sunshine health

Facility & Ancillary Application

This application is to be utilized exclusively by Facility and Ancillary providers wishing to participate with the plan.

Application being submitted:

☐ Initial Credentialing ☐ Recredentialing ☐ Addition of a new site to current contract

Instructions:

Please type or print legibly when completing this form. If you need more space or have more additional locations, attach additional sheets and reference the question being answered. To assist in the timely processing of your application, we have provided the following checklist of documents necessary to complete your application packet for review.

Application Checklist:

☐	Copy of all Federal, State, and/or local licenses required to operate the facility
☐	Current Malpractice Coverage
☐	Completed W9 Form
☐	Disclosure of Ownership Statement
☐	A completed and signed Sunshine Health application and attestation forms
☐	Copy of the most recent accreditation certificate, if applicable, for the institution. • If the institution is not accredited, please attach a copy of the most recent State or Medicare site survey results. • If the institution has never had a site survey performed by Medicare or the State; Sunshine Health must complete a site survey before the facility can be credentialed.

If information is missing, a Sunshine State Health Plan (Sunshine Health) Provider Representative will notify the applicant of receipt of missing or incomplete application elements. Applicants have thirty (30) days from the date of submission to provide all missing elements to Sunshine Health. If all elements have not been submitted within the 30-day timeframe, the application will be closed as incomplete. Once your credentials have been verified, the Sunshine Health Credentialing Committee will review your application and you will be notified of our decision in writing. The Credentialing Committee meets monthly to review completed files and determine provider participation status.

During the credentialing and recredentialing process, Sunshine Health obtains information from various outside sources to evaluate your application. You have the right to review any primary source information that Sunshine Health collected during this process, this does not include information that is considered peer review protected.

You also have the right to request the status of your application at any time during the credentialing/recredentialing process. Requests for primary source verification documentation must be submitted in writing directly to Sunshine Health, Attn: Credentialing Department P.O. BOX 459089, Ft Lauderdale FL 33345-9089

Children's Medical Services Health Plan
OPERATED BY SUNSHINE HEALTH

sunshine health

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Facility credentialing is required for the following facility types – Choose all that apply:

☐	Ambulatory Surgery Center		☐	Hospital (Acute, Critical, or Rural)
☐	Adult Living Facility		☐	Hyperbaric Center
☐	Birthing Center		☐	Laboratory
☐	Diagnostic Imaging Center		☐	Orthotics/Prosthetics
☐	Dialysis Center		☐	Rehabilitation Center
☐	Durable Medical Equipment (DME)		☐	Skilled Nursing Facility
☐	Home Health Agency		☐	Sleep Disorder Center
☐	Hospice		☐	Other:

Please indicate services provided at the facility:

☐	Cardiac Catheterization Service		☐	Other Services – List Below:
☐	Cardiac Surgery Program			
☐	Critical Care – Intensive Care			
☐	Diagnostic Imaging Center			
☐	Emergency Services			
☐	Infusion Therapy			
☐	Laboratory Services			
☐	Mammography			
☐	Maternity Care			
☐	Mental Health Care			
☐	Oncology Services			
☐	Pharmacy			
☐	Physical Therapy & Rehab Services			
☐	Pediatric Specialty Care			

sunshine health

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I. Facility Information

Legal Business Name:			
Doing Business as (DBA) Name:			
Tax Identification #:		Type 2 NPI #:	
Medicaid Provider #		Medicare Provider #:	
Address:			

City:		State:		Zip Code:	
Phone #:		Fax #:			

Accepting new patients?	☐Yes ☐ No	Is the facility open at least five (5) days per week?	☐Yes ☐ No

** Please note: A separate application must be completed for each facility with a unique Federal Tax ID and/or site address.*

Hours of Operation:

Mon	Tue	Wed	Thurs	Fri	Sat	Sun

Age Groups Treated						
☐ 0 -12 years	☐ 13-17 years	☐ 18-64 years	☐ 65 +	☐all ages	☐ Other:	

Is facility handicapped accessible?	☐ Yes ☐ No

Language(s) spoken by the practitioner or clinical staff *(other than English)*:

Identify the percentage of your practice dedicated to the following patient population:					
Medicare FFS		Medicare Managed Care		Medicaid Managed Care	
Medicaid FFS		Commercial HMO/PPO/POS		Self-Pay	

Under what specialty do you choose to be listed in the directory at this location?

sunshine health

Facility & Ancillary Application

II. Licensure

State License #:		Expiration Date:	
DEA#:		Expiration Date:	

III. Malpractice Insurance - attach current copy of declaration page

Current Professional Carrier:			
Address and phone number of carrier:			
$ Amount per Occurrence:		$ Amount per Aggregate:	
Date of Coverage from:		Date of Coverage to:	

IV. Accreditation and/or Certification - attach current copy if applicable

If the institution is not accredited, please include a copy of the most recent State or Medicare site survey results. If the institution has never had a site survey performed by Medicare or the State; Sunshine Health must complete a site survey before the facility can be credentialed.

Agency Name	Acronym	Accredited Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Board for Certification in Orthotics & Prosthetics	ABCOP		
American College of Radiology	ACR		
American Osteopathic Hospital Association	AOHA		
Board of Orthotist/Prosthetist Certification	BOCUSA		
Commission on Accreditation for Rehab Facilities	CARF		
Clinical Laboratory Improvement Act	CLIA		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
The Joint Commission	TJC		
National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission	URAC		
State Facility Operating License	N/A		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
Det Norske Veritas Healthcare Accreditation	DNV		
Others (please list)			

sunshine health

Facility & Ancillary Application

V. Sanctions & Attestation – If you answer yes to questions 1 through 7 below, please explain on a separate sheet.

1.	Has the facility ever or currently have any pending claims, suits, settlements or proceedings excluding medical malpractice?	☐Yes	☐ No
2.	Has the facility ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐Yes	☐ No
3.	Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct?	☐Yes	☐ No
4.	Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payor, or a Regulatory Agency?	☐Yes	☐ No
5.	Has an officer of the facility ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?	☐Yes	☐ No
6.	Has the corporation, an officer or a board member ever been convicted of a felony?	☐Yes	☐ No
7.	Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?	☐Yes	☐ No
8.	Had the facility attested to Meaningful Use of EHRs?	☐Yes	☐ No
9.	Does the facility currently use an Electronic Health Record (EHR)?	☐Yes	☐ No
10.	Is the facility currently participating in Florida's Health Information Exchange (HIE)?	☐Yes	☐ No
11.	I attest that all personnel/FDRs have participated in the fraud, waste and abuse awareness compliance training (FWA) as required by the final rules in 42 CFR Parts 422.503 and 423.504. (Required for All Facility Types)	☐Yes	☐ No
12.	I attest that staff has received appropriate training in reporting abuse, neglect and exploitation (ANE) and will report knowledge or reasonable suspicion of these activities via the Florida abuse statewide toll free hotline (1-800-96-Abuse) in accordance with F.S. 415	☐Yes	☐ No

I certify that I have answered all the questions on the application truthfully, correctly and completely.

Provider Signature: ______________________________ Date: ____________

Provider Name (print): ______________________ Title: ______________

sunshine health

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VI. Provider Responsibility Form

I hereby understand that as a prospective/current Sunshine Health provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunshine Health Credentials Committee for their review and approval, and, absent such affirmative approval, Sunshine Health members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunshine Health. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunshine Health in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunshine Health credentials/recredentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, AHCA, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

Facility & Ancillary Application

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Facility Name: ______________________________ Date: ____________

Signature of Provider or Authorizing Representative: ______________________________

Title: ______________________________

Print or type name: ______________________________