INSPIRA MENTAL HEALTH MANAGEMENT

(787) 704-0705
www.inspirapr.com

Requisitos de Contratación para los Grupos

☐ Completar la solicitud de contratación en su totalidad debe estar completada en todos los campos que apliquen.

☐ Tener un número de seguro social patronal otorgado por el IRS.

☐ Contar con una oficina para recibir pacientes. Deberá obtener un resultado de 80% de cumplimiento o más en la evaluación de la facilidad.

☐ Tener un número NPI (National Provider Identifier) a nombre de la corporación y/o sus localidades. Se requiere un NPI exclusivo para los servicios de salud mental (independiente de NPI para servicios físicos), si aplica.

☐ Ser una corporación registrada por el Departamento de Estado de Puerto Rico.

☐ Tener Medicaid ID. (La dirección debe ser exacta a la que coloque en la solicitud de credencialización/ dirección de su práctica que desea contratar)

☐ Tener certificado del Seguro de Responsabilidad Profesional vigente y endosado a Inspira

☐ Tener certificado del Seguro de Responsabilidad Pública de la Localidad vigente y endosado a Inspira

☐ Completar la lectura de los adiestramientos disponibles en la página proveedores y firmar el acuse de recibo. (una vez se les envié los contratos para firma)

☐ Todos los proveedores incluidos bajo el grupo deberán ser credencializados y contratados por INSPIRA antes de comenzar a proveer servicios.

☐ Firmar los contratos y tarifas que apliquen.

INSPIRA MENTAL HEALTH MANAGEMENT

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Documentos Requeridos para la Credencialización de los Grupos

☐ Solicitud- “INSPIRA Mental Health Management Credentialing and Re-credentialing Group Application Form” **es una solicitud por cada localidad de servicio**. completamente llena, con la firma y la fecha

☐ Evidencia de Carta de Aprobación de Medicaid de cada facilidad -debe indicar ID de Medicaid, dirección y fecha de efectividad. (La dirección debe ser exacta a la que coloque en la solicitud de credencialización/ dirección de su práctica que desea contratar)

☐ W-9

☐ Listado de los proveedores de salud mental que ofrecen servicios en la facilidad
- ✓ Debe completar el proceso de credencialización de cada proveedor que desee afilar

☐ Certificado del Seguro de Responsabilidad Profesional cubierta mínima de $100,000 a $300,000 vigente y endosado a Inspira

INSPIRA
Departamento de Proveedores
PO Box 9809
Caguas, P.R. 00726-9809

☐ Certificado del Seguro de Responsabilidad Pública de la Localidad vigente y endosado

INSPIRA
Departamento de Proveedores
PO Box 9809
Caguas, P.R. 00726-9809

☐ Permiso de Único (copia) – incluye bomberos y licencia sanitaria

☐ Licencia para Operar de ASSMCA vigente (copia)
- ✓ Clasificación CASM para ambulatorio
- ✓ Clasificación CB para facilidades que incluyan buprenorfina

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

GENERAL INSTRUCTIONS
• All information requested must be **fully** and **truthfully** provided and type or print legibly your responses. • Any changes to your responses must be lined through and initialed. Use of any form of correctional fluid or tape is not acceptable. • **Complete all sections. If a section is no filled out, the application will be returned, thus, delaying the credentialing process.** Use N/A if not applicable. • If more space is needed in order to answer a question completely, use the attached Explanation Form as necessary. • Please sign and date the Application and Schedule A.

TYPE OF APPLICATION:	☐Credentialing ☐Re-credentialing ☐Change of ownership or Group Name

GROUP INFORMATION

PRIMARY OFFICE				Practice Date:	
Legal Business Name: (as reported to IRS)					
Doing Business As Name:					☐N/A
Name of Office Contact:					
Location Physical Address:					
City:		State:		Zip Code:	
Telephone Number:		Fax Number:			
Email Address:		Web Page Address:			
Emergency Telephone Number:		Appointment Telephone Number:			

Hours of Operation *(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Is this office handicapped available? ☐Yes ☐No	**Is this office accessible to public transportation?** ☐Yes ☐No
Is this office accessible via train? ☐Yes ☐No	**Does this office meet ADA Accessibility Requirements?** ☐Yes ☐No
Is this office accessible via bus? ☐Yes ☐No	**If Yes, which public transit routes:**

Billing Information

Make checks payable to:			
Name of Billing Contact:			
Medicaid Number:		Tax ID #:	

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Medicare Number:		NPI:	
24/7 Phone Coverage? ☐Yes ☐No If Yes, select one option: ☐ Answering Service ☐ Voicemail w/message to call Answering Service ☐ Voicemail w/other instructions		Telephone Number: Fax Number:	
Billing Address:			
City:		State:		Zip Code:	

OPEN PRACTICE

Are you currently accepting new patients into practice? ☐Yes ☐No	**Are you accepting existing patients with charge of payer practice?** ☐Yes ☐No
Are you currently accepting new patients with physician referral? ☐Yes ☐No	**Are you currently accepting all new patients?** ☐Yes ☐No
Are you currently accepting new Medicare patients? ☐Yes ☐No	**Are you currently accepting new Medicaid patients?** ☐Yes ☐No

SECONDARY OFFICE ☐N/A — Practice Date:

Name of Clinical Practice:	
Name of Office Contact:	
Location Physical Address:	

City:		State:		Zip Code:	

Telephone Number:		Fax Number:	
Emergency Telephone Number:		Appointment Telephone Number:	

Hours of Operation *(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Is this office handicapped available? ☐Yes ☐No	**Is this office accessible to public transportation?** ☐Yes ☐No
Is this office accessible via train? ☐Yes ☐No	**Does this office meet ADA Accessibility Requirements?** ☐Yes ☐No
Is this office accessible via bus? ☐Yes ☐No	**If Yes, which public transit routes:**

Billing Information

Make checks payable to:			
Name of Billing Contact:			
Medicaid Number:		Tax ID #:	

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Medicare Number:		NPI:	
24/7 Phone Coverage? ☐Yes ☐No If Yes, select one option: ☐ Answering Service ☐ Voicemail w/message to call Answering Service ☐ Voicemail w/other instructions		Telephone Number:	
		Fax Number:	

Billing Address:					
City:		State:		Zip Code:	

ORGANIZATIONAL STAFF INFORMATION

Executive Director/Administrator: ☐N/A

Name:		Email:			
Telephone Number:		Fax Number:			
Address:					
City:		State:		Zip Code:	

Clinical Services Director: ☐N/A

Name:		Email:			
Telephone Number:		Fax Number:			
Address:					
City:		State:		Zip Code:	

Staff Supervisor: ☐N/A

Name:		Email:			
Telephone Number:		Fax Number:			
Address:					
City:		State:		Zip Code:	

Billing Staff Manager: ☐N/A

Name:		Email:	
Telephone Number:		Fax Number:	

Address:					
City:		State:		Zip Code:	

CORPORATION INFORMATION & PROFILE

Identify what type of organization is the group:

☐ Corporation (including non-profit organization)
☐ Partnership and Limited Partnership
☐ Limited Liability Company
☐ Charitable and/or Religious Organization
☐ Governmental and/or Tribal Organization
☐ Other: ____________________________

Question		
The organization has a government body and an organized professional staff?	☐ Yes	☐ No
Is the organization a legal business entity and has it been in operation and been admitting patients for six months or greater?	☐ Yes	☐ No
The organization has a multidisciplinary staff that includes at least one psychiatrist, psychologists and licensed masters level mental health clinicians?	☐ Yes	☐ No
Are all outpatient professional services provided billed under the organization's name and tax id number?	☐ Yes	☐ No

Does your organization provide the following?

Item		
a. Written credentialing criteria for all clinical staff	☐ Yes	☐ No
b. Written criteria for screening and referral?	☐ Yes	☐ No
c. Written comprehensive individualized treatment plans?	☐ Yes	☐ No
d. Coverage for crisis assessment/intervention?	☐ Yes	☐ No
e. Centralized Intake and Billing?	☐ Yes	☐ No
f. Individual, group and family therapy?	☐ Yes	☐ No
g. Written Quality Improvement Program?	☐ Yes	☐ No
h. Oversight by a medical director?	☐ Yes	☐ No

If answered no to any of the questions above, please provide a brief explanation:

____

____

____

____

____

CORPORATION ADVERSE LEGAL HISTORY

Question		
Has this group or any shareholders/owners/partners, ever had an adverse legal action imposed against it, been named in any malpractice action or convicted of a crime excluding misdemeanors?	☐ Yes	☐ No
Has this group or any shareholders/owners/partners, ever been fined, suspended or expelled from participation, or had criminal charges brought against it by a Medicare, Medicaid or TRICARE program?	☐ Yes	☐ No
Has this group or any shareholders/owners/partners, ever had professional liability refused, declined, canceled or accepted on special terms?	☐ Yes	☐ No
Has any government agency ever investigated, suspended, revoked, or taken action against this group's license to conduct business?	☐ Yes	☐ No

*If **Yes** to any of the above, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative*

body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).

Adverse Legal Action	Date	Taken by	Resolution

OWNER(S) INFORMATION

(Please copy and fill this page for every person that has ownership interest and/or managing control over the group)

The group MUST have at least ONE owner and or managing employee.

The following individuals must be reported in this section:

- All persons who have 5 percent or greater direct or indirect ownership interest in the group.
- If (and only if) the group is a corporation (whether for-profit or non-profit), all officers and directors of the group.
- Authorized and delegated officials.

What is this individual's relationship with the group? (check all that apply)

☐ 5 Percent or Greater Direct/Indirect Owner ☐ Director / Officer

☐ Partner ☐ Contracted Managing Employee

☐ Managing Employee (W-2) ☐ Other:_______________________________

Last Name:		Mother's Maiden Name:			
First Name:		Initial:		Gender:	☐ F ☐ M
Telephone Number:		Mobile:			
Email:		Social Security Number:			
Specialty (If is a provider that offers services for the group)		% of Participation:			

OWNER(S) ADVERSE LEGAL HISTORY

Has this person, under any current or former name or business identity, ever had an adverse legal action imposed against them?	☐ Yes ☐ No
Has this person, ever been fined, suspended or expelled from participation, or had criminal charges brought against it by a Medicare, Medicaid or TRICARE program?	☐ Yes ☐ No
Has this person ever been arrested, charged with or convicted of a felony or involved in charges relating to moral or ethical turpitude, including crimes with children?	☐ Yes ☐ No

*If **Yes** to any of the above, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution. Attach a copy of the adverse legal action documentation(s) and resolution(s).*

Adverse Legal Action	Date	Taken by	Resolution

LICENCES AND ACCREDITATIONS

Please answer the following questions for credentialing purposes:

Is this group Medicaid certified? ☐ Yes ☐ No If yes, Medicaid # ______________________

Is this group Medicare certified? ☐ Yes ☐ No If yes, Medicare # ______________________

Is this group registered as a health care provider with ASES? ☐ Yes ☐ No

Is this group certified by the Health Department? ☐ Yes ☐ No License # ___________ Exp. Date___________

Which is the name of the Licensing Body? ____

Is the group accredited by one agency that provides a health care accreditation? ☐ Yes ☐ No

If is yes, what accreditation? ____

Is the site having authorization by the State (Use Permission)? ☐ Yes ☐ No If yes, from year: __________

PROFESSIONAL LIABILITY INSURANCE

Current Insurance Carrier	Policy Number	Dates of Coverage (MM/DD/YY)		Coverage Limits	
		Original Eff.		Each	
		Eff.		Aggr.	
		Exp.			

COMMERCIAL LIABILITY INSURANCE

Current Insurance Carrier	Policy Number	Dates of Coverage (MM/DD/YY)		Coverage Limits	
		Original Eff.		Each	
		Eff.		Aggr.	
		Exp.			

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

CLINICAL MODALITIES – TREATMENT SPECIALTIES				
Age Range *(You can select more than one)*				
☐ Young Children (0 – 5)	☐ Children (6 – 12)	☐ Adolescent (13 – 17)	☐ Adult (18 – 64)	☐ Geriatric (65+)
Gender *(You can select more than one)*				
☐ Male Only	☐ Female Only	☐ No limitations		

Areas of Expertise *(You can select more than one)*		
☐ ADD / ADHD	☐ Addictions, Non-Chemical	☐ Alcohol/Chemical Dependency
☐ Anger Management	☐ Autism	☐ Child Abuse
☐ Chronic Pain	☐ Crisis Stabilization	☐ Dissociative Identity Disorder
☐ Domestic Violence	☐ Eating Disorders	☐ Gay / Lesbian / Bisexual Issues
☐ Grief / Separation and Loss	☐ Head Trauma	☐ Hearing Impaired
☐ Infertility	☐ Marital / Separation / Divorce	☐ Men's Issues
☐ Mental Retardation / Developmental	☐ Obsessive Compulsive Disorder	☐ Personality Disorder
☐ PTSD	☐ Rape Crisis	☐ Schizophrenic Disorder
☐ Sex Offender Treatment	☐ Sexual Dysfunction	☐ Sexual Abuse / Sexual Disorder
☐ Severe & Persistent Mental Illness	☐ Sleep Disorder	☐ Smoking Cessation
☐ Stress Management	☐ Terminal Illness/ Death	☐ Trauma & Relief Recovery
☐ Women's Issues	☐ Other:	

Type of Therapy *(You can select more than one)*		
☐ Brief Therapy	☐ Child Therapy	☐ Christian/Faith Based Therapy
☐ Cognitive Behavioral Therapy	☐ Couples Therapy	☐ Critical Incident Stress Debriefing (CISD)
☐ Dialectical Behavior Therapy	☐ Family Therapy	☐ Group Therapy
☐ Hypnotherapy	☐ Multi-Cultural Issues	☐ Neuropsychology Testing
☐ Psychological Testing	☐ Psychopharmacology	☐ Psychosomatic Therapy
☐ Short Term Problem Counseling	☐ Systematic Desensitization	☐ Other:

Description of Services *(You can select more than one)*		
☐ 23- Hour Hold	☐ Inpatient – Mental Health	☐ Inpatient - Detoxification
☐ Partial Hospitalization	☐ Outpatient	☐ Intensive Outpatient Program
☐ Reverse Colocation	☐ Buprenorphine/Suboxone	☐ Other:

Home Visits *(Home Visit includes house, home care, and any place that represents affiliate's home)*	☐ N/A

Indicate the geographic areas or municipalities where you will be offering services:		
1.	2.	3.
4.	5.	6.

Additional Abilities *(You can select more than one)*			☐ N/A
☐ American Sign Language	☐ Braille writing method	☐ Other:	

OTHER INFORMATION		
1. Have provisions been made for afterhours coverage?	☐Yes	☐ No

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

Question	Response	
2. Who normally covers you when your locations are unavailable?	Name: Phone Number:	
3. If you do not have after hours coverage, would you be willing to participate in an afterhours nurse advice service?		☐Yes ☐ No
4. How do patients contact you afterhours?		
5. Approximatively how many active patients make up your total practice?		
6. Approximatively how Government Health Plan enrollees do you currently have as patients?		
7. Any of your staff serve as a PCP in the Government Health Plan Program?		☐Yes ☐ No
8. How many Medicare beneficiaries do you currently have as patients?		
9. Do you make appointments and in what manner (day only, no set hours)?		
10. What is the expected waiting time for an appointment to see patients who have: a. An emergent situation: b. An urgent situation: c. A routine situation:	a: b: c:	

11. Check the following procedures performed in your office (attach any required certifications):

- ☐ Therapy Service (Physical/Occupational/Speech)
- ☐ Chest X Rays
- ☐ Endoscopic Procedures
- ☐ Mammograms
- ☐ Immunizations (Influenza (Flu) / Hepatitis B / Pneumonia/H1N1)
- ☐ Extremity X Rays
- ☐ Pap Smears
- ☐ Non-invasive cardiology test
- ☐ EKG's
- ☐ Other Procedures (Specify):

____

e.g. PHQ-9 or GAD7

12. What laboratory services are provided in your office? *(Please check N/A if not applicable)*	☐N/A
• *Is your laboratory Medicare approved?*	☐Yes ☐ No
• *Is your office computerized?*	☐Yes ☐ No
• *Do you have Internet access in your medical office?*	☐Yes ☐ No

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

OTHER OFFICE/LOCATIONS ☐N/A *(If you have more locations please copy this page and fill this section with information of other locations)*	Practice Date:	

Name of Clinical Practice:	
Name of Office Contact:	
Location Physical Address:	

City:		State:		Zip Code:	
Telephone Number:		Fax Number:			
Emergency Telephone Number:		Appointment Telephone Number:			

Hours of Operation *(Actual practice hours each day at this location, e.g. 8:00am to 4:30pm)*

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:	From:	From:	From:	From:	From:	From:
To:	To:	To:	To:	To:	To:	To:

Is this office handicapped available? ☐Yes ☐No	**Is this office accessible to public transportation?** ☐Yes ☐No
Is this office accessible via train? ☐Yes ☐No	**Does this office meet ADA Accessibility Requirements?** ☐Yes ☐No
Is this office accessible via bus? ☐Yes ☐No	**If Yes, which public transit routes:**

Billing Information

Make checks payable to:	
Name of Billing Contact:	

Medicaid Number:		Tax ID #:	
Medicare Number:		NPI:	
24/7 Phone Coverage? ☐Yes ☐No If Yes, select one option: ☐ Answering Service ☐ Voicemail w/message to call Answering Service ☐ Voicemail w/other instructions		Telephone Number:	
		Fax Number:	

Billing Address:	

City:		State:		Zip Code:	

AUTHORIZATION AND RELEASE OF INFORMATION FORM

For purposes of making this application for participation in the INSPIRA Mental Health Management, Inc. provider network, I authorize INSPIRA and/or its Credentialing Verification Organization (CVO) to consult with the National Practitioner Data Bank, and associate Data Banks, State Licensing Board(s), educational institutions, specialty boards, malpractice insurance carriers, Educational Commission for Foreign Medical Graduates, hospitals, professional references and any other person or entity from whom/which information may be needed to complete the credentialing process or to obtain and verify information concerning my membership, professional competences, character, moral and ethical qualifications. I understand that INSPIRA may be required by the federal government or its clients to perform a criminal record check as a condition for participation and that INSPIRA has the right to obtain a copy of a criminal history report. I also authorize all of them to release such information to INSPIRA Mental Health Management, Inc. I release INSPIRA and/or its CVO and employees and agents and all those whom INSPIRA and its contacts from any and all liability for their acts performed in good fight and without malice in obtaining and verifying such information and in evaluating my application.

I consent to the release by any person to INSPIRA and/or its CVO, all information that may reasonably be relevant to an evaluation of my professional competency, character and moral and ethical qualifications, including any information relating to any disciplinary action or suspension or curtailment of privileges, and hereby release any such person providing such information from any and all liability for doing so.

I further understand and agree that I am responsible for producing all information required or requested by INSPIRA in connection with this application and that INSPIRA shall not complete the processing of this application until such information is provided by me. I agree to notify INSPIRA promptly if there are any material changes in the information provided, whether prior to or after my acceptance as an INSPIRA participating provider. I understand and agree that if INSPIRA discovers that my application contains any significant misstatement, misrepresentation or omissions, INSPIRA may void, in its sole discretion, this application and any related participating provider agreements. I also understand that this application does not entitle my business to any participation agreements in any of the network of INSPIRA.

I certify that I'm being notified about my rights to: (a) review information submitted to support credentialing application, (b) correct erroneous information INSPIRA collected during the credentialing and/or re-credentialing process and, (c) request and receive the status of my credentialing and/or re-credentialing application. I understand that I am not precluded from pursuit of any separate rights that I may have under state or federal laws.

By submitting this application, I acknowledge, understand, consent and agree that a photocopy of the Authorization and Release of Information Form shall be as effective as the original and shall constitute my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

By signing this Authorization and Release of Information Form, I certify the completeness of the application and that all information provided to INSPIRA is true and correct to the best of my knowledge and belief.

Printed Name   **Date (mm/dd/yyyy)**

Signature

INSPIRA Mental Health Management

CREDENTIALING AND RE-CREDENTIALING GROUP APPLICATION FORM

OWNERSHIP/CONTROLLING INTEREST DISCLOSURE FORM	☐ N/A
All information disclosed in this section will remain entirely confidential and will only be used for the purposes specified in Federal Law (42 CFR, SECTION 455).	

Section One:

1. Have you or any person who has ownership or control interest in your practice who is an agent or managing employee been convicted of a criminal offense related to the involvement of your practice in any program under Medicare, Medicaid or the Title XX services since the inception of those programs? (42 CFR §455.106) If yes, give the name(s) of person(s) and description(s) of offenses(s). Please use additional pages if necessary.	☐Yes ☐No

Name	Social Security No.	Tax ID No.	Date of Birth	Description

2. Federal regulation requires the following information to be disclosed on all managing employees. (42 CFR §455.101). Please use additional pages if necessary. A managing employee is a "general manager, business manager, administrator, director, officer, governing board member, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization or agency". (42 CFR §455.101).	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Address / Telephone No.

3. Provide the name and address of each person or organization with a direct or indirect ownership or control interest of five percent or more (5%+) of your practice. (42 CFR §455.104). Please use additional pages if necessary.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Address / Telephone No.

4. Please provide the ownership name and address of any subcontractor with whom you have had business transaction totaling more than $25,000 during the most recent 12-month period.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Address / Telephone No.

Section Two:

1. Are you an Out-of-Network provider? If yes, please complete the questions in section two.	☐Yes ☐No
2. Do you have any current of previous affiliations with a provider or supplier that has uncollected debt or has been subject to a payment suspension? If yes, give the name(s) of person(s) and description(s) of uncollected debt or payment suspension. Please use additional pages if necessary.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Description

3. Do you have any current of previous affiliations with a provider or supplier that has been excluded from Federal Health Care programs? If yes, give the name(s) of person(s) and description(s) of exclusions. Please use additional pages if necessary.	☐Yes ☐No

Name	Social Security No.	Tax ID No.	Date of Birth	Description

4. Do you have any current of previous affiliations with a provider or supplier that has had its billing privileges denied or revoked? If yes, give the name(s) of person(s) and description(s) of denial(s) or revocation(s). Please use additional pages if necessary.	☐ N/A

Name	Social Security No.	Tax ID No.	Date of Birth	Description

EXPLANATION FORM

Please make as many copies of this page as needed to fully respond each question. For each response/explanation, please provide the corresponding page and section name from the Application.

Section Name:	**Page #:**