonial Heights
☐ Covington
☐ Danville
☐ Emporia
☐ Fairfax
☐ Falls Church
☐ Franklin
☐ Fredericksburg
☐ Galax
☐ Hampton
☐ Harrisonburg
☐ Hopewell
☐ Lexington
☐ Lynchburg
☐ Manassas
☐ Manassas Park
☐ Martinsville
☐ Newport News
☐ Norfolk
☐ Norton
☐ Petersburg
☐ Poquoson
☐ Portsmouth
☐ Radford
☐ Richmond
☐ Roanoke
☐ Salem
☐ South Boston
☐ Staunton
☐ Suffolk
☐ Virginia Beach
☐ Waynesboro
☐ Williamsburg
☐ Winchester

SECTION 8: SIGNATURE

My signature legally and financially binds this provider to the rules and program instructions of Virginia Premier Health Plan, Inc. (VPHP). By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize VPHP to verify this information. Further, if I become aware that any information in this application is not true, correct, or complete, I agree to notify VPHP of this fact immediately.

Authorized Signature **Date**

Name (Print) **Title**