Enhanced Care Management (ECM)
Organizational Provider Credentialing Application

Dear Provider,

Thank you for your interest in joining the CenCal Health provider network. We greatly value your partnership in better serving our community.

Enclosed is an Enhanced Care Management (ECM) Organizational Provider Credentialing Application and supplemental required forms.

In addition to this fully completed application, please also include the following:

- A copy of general/professional liability coverage
- A copy of applicable state licenses and/or a copy of current business license,

If any of the following apply to your organization, please include with this application:

- Disclosure of any history of liability claims in the past 7 years (if applicable, not required)
- A Copy of current state (Center for Medicare Services) site review (if applicable, not required)
- A Copy of accreditation/certification (if applicable, not required)

DHCS Medi-Cal Provider Screening and Enrollment

Federal law requires that all CenCal Health-contracted providers are screened and enrolled in the Department of Health Care Services (DHCS) Medi-Cal Fee-for-Service Program, if applicable.

All ECM Providers for whom a DHCS state-level enrollment pathway exists must enroll in Medi-Cal via the DHCS Provider Enrollment Division portal at pave.dhcs.ca.gov/sso/login.do. To create an account, click on the "Sign Up" button at the top right corner ofthe page.

An ECM Provider may be a non-traditional provider type for whom there is no established credentialing pathway. In these instances, CenCal Health will verify the ECM Provider's credentials through credentialing in addition to requiring any or all the following documents: applicable business or professional license, IRS Form 990, nonprofit status, and/or other documentation demonstrating official established business and/or individual entity.

Thank You,

Provider Services Credentialing Department

CenCal Health

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Facility Type (Please check all that apply):

☐ Behavioral Health Provider or entity	☐ PCP Group	☐ Specialist Group	☐ Organization serving individuals experiencing homelessness
☐ Federally Qualified Health Center	☐ Community Health Center	☐ Hospital	☐ Hospital based Physician Group or Clinic
☐ Community Mental Health Center	☐ Organization servicing justice-involved individuals	☐ California Children's Services Provider	☐ Substance Use Disorder Treatment Provider
☐ Rural Health Clinic/Indian Health Service Program	☐ Local Health Department; Behavioral Health Entity	☐ County Behavioral Health Provider	☐ County
☐ Other Qualified Providers: (Please Describe)			

General Information

Office Manager or Admin Staff Name:			
Doing Business as (DBA), if Different than name:			
Telephone Number:		Fax Number:	
Business Address:		City/State/Zip:	
Email Address:		Website Address:	
Office Contact Name:			
Phone:		Email:	
Are you enrolled in Medi-Cal?	Yes or No ☐ ☐	Are you enrolled in Medicare?	Yes or No ☐ ☐
Credentialing Contact Name: Email Address: Phone:			

Facility License Information – State Issued, Business License, Accreditations (Accreditations not required), and/or Non-Profit Status

California LicenseNumber	Type:
Issue Date:	Expiration Date:
Additional Licensure (Business or other):	Type:
Issue Date:	Expiration Date:
Additional Licensure (Business or other):	Type:

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Insurance Information

Name of General Liability InsuranceCompany:	Insurance Per Occurrence/Aggregate Amount:
Policy Number:	Policy Issued/Expiration Date(s):

Offices/Sites where Members will be served (if additional, please add to end of application)

Office/Site #1 Name:			
Address:		City/State/Zip:	
Phone:		Fax:	
Email:		Website:	
Location Hours:			
Office/Site #2 Name:			
Address:		City/State/Zip:	
Phone:		Fax:	
Email:		Website:	
Location Hours:			
Office/Site #3 Name:			
Address:		City/State/Zip:	
Phone:		Fax:	
Email:		**Website**	
Location Hours:			

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Disclosure of any history of liability claims in the last 7 years:

Does your organization have any liability claims within the last 7 years?

- ☐ No
- ☐ Yes, please provide with your completed credentialing application, a copy of any liability claimsagainst your organization within the last 7 years.

I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR section51000.30(a)(2)(B). I hereby affirm that the information submitted to CenCal Health and any addenda thereto is true, current, and complete to the best of my knowledge and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Services Agreement.

Signature:_____Title:_____

Date: _____

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Individual ECM Staff - This list is meant to encompass all ECM staff within your organization, CenCal Health may request additional information regarding individuals on this roster, if needed.

Additional information regarding credentialing requirements are outlined in PS-CR01 Provider Enrollment and Screening, PS-CR03 Provider Credentialing and Peer Review Policy and PS-CR11 Credentialing of Organizational Providers.

Individual ECM Staff -Including Lead Care Managers

Last, First Name	Title	NPI*	License Type*	License Number*	Race/ Ethnicity	Offices/Site Located	

***If applicable**

I attest that background screenings have been performed on all ECM staff.

I certify that no ECM Staff at our Organization:

- ☐ Currently have their Medicaid billing privileges terminated for-cause or are excluded by a StateMedicaid agency;
- ☐ Currently are excluded from any other Federal health care program;
- ☐ Have a history of fraud, waste and/or abuse;
- ☐ Have a recent history of criminal activity, including a history of criminal activities that endangerMembers and/or their families;
- ☐ Currently are debarred, suspended, or otherwise excluded from participating in any other Federal procurement or non-procurement program or activity in accordance with the Federal Acquisition Streamlining Act implementing regulations and the Department of Health and Human Services non-procurement common rule at 45 CFR part 76;

For any boxes you are unable to check, please provide a detailed explanation on a separate sheet.

Signature:_____ Date:_____

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The form below is a requirement of our Medi-Cal contract with the State. Please review and sign below whereindicated.

LETTER OF AUTHORIZATION PROCEDURES
RELEASE/ACCESS OF DHS COMPUTER FILES FOR THE
MEDI-CAL PROGRAM DECLARATION OF
CONFIDENTIALITY

As a condition of obtaining access to information concerning procedures or other data records utilized / maintained by the Department of Health Services, I,_____, agree
(Provider name)
not to divulge any information obtained in the course of my assignment to unauthorized persons and agree not topublish or otherwise make public any information regarding persons receiving Medi-Cal services such thatthe persons who receive such services are identifiable.

Access to such data shall be limited to the Plan, myself, my employees, fiscal agents, State and federal personnel who require the information in the performance of their duties, and to such others as may be authorized by the Department of Health Services.

I recognize that unauthorized release of confidential information may make me subject to civil and criminal sanctions pursuant to the provisions of the Welfare and Institutions Code Section 14100.2.

_____
Signature of Provider

_____
Date

ATTESTATION QUESTIONS
Please answer the following questions "yes" or "no." ***If your answer to questions A through K is "yes," or if your answer to N is "no," please provide full details on separate sheet.***
A. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? Yes ☐ No ☐
B. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? Yes ☐ No ☐
C. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 - Code of Federal Regulations Section 1001.1001 or 1001.201? Yes ☐ No ☐
D. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? Yes ☐ No ☐
E. Has the facility ever had the State license involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the State license in anticipation of any of these actions; or are any of these actions pending with respect to the State license? Yes ☐ No ☐
F. Has the facility ever been charged, suspended, fined, disciplined, or otherwise sanctioned, submitted to probationary conditions, restricted or excluded, or has the facility voluntarily relinquished eligibility to provide services or accepted conditions on its eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? Yes ☐ No ☐
G. Has the facility had its membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public programs), medical society, professional association or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? Yes ☐ No ☐
H. Has the facility ever had any other regulatory agency (OSHA, etc.) deny, revoke, suspend, not renew, place under probation, subject to disciplinary action or otherwise limited or curtail operations; or are any actions pending from any other regulatory agency? Yes ☐ No ☐
I. Has the facility ever had accreditation by an organization (CLIA, JCAHO, etc.) involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the accreditation in anticipation of any of these actions; or are any of these actions pending with respect to any such accreditation? Yes ☐ No ☐
J. Has the facility ever been placed under temporary government ordered management? Yes ☐ No ☐
K. Has the facility ever permitted the appointment of a receiver for its business or its assets? Yes ☐ No ☐
L. Do you understand that subject to proper confidentiality restrictions and authorizations, medical records might be subject to on site review by CenCal Health representatives for peer review, utilization review, and quality assurance purposes? Yes ☐ No ☐
M. Does the facility currently participate or have you ever participated as a provider in the Medi-Cal program or in another state's Medicaid program? Yes ☐ No ☐
N. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? Yes ☐ No ☐

I hereby affirm that the information submitted to CenCal Health and any addenda thereto is true, current, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Services Agreement.

Print Name: _____

Signature: _____ **Date:** _____

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INFORMATION RELEASE/ACKNOWLEDGEMENTS

I hereby consent to the disclosure, inspection and copying of information and documents relating to the credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any re-credentialing application regarding applicant organization. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of applicant organization qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to applicant organization participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that as an applicant, the applicant organization has the burden of producing adequate information for proper evaluation of professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or non-renewal of license to practice medicine in California; (ii) any cancellation or non-renewal of professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against applicant organization by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting license to practice medicine; or (ii) any adverse action against applicant organization by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) any material reduction in professional liability insurance coverage; or (iv) receipt of written notice of any legal action against applicant organization, including, without limitation, any filed and served malpractice suit or arbitration action; or (v) receipt of written notice of any adverse action against applicant organization under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I hereby affirm that the information submitted in this application and any addenda thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of the application or termination of the Services Agreement. A photocopy of this document shall be as effective as the original; however, original signatures and current dates are required on all pages.

Print Name Here: _____ **Organization Name:** _____

Signature _____ **Date:** _____

New Provider Training
Attestation Form

Practice Name: _____

By signing below, I am acknowledging having received the below information as part of CenCal Health's new provider orientation. I understand that this information is always available to me within the CenCal Health Provider Manual, via the New Provider Orientation training videos located online at www.cencalhealth.org/providers/welcome-to-the-network, and through the Provider Relations Department.

A. Overview of CenCal Health

- ✓ Summary of Managed Care
- ✓ CenCal Health Programs
- ✓ Acronyms
- ✓ Provider Communication

B. Standard Training Material

- ✓ Member Eligibility
- ✓ Covered Services and Carved Out Services
- ✓ Member Access (including appointment waiting time standards and ensuring telephone translation and language access)
- ✓ Required Preventive Services [including Early, Periodic Screening, Diagnosis and Testing (EPSDT)] services for Members less than 21 years of age
- ✓ Coordination of Care and Referrals (including non-covered services)
- ✓ Radiology Benefit Manager (RBM)
- ✓ Medical Record Documentation and Coding Requirements
- ✓ Prior Authorization and Utilization Management (including policies and procedures for clinical protocols governing Referral Authorization Forms (RAFs) & Treatment Authorization Requests (TARs)
- ✓ Mental Health & Behavioral Health Therapy Benefit [includes Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS), Substance Use Disorder (SUD) and Intellectual and Developmental Disabilities (IDD)], and children with special health care needs
- ✓ California Children's Services (CCS) and Whole Child Model (WCM)
- ✓ Regional Centers (including Tri-Counties Regional Center)
- ✓ Child Health and Disability Prevention Program (CHDP)
- ✓ Seniors and Persons with Disabilities (SPD)
- ✓ Members with chronic conditions
- ✓ Cultural Linguistics, Interpreter Services, Alternative Format Selection and Language Requirements
- ✓ Pharmacy
- ✓ Grievance and Appeals Policies and Procedures
- ✓ Member Rights and Responsibilities
- ✓ Diversity, Equity, and Inclusion (DEI) (including sensitivity, diversity, communication skills, cultural competency, health needs for various populations, Social Drivers of Health and disparity impacts on Member's health care) – *Coming Soon!*
- ✓ Quality Improvement and Health Equity Transformation Program
- ✓ Population Health Management Program
- ✓ Health Education Resources
- ✓ Provider and Member Incentive Programs, as applicable

C. Information/Data Sharing

- ✓ Secure Data Sharing Methods
- ✓ Member and Member Care Team Contact Information

D. Data Collection and Reporting Requirements

E. Website Demonstration

- ✓ Online Provider Directory
- ✓ Contracted Provider List (PDF)
- ✓ Provider Manual
- ✓ Transaction Services
- ✓ Provider Portal

In addition to the above topics, CenCal Health provides additional information to Primary Care Providers (PCPs), including:

- ✓ Facility Site Review
- ✓ Incentive Programs
- ✓ Reports available for Primary Care Providers

_____ _____
Signature Date

_____ _____
Print First & Last Name Group Billing NPI#

_____
Title

☐ Our practice, including Practitioners and Medical Staff, acknowledges and confirm(s) to have received Cultural Competency, Health Literacy & Linguistics training and Seniors and Persons with Disabilities (SPD) Sensitivity training resources located online at cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/

Please list all Rendering Practitioners within your organization that received these training resources below. This applies to newly joining physicians to your organization, and/or being re-credentialed with CenCal Health.

_____ _____
Signature Date

_____ _____
Print First & Last Name Practitioner NPI#

_____ _____
Signature Date

_____ _____
Print First & Last Name Practitioner NPI#

_____ _____
Signature Date

_____ _____
Print First & Last Name Practitioner NPI#

Signature ______________________ Date ______________

Print First & Last Name ______________________ Practitioner NPI# ______________

Signature ______________________ Date ______________

Print First & Last Name ______________________ Practitioner NPI# ______________

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Print First & Last Name ______________________ Practitioner NPI# ______________

Signature ______________________ Date ______________

Print First & Last Name ______________________ Practitioner NPI# ______________

Signature ______________________ Date ______________

Print First & Last Name ______________________ Practitioner NPI# ______________