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APPLICATION FOR INITIAL CREDENTIALING for ALLIED HEALTH PROFESSIONALS (AHP) to the OhioHealth Clinically Integrated Network (CIN)

** The AHP applicant must be employed by a physician/practice currently participating in the Clinically Integrated Network.

Providers eligible to apply with these health plan(s) are defined as the following:

- ☐ Audiologist
- ☐ Dietician
- ☐ Speech Therapist/Speech-Language Pathologist
- ☐ Physician Assistants
- ☐ Certified Nurse Practitioners
- ☐ Certified Nurse Midwife
- ☐ School Psychologist
- ☐ Certified Registered Nurse Anesthetist
- ☐ Clinical Nurse Specialists
- ☐ Licensed Independent Social Worker
- ☐ Licensed Professional Clinical Counselor
- ☐ Licensed Independent Marriage & Family Therapist
- ☐ Licensed Independent Chemical Dependency Counselor

Once a complete application is received, the initial credentialing process can take up to 60 days to complete. **Please note: this timeframe does NOT include applicable committee meeting dates, at which applications are approved.**

There are **three steps** that must be completed in order to proceed with the applicant's credentialing:

1. The enclosed application must be completed in its entirety
2. The online CAQH application must be completed and/or updated via the CAQH website
3. Provider agreements/addendums for the CIN must be signed and returned

Submit your completed application in one of the following ways:

- Fax your documents to 614-566-0401 to the attention of OhioHealth Credentialing Services (OHCS)
- Email your documents to OhioHealthCredentialing@ohiohealth.com

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AHP APPLICANT CHECKLIST

It is the applicant's responsibility to ensure that he/she is completing the most current version of the application and provider agreements. Outdated versions of the application and/or provider agreements will not be accepted.

Please utilize this checklist as a tool for completing the application. The detailed notes are meant to assist you with the pertinent information that must accompany the application. The documents listed below are considered to be, in their entirety, your credentialing application. Please note that your application will not be considered or processed until all of these documents are completed, as instructed, and received.

❑ **Completed CAQH Application**

- The CAQH has been updated and re-attested within the past 4 weeks from the date the applicant applied for credentialing with the CIN.
  - In addition to completing the entire application, please ensure that the CAQH application documents what group (Tax ID) the applicant is joining/getting credentialed for.
- CAQH includes all state license(s) numbers, DEA Registration numbers and current insurance. The CAQH application must indicate if any of these documents are pending.
  - The applicant's DEA must have an Ohio address and considered to be "fee paid" before the applicant is scheduled to start working. (This rule does not apply to locum tenens and telemedicine physicians)

❑ **Gap in Timeline** – all gaps in the applicant's professional timeline that span greater than 6 months require an explanation

❑ **Current Malpractice Insurance Face Sheet** (if available at the time of submitting the application) – the policy must document the provider's name on either the actual face sheet or an attached roster. Documentation of current malpractice insurance is necessary in order to complete the file but not required at the time of submission.

❑ **<u>Current</u> copy of the Curriculum Vitae / Resume**

- Start and end dates for Education and Work History must be in **month/year** format

❑ **Completed OhioHealth Clinically Integrated Network provider addendum**

- Page 1: The date that needs to be populated on the first page of the addendum is the date that the applicant signs the addendum.
- Page 3: Check mark type of healthcare professional
  - APPs need to list all supervising or collaborating physicians that are credentialed or will be credentialed with the CIN. These physicians <u>are not required</u> to be in the same group to which the applicant is getting credentialed but are required to be in the CIN.
  - Behavioral Health Specialists need to list at least one collaborating physician in his/her practice (same TIN).

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AHP APPLICANT CHECKLIST – CONTINUED

❑ **Unique Provider Email address**

- OhioHealth communicates pertinent information via email. This email address is NOT shared with patients. **Your unique email address must belong to you specifically and cannot be your office manager.**

❑ **Unique Provider Cell Phone number**

- OhioHealth requires a cell phone number to obtain remote access to OhioHealth computer systems.

❑ *If applicable*: A **W-9** for verification of each tax identification number (TIN) used for the practice that the applicant will be working under *if* the group that is applying for credentialing is considered to be a new group to OHCS.

Voluntary Form for Submission

❑ OhioHealth Self-Disclosure of Race and Ethnicity

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Applicant Email Address

Please provide the applicant's unique email address. OhioHealth communicates pertinent information via email. This email address is NOT shared with patients. **Your unique email address must belong to you specifically and cannot be your office manager.**

Providing a unique email address is a requirement for getting credentialed into the CIN. Failure to provide a unique email address will result in your application being deemed incomplete.

Applicant Email Address: _____

Applicant Cell Phone Number

Please provide the applicant's cell phone number. This information is required to obtain remote access to OhioHealth computer systems.

Cell Phone #: ( ) _____

OHCS – Notification of Practitioner Rights

- Practitioners have the right to be informed of the status of their credentialing or reappointment application upon request.
- Practitioners have the right to review information obtained and used for purposes of credentials evaluation with the exception of professional references and/or any other type of information that is deemed to be privileged and confidential and/or is protected under Ohio peer review statute.
- Practitioners have the right to correct information collected from outside sources that is erroneous. Corrections to erroneous information must be made in writing and sent to OHCS within 15 days of notification that erroneous information has been received.
- Practitioners have the right to copy only documents in their file which they have submitted with regard to their application.
- Practitioners have the right to be credentialed in a non-discriminatory manner based upon race, gender, nationality, origin, and/or religion.

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Completing CAQH Online Application

The CAQH application is an online service where practitioners can provide standardized credentialing information to multiple organizations without filling out multiple forms. By signing the CAQH Standard Authorization, Attestation and Release form you understand the term "Entity" applies to any of the entities that OHCS provides credentialing services on your behalf.

If you have any questions regarding your CAQH ID number, username, password, an incomplete application, unapproved document, etc., please refer to the CAQH website at https://proview.caqh.org or call the CAQH Help Desk at 1-888-599-1771. New users can also register on the CAQH website by clicking on "Self-Register." The CAQH ID Number will be sent to the email address provided during registration.

- If you are already a CAQH Provider, list your ID. My CAQH Provider ID Number is: _____

- If you do NOT have a CAQH ID number, you are able to self-register on the CAQH website. The Provider Registration Email with the ID Number will be sent to the primary method of contact email address set up at time of registering. Make sure to list your ID Number above for credentialing.

THE CAQH ONLINE APPLICATION MUST BE COMPLETED IN ITS ENTIRETY OR THE APPLICATION WILL BE DEEMED INCOMPLETE BY OHIOHEALTH CREDENTIALING SERVICES. PLEASE MAKE SURE THAT THE CAQH APPLICATION IS REFLECTIVE OF ANY NEW ACTIVITY (PRACTICE LOCATION, CURRENT MALPRACTICE CLAIMS, HOSPITAL AFFILIATIONS, ETC.)

Provider Information Specific to Credentialing

Applicant Name _____ Degree _____

Name of Your Current Primary Hospital _____

Will your primary hospital named above change once you are credentialed with this group? ◯ NO ◯ YES

*If yes, name of upcoming Primary Hospital_____

Practice Name: **Midwest Physician Anesthesia Services, Inc** Tax ID: **31-1039177**

Practice Manager: **Pam Brown** Group NPI: **1598703951**

Credentialing Contact: _____ Phone Number: ( )**614-884-0641** ext. _____

Credentialing Contact's Email Address: **Credentialing@mpasohio.com**

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Helpful Instructions for Completing the CAQH Application

If applicants have any questions regarding their CAQH ID number, username, password, an incomplete application, unapproved document, etc., please refer to the CAQH website at https://proview.caqh.org or call the CAQH Help Desk at 1-888-599-1771. New users can also register on the CAQH website by clicking on "Self-Register."

Steps to complete the CAQH Application

1. **General Info:** Enter identification information in every section of the online application.
2. **Credentialing Contact:** This is the person responsible for credentialing at the practice the applicant is joining (if a solo practice, please enter the applicant's information).
3. **Practice Info:** We need to know what group (Tax ID) the applicant is joining – specifically – start date, group name, Tax ID, and primary and billing addresses. Please note, a primary address cannot be a home address. If there are issues with the current practice's knowledge of the applicant leaving, please contact the OhioHealth Credentialing Services office at 614-566-0010 for assistance.
4. **Malpractice Claims:** List any pending and/or settled malpractice claims. All claims against the applicant within the last 10 years, regardless if they are pending or settled, must be listed on the CAQH Application.
5. **Review:** Once all data entry is complete, the data needs to be audited. If any required fields are missing information, these need to be completed before progressing.
6. **Attest:** Once the audit is complete, the applicant needs to attest the application. Then, the data will be "entered" and appear complete.
7. **Supporting Documents:** After completion, the applicant needs to upload any required supporting documents directly into the system. This includes the Attestation & Release and any other documents based on the data entry such as DEA and Malpractice.
8. **Activity Log:** Documents can also be uploaded as the application is being completed. To do so, follow these steps:
    a. The "Documents" or "Review" pages will inform the applicant what documents are needed to complete the application.
    b. Upload the supporting documents (ex. Attestation & Release, DEA certificates, Malpractice) directly to CAQH ProView by following the instructions.
9. **Completion:** Once the application is complete and the supporting documents are reviewed for accuracy, the applicant's information will become available to the organizations that were authorized. The applicant needs to check with each individual organization to determine his/her credentialing status. If a document is not approved, an email will be sent to the user, indicating that the application is incomplete.
10. **Re-Attesting:** The CAQH application needs to be **re-attested every 120 days** to retain a "current" status. If the application does not remain current, it will change to an "expired" status and any entity the applicant participates with will be unable to process the application. The profile can be updated by clicking on "Manage Information," upload new documents by clicking on "Documents," and finish by clicking on "Attest."

If the applicant is coming from out of state, he/she must also change the primary practice state to Ohio.
In the beginning of the application process, there is a section for the provider type and primary practice state. Please list Ohio. Some states have a state mandated application, and, in that instance, we cannot credential the applicant until an Ohio application is accessible. Please note the applicant will be required to also sign/date and fax an updated Attestation & Release form if coming from out of state. ***Failure to do this will delay the credentialing process.***

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VOLUNTARY SELF-DISCLOSURE OF RACE AND ETHNICITY

To assess the diversity of its provider workforce (independent and employed) OhioHealth requests each applicant to self-disclose his/her race and ethnicity. Self-disclosure, while important, is not required for credentialing.

Refusal to complete this information will NOT subject you to adverse treatment. The information you provide is confidential and will be kept separate from your other credentialing information. This information will not be considered in making any decisions regarding your credentialing.

Race & Ethnic Identification

☐ **Hispanic or Latino**
A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture origin, regardless of race.

☐ **White (Not Hispanic or Latino)**
A person having origins in any of the original peoples of Europe, the Middle East or Asia.

☐ **Black or African American (Not Hispanic or Latino)**
A person having origins in any of the Black racial groups of Africa.

☐ **Native Hawaiian or Other Pacific Islander (Not Hispanic or Latino)**
A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

☐ **Asian (Not Hispanic or Latino)**
A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

☐ **American Indian or Alaska Native (Not Hispanic or Latino)**
A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

☐ **Two or More Races (Not Hispanic or Latino)**
All persons who identify with more than one of the above six races.

☐ **I do not wish to provide this information**

Individual Healthcare Professional Participation Addendum

This Individual Healthcare Professional Participation Addendum (this "Addendum") is hereby entered into as of this _____, 20____, by and among the undersigned healthcare professional ("Healthcare Professional"), the undersigned Participating Practitioner Group, and OhioHealth Group, Ltd. ("OHG").

Background Information

A. OHG entered into that certain Participating Practitioner Group Agreement (the "Group Agreement") with the Participating Practitioner Group (the "Group") of which Healthcare Professional is an employee or independent contractor.

B. Healthcare Professional is duly licensed and qualified under applicable state law to practice with the Group in one of the following capacities: (i) physician assistant, (ii) certified nurse midwife, (iii) certified nurse practitioner, (iv) clinical nurse specialist, (v) certified registered nurse anesthetist, (vi) master's level state certified or state licensed clinical counselor, (vii) audiologist, (viii) speech therapist, (viii) dietician, or (ix) school psychologist.

C. Healthcare Professional, Group, and OHG each acknowledges that, by executing this Addendum, Healthcare Professional becomes a Participating Provider as set forth in the Group Agreement.

D. All Terms capitalized in this Addendum, but not otherwise defined, shall have the respective meaning ascribed to them in the Group Agreement.

Statement of Agreement

For good and valuable consideration, the adequacy of which is hereby acknowledged, the parties hereto acknowledge the accuracy of the foregoing Background Information and agree as follows:

§1. Healthcare Professional hereby agrees that he or she will actively support the ongoing development and implementation of the Clinical Integration Program as may be reasonably requested by OHG from time to time, and will abide by the terms, conditions, standards and requirements of the Group Agreement and the Clinical Integration Program.

§2. Healthcare Professional hereby agrees that he or she will fully perform and observe all obligations to be performed or observed by a Participating Practitioner under the terms and conditions of the Group Agreement, provided, however, that such activity is limited by, and does not extend beyond, the scope of Healthcare Professional's license, and Healthcare Professional's obligation to satisfy any financial term or condition arising under the Group Agreement shall be limited to an amount representative of Healthcare Professional's level of participation under the Group Agreement as reasonably determined by OHG. The intent of the foregoing sentence is to

ensure that Healthcare Professional shall not have any personal obligation to OHG for the financial obligations of other members, shareholders, partners, employees, or independent contractors of the Group.

§3. Healthcare Professional shall only provide Covered Services as may be authorized by the following, as applicable to Healthcare Professional: (i) his or her supervision agreement approved by the appropriate State licensing board, (ii) his or her standard care arrangement approved by his or her collaborating physician(s), and/or (iii) applicable federal and state law.

§4. Healthcare Professional hereby authorizes OHG to pay to the Group (rather than to Healthcare Professional) any CI Payments, or portions thereof, that may arise from payments received by OHG from a Payor pursuant to the terms of a Clinical Integration Service Agreement and that OHG determines in its sole discretion are payable to the Group or Healthcare Professional.

§5. Healthcare Professional hereby agrees this Addendum: (A) is effective as of the latter of (i) the Effective Date of the Group Agreement, or (ii) the date set forth above; (B) will terminate upon (i) termination of the Group Agreement or earlier termination of this Addendum by OHG, or (ii) earlier termination of his or her employment or independent contractor agreement with the Group; and (C) is entered into for the benefit of OHG and that OHG shall have the right fully to enforce Healthcare Professional's personal obligations arising under this Addendum.

§6. Healthcare Professional hereby acknowledges, understands and agrees that he or she will have no rights to any review, hearing or appeal as may otherwise be provided to a practitioner under OHG's Credentialing Plan or OHG's Credentialing Policy for Healthcare Professionals following termination of this Addendum as provided in Section 4 above.

Healthcare Professional:	**Participating Group Name:**
_____	Midwest Physician Anesthesia Services, Inc
Printed Name	Group Name Printed
_____	_____
Signature	Signature of Group Representative

OhioHealth Group, Ltd.

By: _____
Its: _____

Category of Healthcare Professional – Please check one:

Advanced Practice Provider:

_____Nurse Practitioner _____ Nurse Midwife

_____ Physician Assistant _____ Clinical Nurse Specialist

__[x]__Certified Registered Nurse Anesthetist

Allied Health Professional:

__[ ]__Audiologist

__[ ]__ Dietician

__[ ]__Speech Therapist

__[ ]__ School Psychologist

Clinical Counselor:

__[ ]_Licensed Independent Social Worker (LISW)

__[ ]_ Licensed Professional Clinical Counselor (LPCC)

__[ ]_Licensed Independent Chemical Dependency Counselor (LICDC)

__[ ]_Licensed Independent Marriage and Family Therapist

List your Supervising or Collaborating Physician(s) below (as applicable). If more than one, please list in order from most frequently supervises/collaborates to least frequently supervises/collaborates.

Please Print Clearly. Attach additional sheets if necessary:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____