New Mexico
Health Organization Provider Application

1. ORGANIZATION INFORMATION: *(Provide physical location information on the following page.)*	
Legal Name of Organization (Legal name listed with the IRS)	
DBA Name of Organization (If applicable)	
Historic Name(s) of Organization (If under same ownership)	
Hospital or Health System Affiliation (If applicable)	
Provider Type:	
Organization Medicare # *(Primary)*:	Organization Medicaid # *(Primary)*:
Organization TIN *(Primary)*:	Organization NPI *(Primary)*:

Ownership Type: (Select one) ☐ Sole proprietorship ☐ City/County/State owned ☐ Corporation/LLC/Partnership ☐ Federally owned

Select One: ☐ For profit ☐ Non-profit

Mailing Address	**Billing Address** *(If different than mailing)*
Street Address:	Street Address:
Address Line 2:	Address Line 2:
City: State: Zip:	City: State: Zip:
Contact:	Contact:
Email:	Email:
Phone: Fax:	Phone: Fax:

2. CURRENT INSURANCE COVERAGE:
(Please attach a copy of your current facility professional/general liability insurance face sheet.)

Professional Liability Insurance Information

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type: (Malpractice, general, etc.):
Coverage Amount per Occurrence:		Coverage Amount Aggregate:

General Liability Insurance Information

Current Carrier Name:		Policy Number:
Policy Start Date:	Policy End Date:	Policy Type (Malpractice, general, etc.):
Coverage Amount per Occurrence:		Coverage Amount Aggregate:

New Mexico
Health Organization Provider Application

COMPLETE THE BELOW INFORMATION FOR EACH PRACTICE LOCATION

3. PHYSICAL LOCATION INFORMATION:
(Include any additional information relevant to this location on a separate sheet.)

Location DBA
(If different than the Organization DBA)

Other DBAs Previously Used
(If under same ownership)

Is this a satellite facility? ☐ **Yes** ☐ **No**
If yes, does the facility follow the same policies and procedures as the main facility? ☐ **Yes** ☐ **No**
Please list the name of the main facility: ______________________________

Is this location Medicare-certified? ☐ **Yes** ☐ **No**	Is this the primary address? ☐ **Yes** ☐ **No**
Number of Medicare-certified beds? ____________	Are interpreters available? ☐ **Yes** ☐ **No**
Site-specific Medicare #:	Site-specific Medicaid #:
Site-specific TIN:	Site-specific NPI:
Physical Practice Location Street Address: ____________ Address Line 2: ____________ City: ____________ State: ______ Zip: ______ Phone: Secure Fax:	State provider # *(If applicable, LTC, etc.)*: Location is handicap accessible? ☐ **Yes** ☐ **No** American with Disabilities (ADA) Compliant: ☐ **Yes** ☐ **No** Describe your service area *(States, counties, cities, etc.)*:
Practice limitations (e.g., age, gender, etc.)	TDD capability: ☐ **Yes** ☐ **No**
Location offers pediatric services? ☐ **Yes** ☐ **No**	Please list any languages spoken by office personnel:

Hours of Operation

Standard Business Hours		Evening Hours (Any hours after 5 p.m.)		Weekend Hours	
Monday		Monday		Saturday	
Tuesday		Tuesday		Sunday	
Wednesday		Wednesday			
Thursday		Thursday			
Friday		Friday			

Location State License(s) and/or State Registration(s) *(Attach a copy of all.)*

☐ *Please check here if this location is not required to be licensed, certified, or registered by a State agency.*

Type of Credential	State	Number	Expiration Date	Most Recent Survey Date
State License				
State Registration				
State Certification				
Other:				

Additional Location Credentials *(Attach a copy of all.)*

☐ *Please check here if this location holds no additional licenses, certificates, registrations, etc.*

Type of Credential	State	Number	Expiration Date	Additional Notes/Info
DEA				
CLIA				
State CSR/CDS/DPS				
Other:				

New Mexico
Health Organization Provider Application

4. ACCREDITATION/CERTIFICATION:
(Check all that apply.)

☐ *Please check here if the State conducts routine surveys of your organization for license, registration, or clinical oversight.*

☐ *Please check here if (CYFD) Children,Youth and Families Department (New Mexico) conducts routine surveys of your organization for license, registration, or clinical oversight.*

☐ *Please check here if your organization is NOT accredited.*

List Accreditation Organizations and Attach Copies of Current Certificates	Date of Last Survey

5. CREDENTIALING PROGRAM:
(All questions MUST be answered by ALL organizations.)

Organizational Service Provider Screening
(Mark ONE option for each question.)

1) Please select the method utilized to verify the license/certification of individuals rendering services for your organization:

- ☐ Online directly with the appropriate State and/or Federal licensure or certification board
- ☐ Background check agency, contracted organization, or vendor
- ☐ Other process (please describe): _____
- ☐ No process (please explain):_____

2) Please indicate the method utilized to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:

- ☐ Online directly with the appropriate State and/or Federal licensure or certification board
- ☐ Obtaining a current copy of the license/certification
- ☐ Background check agency, contracted organization, or vendor
- ☐ Other process (please describe): _____
- ☐ No process (please explain):_____

3) Please indicate the method utilized to verify the <u>identity</u> of individuals rendering services for your organization:

- ☐ Verification of a state driver's license or other government identification
- ☐ Background check agency, contracted organization, or vendor
- ☐ Other process (please describe): _____
- ☐ No process (please explain):_____

4) **Please indicate the method utilized to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a health-care related crime (including but not limited to health care fraud; patient abuse; and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance) are rendering services:**

- ☐ Federal and/or State criminal background check(s)
- ☐ Background check agency, contracted organization, or vendor
- ☐ Search a State 'Misconduct Registry' or equivalent
- ☐ Other process (please describe): _____
- ☐ No process (please explain):_____

5) **Has your organization or any of its authorized representatives ever been convicted of, pled guilty to, or pled nolo contendre to any legal actions (excluding medical malpractice and misdemeanors)?**

☐ NO ☐ YES *(provide an explanation)*: _____

6) **Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?**

☐ NO ☐ YES *(provide an explanation)*: _____

7) **Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military, or State Department of Health programs?**

☐ NO ☐ YES *(provide an explanation)*: _____

8) **At any time, has any license or certification held by the organization or its branch locations ever been revoked, denied, or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are there any actions or investigations currently under way which may lead to one of these outcomes?**

☐ NO ☐ YES *(provide an explanation)*: _____

9) **Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?**

☐ NO ☐ YES *(provide an explanation)*: _____

10) **At any time, has any third party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management or quality of care issues?**

☐ NO ☐ YES *(provide an explanation)*: _____

11) **Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?**

☐ NO ☐ YES *(provide an explanation)*: _____

12) **Has the facility been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?**

☐ NO ☐ YES (provide an explanation):

13) Does each service location associated with the facility follow the policies and procedures as defined by the facilities service location?

☐ NO ☐ YES (provide an explanation):

14) Is the location within one block of a public transportation stop?

☐ NO ☐ YES (provide an explanation):

15) Please submit your organization's Quality Improvement Plan.

Additional specialty and roster information may be requested by credentialing entity.
Please attach a list of physical locations.

New Mexico
Health Organization Provider Application

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant the Managed Care Organization permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Managed Care Organization to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply the Managed Care Organization with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:

I hereby grant permission for the Managed Care Organization to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support the Managed Care Organizations quality improvement and utilization review programs.

ATTESTATION:

I certify the information on this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that decision of participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with, the Managed Care Organization and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by the Managed Care Organization. All services rendered to its Members must be individually authorized until a written notice of participation and conditions of participation is issued by the Managed Care Organization.

This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers in order to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance.

I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (http://oig.hhs.gov/exclusions/exclusions_list.asp) and System for Award Management (https://www.sam.gov/portal/public/SAM/) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Signature: ____

(Stamped signature is not acceptable.)

Printed Name: ______________________________ Date: ______________