Evernorth Behavioral Health, Inc.
Ancillary Provider Credentialing Attestation Form

EVERNORTH℠

CLEAR FORM

DIRECTIONS:
To avoid the potential loss of data, please complete the following steps and submit this form.

Step 1: Save this form to your computer
Step 2: Complete the form in its entirety using Adobe Acrobat Reader DC
Step 3: Save the completed form to your computer
Step 4: Submit the saved form to your Evernorth Contractor

Entity Information

Legal or Corporate Name *(as listed on W-9)*:

d/b/a if applicable:

Ownership

Date organization established:	**Date entity opened:**

If Physician owned, please specify physician(s) names *(California only)*:

Please list parent company or companies:

Directory Information

Primary Service Location:

Location Name:

Street Address:

City:	**State:**	**Zip Code:**
County:	**Phone Number:** ( )	**Fax Number:** ( )

Primary Billing Information:

Location Name:

Tax ID Number:	**NPI Number:**

Street Address:

City:	State:	Zip Code:
County:	Phone Number: ( )	Fax Number: ( )
Medicare Number:	Medicaid Number:	

Accreditation

Please indicate if organization is accredited.
****Indicate all that apply and attach proof for each site or specify if accreditation applies to all sites****

Accreditation/Certification Information:

- ☐ The Joint Commission (TJC)
- ☐ AAAHC
- ☐ CCAC
- ☐ CLIA – specific to FA/AN Laboratory
- ☐ COA
- ☐ Det Norski Veritas (DNV)
- ☐ CHAP
- ☐ ACHC
- ☐ CAP
- ☐ None
- ☐ American Osteopathic Association (AOA)
- ☐ CARF
- ☐ ACR
- ☐ COLA
- ☐ Medicare (CMS) Certification or Medicaid-only CMS Certification Number (CCN) *[or explanation of why this cannot be provided]*

Date of last accreditation/Certification: _____ **Expiration date of accreditation:** _____

Does your organization have a contract with a Federal Patient Safety Organization? ☐ Yes ☐ No
If yes, what organization? _____

Has the facility ever applied for and been denied accreditation or certification by any accrediting/certifying organization? ☐ Yes ☐ No
If yes, please explain:

Are there any contingencies or significant recommendation(s) from your last survey? ☐ Yes ☐ No
If yes, please explain:

If not accredited, please attach copy of last full state or Medicare survey results. If deficiencies were noted, provide a copy of the corrective action plan and confirmation of acceptance of the corrective action plan by the surveying entity.

Date of last full State/CMS survey: _____

Corrective Action Required? ☐ Yes ☐ No

Licensure

Please provide information for all of your State/Federal licenses and attach copies of current licensure.
If licensure is not required, please note.

Licensure Type: _____	**Expires:** _____	☐ N/A
Licensure Type: _____	**Expires:** _____	☐ N/A
Licensure Type: _____	**Expires:** _____	☐ N/A
Licensure Type: _____	**Expires:** _____	☐ N/A

Has the facility's license been suspended, revoked, made subject to probationary conditions or otherwise adversely affected? If Yes, please submit explanation. ☐ Yes ☐ No

Are any such proceedings currently pending? ☐ Yes ☐ No

Internal Processes

Is there a process for assessing the professional qualifications, licensure and lack of Medicare Sanctions/inclusion on the state abuse list prior to hiring new staff?	☐ Yes ☐ No
Does the organization monitor professional staff for current and unencumbered licensure on an ongoing basis?	☐ Yes ☐ No
Are professional staff required to participate in continuing education or provided with additional training opportunities after hire?	☐ Yes ☐ No
(Please complete if the entity provides behavioral telehealth/virtual services.)	
Does the entity and its professional staff meet all requirements to provide behavioral telehealth/virtual services, including any licenses or certifications?	☐ Yes ☐ No
The entity agrees to provide behavioral telehealth/virtual services only in state(s) where licensed and that they are appropriately licensed and/or certified to provide services in each state where patients are physically located at the time of treatment.	☐ Yes ☐ No

Quality/Utilization Review

(Please complete if not accredited or certified & submit copy of most recent QA/QI evaluation and plan)	
Are the credentials/certifications of professional staff members and physicians verified?	☐ Yes ☐ No
How frequently are credentials/certifications verified?	
Is continuing education required of your staff?	☐ Yes ☐ No
Is there a formal patient satisfaction or patient advocacy program?	☐ Yes ☐ No
Does the entity have a written quality assurance/quality improvement (QA/QI) plan? **If yes, how frequently does the QA/QI Committee meet?** _____	☐ Yes ☐ No
Has the facility ever been denied membership or renewal or been reprimanded, censured, suspended, terminated, placed on probation or otherwise sanctioned, by any healthcare organization, including but not limited to hospitals, community health facilities, other healthcare facilities, HMOs, PPOs, professional associations or peer review organizations? **If yes, please explain:**	☐ Yes ☐ No

Liability Insurance Information-Current (Provide copy with application)			
General:		**Professional:**	
Name of <u>General</u> Liability Carrier:		**Name of <u>Professional</u> Liability Carrier:**	
Carrier Address:		**Carrier Address:**	
Carrier Telephone Number: **( )**	**Carrier FAX Number:** **( )**	**Carrier Telephone Number:** **( )**	**Carrier FAX Number:** **( )**
Policy Number:		**Policy Number:**	
Expiration Date:		**Expiration Date:**	
Amount of Liability Coverage *(Occurrence/Aggregate)*:		**Amount of Liability Coverage** *(Occurrence/Aggregate)*:	

Liability Insurance Information: Historial
Must have answers to each question below.
Number of prior judgments or settlements against the facility in the past five (5) years:
Please list, by year, the number of suits in which you were a defendant with allegations of malpractice or liability for the past five (5) years Please <u>submit brief explanation</u>, status of case(s) (i.e. pending, settled, judgment, etc.) and the amount of any settlements or judgments, if applicable. If none, must write "None" below.
Has the facility ever been denied professional or general liability insurance? **If yes, <u>please submit explanation</u>, if none; please answer "None" below.**
Has the facility's professional or general liability insurance been cancelled or denied renewal? **If yes, <u>please submit explanation</u>, if none; please answer "None" below.**

Before you complete and sign below, be sure to check your application for completeness and correctness. Incomplete or missing information will delay the processing and approval of your application.

Attestation, Certification and Authorization

For purposes of making this application for participation in the Evernorth (the Plan) provider network(s), I certify that all information provided on behalf of this Organization is true and correct to the best of my knowledge and belief. I agree to notify the Plan within 15 days of any material changes to the information provided in this application. I understand and agree that if the Plan determines, in its sole discretion that this application contains any intentional or significant misstatements or misrepresentations or omissions, the Plan's acceptance of this application for participation and any subsequent participating provider agreement which the Plan enters into with the Organization will be void.

On behalf of the Organization, I hereby authorize the release to the Plan of any information held by any person, entity or governmental agency which in his/her/it's official capacity has information relevant to the evaluation of this original application or any recredentialing information. On behalf of the Organization, I agree to hold any such person, entity or governmental agency providing the Plan with such information harmless from any liability to the organization for providing such information.

On behalf of the Organization, I hereby further authorize the Plan to release any and all information related in any way to the Organization, to any person, entity or governmental agency which a) provides the Plan with an authorization signed by me or another representative of the Organization; or b) has a legal right to know under state or federal law. The Organization agrees to hold the Plan harmless of any liability for providing any such information as specified herein.

I understand and agree that the certifications, authorizations and other provisions contained herein shall remain in force so long as this application is pending and, if accepted for participation, for so long as the Organization's participating provider agreement with the Plan remains in force.

I also understand and agree that: a) the Organization has the burden of producing all information required or requested by the Plan in connection with this application; b) the Plan is under no obligation to complete the processing of this application until such information is provided by the Organization; and c) the Plan has the sole discretion to determine whether or not the Organization will be accepted as a participating provider.

Print signer's name: _____	Signature _____
Title: _____	Date: _____

CLICK TO PRINT