In-Home Infusion and/or Specialty Pharmacy Onboarding Packet

Thank you for your interest in joining the CenCal Health provider network. We greatly value your partnership in better serving our community. CenCal Health credentials all In-Home Infusion and/or Specialty Pharmacies who provide services to our members. Enclosed is a credentialing application and additional documents required to begin the onboarding process. Please complete the packet in its entirety.

The following must accompany your application:

- □ Copy of all applicable required state and local facility licensure and permits
- □ Copy of current Pharmacy DEA Registration
- □ Copy of Board of Equalization Permit
- □ Copy of Pharmacist in Charge (PIC) Registration
- □ Copy of Seller's Permit
- □ Copy of Accreditation (if applicable)
- □ Copy of California Medicaid (Medi-Cal) participation approval
- □ Proof of facility Commercial General Liability coverage
- □ Proof of facility Professional Liability coverage (if applicable)
- □ New Provider Training Orientation Attestation

Medi-Cal Enrollment is Separate and Required
Beginning January 1, 2018, federal law requires that all non-exempt providers of services to Medi-Cal recipients must be screened and enrolled as Medi-Cal providers by the Department of Health Care Services (DHCS). This is a requirement in addition to CenCal Health's onboarding and credentialing process. Please find more information about the Medi-Cal enrollment process on our website here.

All provider credentialing applications are reviewed by the CenCal Health Credentials and Peer Review Committee or a Medical Director. To ensure timely processing of your application, please complete and return all documents listed above as soon as possible. Forms may be submitted in the following ways:

Mail: CenCal Health, Attn: Provider Services Department
4050 Calle Real, Santa Barbara, CA 93110
Email: provideronboarding@cencalhealth.org
Fax: (805) 681-3033

We appreciate your cooperation during the onboarding process. If you have any questions, please contact us at the above email.

Thank You,

CenCal Health – Provider Services Department

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INDEPENDENT PHARMACY APPLICATION AND INITIAL CREDENTIALING VERIFICATION FORM

PHARMACY DEMOGRAPHIC INFORMATION

Pharmacy Name:		
Pharmacy NCPDP #:	Pharmacy Federal Tax ID #:	
Physical Address:		
City:	State:	ZIP Code (+4): -
Phone #:	Fax #:	
Remittance Address:		
City:	State:	ZIP Code (+4): -
Phone #:	Fax #:	
Does your pharmacy have Internet access? Yes ☐ No ☐	E-Mail Address:	

PHARMACY LICENSING/CERTIFICATION INFORMATION

State Pharmacy License #: *(Submit valid copy of document)*	Pharmacy License Expiration Date: / /
Pharmacy DEA Registration #: *(Submit valid copy of document)*	Pharmacy DEA Expiration Date: / /
Board of Equalization Permit #: *(Submit valid copy of document)*	Board of Equalization Expiration Date: / /
Medicare Provider # (if applicable):	Medicaid/Medi-cal Provider #:
Liability Insurance Carrier:	
Liability Insurance Policy #: *(Submit valid copy of document)*	Liability Insurance Expiration Date: / /
Amount Per Occurrence: $	Aggregate: $

PHARMACY STAFF INFORMATION

Pharmacist in Charge (PIC):	
PIC Registration #: *(Submit valid copy of document)*	PIC Registration Expiration Date: / /

** *CA ONLY:* ***Pharmacist in Charge must submit copy of completed and signed Page 1 of State Board of Pharmacy Self-Assessment form*** **

Additional Licensed Staff:

Name: _____ Lic. #: _____ Expiration Date: _____

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PHARMACY HOURS OF OPERATION/SERVICES

Mon: Tue: Wed: Thu: Fri: Sat: Sun:

Holidays:		Open 24 Hours?:	Yes ☐ No ☐
Accept Medicare Assignment?:	Yes ☐ No ☐	Drive Thru services?:	Yes ☐ No ☐
Ability to accept electronic prescriptions?:	Yes ☐ No ☐	Emergency Rx services provided?:	Yes ☐ No ☐
Automatic dispensing units?:	Yes ☐ No ☐	Handicap Accessible?:	Yes ☐ No ☐
Compounded prescriptions?:	Yes ☐ No ☐	Home Infusion Provider?:	Yes ☐ No ☐
Consultation services provided?:	Yes ☐ No ☐	Personal medication records?:	Yes ☐ No ☐
DME Provider?:	Yes ☐ No ☐	Refill notification?:	Yes ☐ No ☐

Prescription Delivery services?: Yes ☐ No ☐ Delivery Radius: miles Delivery Fees:

Languages spoken by staff:

PHARMACY POLICY AND PROCEDURES

Return to Stock Policy: Yes ☐ No ☐

Please provide brief explanation here or attach written policy:

HIPAA Policy and Procedures: Yes ☐ No ☐

Please provide brief explanation here or attach written policy:

ADDITIONAL PHARMACY INFORMATION

Has the license of the pharmacy(ies) been suspended or revoked in the past? ***If yes, please attach written explanation.***	Yes ☐ No ☐
Have any complaints and/or sanctions against the pharmacy(ies) been recorded by the State Board of Pharmacy? ***If yes, please attach written explanation.***	Yes ☐ No ☐
Has the pharmacy(ies) had any sanctions or other disciplinary action taken against it by Medicare/Medicaid? ***If yes, please attach written explanation.***	Yes ☐ No ☐
Has the DEA registration of the pharmacy(ies) been suspended or revoked in the past? ***If yes, please attach written explanation.***	Yes ☐ No ☐
Has the pharmacy(ies) been named in any professional liability judgments or settlements in the past 5 years? ***If yes, please attach written explanation (include settlement amounts and dates).***	Yes ☐ No ☐

Date of the most recent site visit by the State Board of Pharmacy: / / ***Please submit copy of site visit record.***

SIGNATURE

All information submitted in this application, as well as any attachments or supplemental information, is true, current, and complete to the best of my knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

I specifically authorize CenCal Health to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on the pharmacy and/or its licensed staff's professional credentials as well as to inspect or obtain any and all communications, reports, records, statements, documents, recommendations, and/or disclosures of said third party relating to such questions. I also specifically authorize said third parties to release said information to CenCal Health.

Signature:	Date:
Print Name:	Title:

New Provider Training Attestation Form

Organizational 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 Operations Guide**, online at **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) Training
- 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, Data Collection, and Reporting Requirements

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

D. 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

Training Acknowledgment & Attestation

Signature _____ Date _____

Print First & Last Name _____ Group Billing NPI# _____

Title _____ Practitioner NPI# (if applicable) _____

○ Our practice, including Practitioners and Medical Staff, acknowledges and confirm(s) to have received all CenCal Health Provider Regulatory Training resources.

Please provide a list all Rendering Practitioners within your organization who have completed these training resources. This applies to newly joining physicians to your organization, and/or being re-credentialed with CenCal Health. If you are using a Roster, please leave this section blank.

Print First & Last Name _____ Date _____

Practitioner NPI# _____

(continue to next page)

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

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