As part of Carelon, we have established a comprehensive set of standards to ensure patients can trust they will receive the highest quality of service. Please review all the requirements listed in this document before applying or reapplying to the network.

For any questions, please contact us at:

- **Contracting**: Contracting@carelon.com
- **Credentialing**: Credentialing@carelon.com

Application Requirements

- **Completion of Application:** Submit a completed application with a current, signed and dated attestation.
- **On-Call Support (Home Health Only):** Provide 24/7 on-call support services.
- **W-9 Form: Supply a current W-9 form if not already provided during contracting.**
- **Ownership Disclosure (Home Health Only)**: Submit a Disclosure of Ownership and Control Interest Statement.
- **Licenses and Certifications**: Hold all necessary licenses and certifications as mandated by governmental regulatory agencies, including state licenses if applicable.
- **General Liability Insurance**: Maintain comprehensive general liability insurance with minimum coverage of $1,000,000 per claim and $3,000,000 annually. Submit a copy of the current general liability face sheet indicating the applicant as the insured, with policy period and coverage amounts.
    - Insurance must cover acts and omissions of agents and employees.
    - The Network Management Committee may make exceptions in states where the maximum obtainable coverage is less than the specified limits.
- **Professional Liability Insurance (Practitioner Only):** Maintain professional liability insurance coverage of $1,000,000 per claim and $3,000,000 annually. Submit a copy of the currently professional liability face sheet indicating the applicant as the insured, with the policy period and coverage amounts.
    - The Network Management Committee may make exceptions in states where the maximum obtainable coverage is less than the specified limits.
- **Malpractice Claims History**: Provide a malpractice claims history and/or litigation documentation for the past five years, if applicable. Include a brief statement detailing the facts of the claim, the allegation, and the response if a judgment/settlement includes a confidentiality agreement or is pending. Submit a corrective action plan detailing areas of deficiency, action steps implemented, and relevant prevention initiatives.
- **Medicare and Federal Programs**: Maintain good standing with Medicare and Federal programs. Facilities or practitioners cannot be excluded from participating in federal government contracts or funded healthcare programs.

Home Health Agencies (HHA) Specific Criteria

- **Accreditation**: Hold current accreditation with one of the following CMS-recognized accrediting organizations or supply a current (within the last three years) Site Survey with supporting documentation if deficiencies were identified:
    - Accreditation Commission for Health Care, Inc (ACHC)
    - The Joint Commission (TJC)
    - Community Health Accreditation Program (CHAP)
- **Site Survey**: If lacking accreditation, supply a current (within the last three years) Site Survey with supporting documentation if deficiencies were identified.
- **Star Rating**: Maintain a star rating of at least 1.5 to demonstrate quality results consistent with or better than the surrounding market.
    - Exceptions can be made if access to care is not met.
- **CLIA Certification**: Maintain CLIA certification, if applicable.

Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Specific Criteria

- **Accreditation**: Maintain current accreditation with one of the CMS-recognized accrediting organizations and provide a recent Site Survey (conducted within the last three years), including supporting documentation for any identified deficiencies:
    - Accreditation Commission for Health Care, Inc (ACHC)
    - American Board for Certification in Orthotics & Prosthetics, Inc (ABC)
    - Board of Certification/Accreditation International (BOC)
    - Community Health Accreditation Program (CHAP)
    - HealthCare Quality Association on Accreditation (HQAA)
    - National Association of Boards of Pharmacy (NABP)
    - The Compliance Team, Inc
    - The Joint Commission (TJC)

Practitioner Specific Criteria

- **Board Certification**: Hold current board certification in the practicing specialty, if applicable.
- **Education Verification**: For non-MD or DO practitioners, verify the highest level of education or training.
- **DEA and CDS Certification**: Possess a current Drug Enforcement Administration (DEA) Certification and/or State Controlled Substance (CDS) certificate, if applicable.
- **Attestation**: Practitioners must attest to the following:
    - No felony convictions.
    - No history of license loss.
    - Report any loss of privileges or disciplinary actions.
    - Good health status.
    - Report any physical or mental problems that may affect the ability to practice.
    - No history of drug or alcohol abuse.
    - If any criteria are not met, provide an explanation and present the file to the committee for review.
- **ECFMG Certification**: Foreign medical school graduates must submit an Educational Commission for Foreign Medical Graduates (ECFMG) Certificate.
- **Work History**: Disclose all work history gaps greater than six months in the past five years.
- **Disciplinary Actions**: No history of being disciplined, suspended, or terminated for cause from a PPO, HMO, hospital privileges, or other managed care organization.

General Facility Criteria

- **Accessibility**: Ensure the facility is handicapped accessible, including entrance, parking, and bathroom facilities. Regulatory “grandfathering” provisions will be accepted.
- **Waiting Room**: Have a waiting room that can accommodate at least five patients and enough changing rooms to ensure patient privacy.
- **Office Hours**: Post office hours.
- **Medical Records**: Maintain appropriate medical records and provide them to Carelon as necessary for utilization management and/or quality assessment, subject to applicable law.

Closed Markets

- **Market Evaluation**: Evaluate the business needs of the organization to determine market capacity for further contracting efforts. If a contract request is received in a closed market, notify the facility or practitioner of the closure. Keep all contract materials on file for six months. Periodically evaluate market needs to ensure compliance with CMS, state, and federal requirements.

CREDENTIALING REQUIREMENTS FOR HOME HEALTH AGENCIES (HHA)

- Completed Application with Attestation
- Secure Authorization Phone & Fax Number (used for PHI)
- HHA State License (if applicable)
- Accreditation Certificate OR CMS / State Survey Report
- Medicare Certification Letter
- CLIA Certificate or Waiver (if applicable)
- W-9
- General Liability Insurance Certificate
- Disclosure of Ownership (DOO) – Executed Form

Important: Incomplete or missing documents may delay processing.

Please complete all sections and submit required documents to credentialing@carelon.com.

Provider Rights During Credentialing:
At any time during the credentialing process, the applicant has the right to request information regarding the status of their application, review information submitted in support of their credentialing application, and correct any erroneous information (except for references, peer review materials, or recommendations protected by law). Carelon will respond to such requests within 48 hours.

One application is required per Tax ID number. Multiple facilities or licenses under the same Tax ID may be submitted on a single application.

Agency Information

Legal Agency Name: _____

Doing Business As (DBA) Name: _____ (Directory Name)

Federal Tax ID: _____ National Provider Identifier (NPI): _____

Primary Address: _____

City: _____ State: _____ Zip +4: _____

Phone: _____ General Fax: _____

Credentialing Contact Name: _____ Credentialing Email: _____

Directory Verification Contact Name: _____ Verification Email: _____

Secure Authorization Contact (PHI)

Secure Phone: _____ Secure Fax: _____

Additional notes for authorizations:

_____

_____

Licenses & Certifications

State License Number: _____ Expiration Date: _____

Medicare Provider: ☐ Yes ☐ No CMS Certification #: _____

Medicaid #: _____ CLIA Certificate/Waiver #: _____ Expiration Date: _____

Accreditation (check all that apply):

- ☐ The Joint Commission (TJC)
- ☐ CHAP
- ☐ ACHC
- ☐ Not Accredited – CMS/State Survey Attached

Multiple Locations

Do you operate multiple locations under the same Tax ID? ☐ Yes ☐ No

If Yes, number of locations: _____

If same Tax ID → Complete Attachment A

If different Tax ID → Submit separate application for each entity

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Scope of Services	
Wound Care Services	**Personal Care Services**
○ Basic Wound Care ○ Advanced Wound Care ○ Wound Vac Therapy (Negative Pressure Wound Therapy)	○ Home Health Aide ○ Personal/Companion/Respite Care
Skilled Nursing	
○ RN (Registered Nurse) ○ LPN (Licensed Practical Nurse) ○ Pediatric Nurse ○ Psychiatric Nurse ○ Private Duty Nurse	Do you offer these specialized nursing services? Mark, all that applies. ○ PleurX Catheter Care ○ High-Tech Nurse / Tracheostomy / Ventilator Care ○ Enterostomal Care ○ Enteral Feeding
Therapy Services	**Social & Behavioral Health Services**
○ Physical Therapy ○ Occupational Therapy ○ Speech Therapy	○ Medical Social Worker ○ Psychiatric Social Worker

These questions apply to all locations listed under the same Tax ID.
Please include details for each location included in a "YES" response.

Mark with an X

QUESTIONNAIRE If "Yes" for any of the questions, please provide explanation	YES	NO
Have you had any Medicare / Medicaid sanctions within the past 10 years?		
Has your organization or any member of your staff ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid?		
Has your organization had liability restrictions?		
Has any insurance carrier at present or during the last 5 years made an out-of-court settlement or paid a judgment on a professional liability claim on your organization's behalf?		
Have there ever been any actions against your organization's license, accreditation, certifications or permits or the license of any member of your staff, including restrictions, limitations, denial, suspension, revocation, or cancellation?		
Has your organization or any member of your staff ever been convicted of or pleaded nolo contendere to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?		

Attestation, Authorization & Release

I certify that I am authorized to submit this application on behalf of the applying facility and that all information provided is true, complete, and accurate to the best of my knowledge.

I attest that the facility complies with all applicable federal and state laws and regulations, including Medicare (CMS) requirements, HIPAA, and Fraud, Waste and Abuse (FWA) standards. The facility is not excluded or debarred from participating in any federal healthcare program.

I authorize Carelon to verify the information contained in this application and to obtain information from appropriate sources related to licensure, accreditation, and compliance. I agree to notify Carelon of any material changes affecting this application.

This attestation is valid for 180 days from the date signed.

Authorized Representative Signature: _____

Title: _____

Date: _____

ATTACHMENT A
ADDITIONAL LOCATIONS UNDER SAME TAX ID

Complete this section only for agencies operating under multiple service locations or names that share the same Tax ID.

Agency Information

Legal Agency Name: _____

Doing Business As (DBA) Name: _____ (Directory Name)

Federal Tax ID: _____ National Provider Identifier (NPI): _____

Primary Address: _____

City: _____ State: _____ Zip +4: _____

Phone: _____ General Fax: _____

Credentialing Contact Name: _____ Credentialing Email: _____

Directory Verification Contact Name: _____ Verification Email: _____

Secure Authorization Contact (PHI)

Secure Phone: _____ Secure Fax: _____

Additional notes for authorizations:

_____

_____

Licenses & Certifications

State License Number: _____ Expiration Date: _____

Medicare Provider: ☐ Yes ☐ No CMS Certification #: _____

Medicaid #: _____ CLIA Certificate/Waiver #: _____ Expiration Date: _____

Accreditation (check all that apply):

- ☐ The Joint Commission (TJC)
- ☐ CHAP
- ☐ ACHC
- ☐ Not Accredited – CMS/State Survey Attached

Scope of Services	
Wound Care Services	**Personal Care Services**
☐ Basic Wound Care ☐ Advanced Wound Care ☐ Wound Vac Therapy (Negative Pressure Wound Therapy)	☐ Home Health Aide ☐ Personal/Companion/Respite Care
Skilled Nursing	
☐ RN (Registered Nurse) ☐ LPN (Licensed Practical Nurse) ☐ Pediatric Nurse ☐ Psychiatric Nurse ☐ Private Duty Nurse	Do you offer these specialized nursing services? Mark, all that applies. ☐ PleurX Catheter Care ☐ High-Tech Nurse / Tracheostomy / Ventilator Care ☐ Enterostomal Care ☐ Enteral Feeding
Therapy Services	**Social & Behavioral Health Services**
☐ Physical Therapy ☐ Occupational Therapy ☐ Speech Therapy	☐ Medical Social Worker ☐ Psychiatric Social Worker

Counties Form

State _____

County Name	Partial County

Instructions for Completing the Disclosure of Ownership and Control Interest Statement

Completion and submission of this form is a condition of participation, certification or recertification under any of the programs established by Titles V, XVIII, XIX and XX or as a condition of approval or renewal of a contractor agreement between the disclosing entity and the secretary of appropriate state agency under any of the above-titled programs, a full and accurate disclosure of ownership and financial interest is required. Failure to submit requested information may result in a refusal by the appropriate State agency to enter into an agreement or contract with any such institution in termination of existing agreements.

GENERAL INSTRUCTIONS

Please answer all questions as of the current date. If the yes block for any item is checked, list requested additional information under the Remarks Section referencing the item number to be continued. If additional space is needed, use an attached sheet.

DETAILED INSTRUCTIONS

These instructions are designed to clarify certain questions on the form. Instructions are listed in order of question for easy reference. NO instructions have been given for questions considered self-explanatory.

IT IS ESSENTIAL THAT ALL APPLICABLE QUESTIONS BE ANSWERED ACCURATELY AND THAT ALL INFORMATION BE CURRENT.

ITEM I – Identifying Information

(a) Under identifying information specify in what capacity the entity is doing business as (DBA), example, and name of trade or corporation.

ITEM II – Self–explanatory.

ITEM III – Owners, Partners, Officers, Directors, and Principals

List the names of all individuals and organizations having direct or indirect ownership interests, or controlling interest separately or in combination amounting to an ownership interest of 5 percent or more in the disclosing entity. 501 (c) (3) nonprofit and state-owned entities must list the officers or directors that have a control interest in the entity and managing employees in Section III(a). Since there will be no entries for any person with an ownership interest (Section III[b]), the percentage of ownership will always be less than 100 percent.

Direct ownership interest is defined as the possession of stock, equity in capital or any interest in the profits of the disclosing entity. A disclosing entity is defined as a Medicare provider or supplier or other entity that furnishes services or arranges for furnishing services under Medicaid or the Maternal and Child Health program or health related services under the social services program.

Indirect ownership interest is defined as ownership interest in an entity that has direct or indirect ownership interest in the disclosing entity. The amount of indirect ownership in the disclosing entity that is held by any other entity is determined by multiplying the percentage of ownership interest at each level. An indirect ownership interest must be reported if it equates to an ownership interest of 5 percent or more in the disclosing entity. Example: if "A" owns 25 percent of the stock in a corporation that owns 80 percent of the stock of the disclosing entity, "A's" interest equates to a 20 percent indirect ownership and must be reported.

Controlling interest is defined as the operational direction or management of a disclosing entity which may be maintained by any or all of the following devices; the ability or authority, expressed or reserved to amend or change the corporate identity (i.e., joint venture agreement, unincorporated business status) of the disclosing entity; the ability or authority to nominate or name members of the Board of Directors or Trustees of the disclosing entity; the ability or authority, expressed or reserved to amend or change the by-laws, constitution or other operating or management direction of the disclosing entity; the right to control any or all of the assets or other property of the disclosing entity upon the sale or dissolution of that entity; the ability or authority, expressed or reserved to control the sale of any or all of the assets to encumber such assets by way of mortgage or other indebtedness, to dissolve the entity or to arrange for the sale or transfer of the disclosing entity to new ownership or control.

ITEMS IV through VII – Changes in Provider Status

Change in provider status is defined as any change in management control. Examples of such changes would include a change in Medical or Nursing Director, a new Administrator, contracting the operation of the facility to a management corporation, a change in the composition of the owning partnership which under applicable State law is not considered a change in ownership, or the hiring or dismissing of any employees with 5 percent or more financial interest in the facility or in an owning corporation, or any change of ownership.

For items IV through VII, if the **Yes** box is checked, list additional information requested under Remarks. Clearly identify which item is being continued.

ITEM IV – Ownership

(a & b) If there has been a change in ownership within the last year or if you anticipate a change, indicate the date in the appropriate space.

ITEM V – Management

If the answer is **Yes**, list name or the management firm a nd employer identification number (EIN) or the leasing organization. A management company is defined as a ny organization t hat operates and names a business on behalf of the owner of that business with the owner retaining ultimate legal responsibility for operation of the facility.

ITEM VI – Staffing

If the answer is **Yes**, identify which has changed (Administrator, Medical Director or Director of Nursing) and the date the change was made. Be sure to include name of the new administrator, Director of Nursing or Medical Director, as appropriate.

ITEM VII – Affiliation

A chain affiliate is any freestanding health-care facility that is owned, controlled, or operated under lease or contract by an organization consisting of two or more freestanding health-care facilities organized within or across State lines which is under the ownership or through any other device, control and direction of a common party. Chain affiliates include such facilities whether public, private, charitable or proprietary. They also include subsidiary organizations and holding corporations. Provider-based facilities such as hospital–based home health agencies are not considered to be chain affiliates.

ITEM VIII – Capacity

If the answer is **Yes**, list the actual number of beds in the facility now and the previous number.

ITEM IX - Disclosure of Relationship

Please disclose any of familial relationships between principals and/ or the provider (i.e., Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling).

I.	Identifying information		
(a)	**Legal Name:** *(according to the IRS)*	**DBA:**	**Telephone number:**
	Physical/Corporate Address: Number Street Suite City State ZIP		

II.	Answer the following questions by checking Yes or No. *If any of the questions are answered Yes, list names and addresses of individuals or corporations under Remarks on the Disclosure of Ownership and Control Interest Statement form. Identify each item number to be continued.*	
(a)	**Are there any individuals or organizations having a direct or indirect ownership or control interest of five percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations, in any of the programs established by Titles XVIII, XIX, or XX?**	☐ Yes ☐ No
(b)	**Does this provider have any current employees in the position of manager, accountant, auditor, or in a similar capacity and who were previously employed by this provider's fiscal intermediary or carrier within the last 12 months?** *(Medicare providers only)*	☐ Yes ☐ No

III.	Owners, Partners, Officers, Directors, and Principals	
(a)	**Identify individuals who are sole proprietors or owners, partners, officers, directors, and principals of the applicant and list the percentage of ownership, if applicable. Total ownership should equal 100 percent unless otherwise noted in the instructions (see previous page). If ownership does not total 100 percent, the provider must submit a letter explaining the discrepancy. As it relates to owners, include all individuals with 5 percent or more ownership in the company, whether this ownership is direct or indirect.** ***(Add additional pages if necessary.)***	
	1. Name:	**Percentage Owned:**
	2. Name:	**Percentage Owned:**
	3. Name:	**Percentage Owned:**
	4. Name:	**Percentage Owned:**

(b)	**Identify the entities with ownership of a controlling interest in the applicant (whether such ownership of the controlling interest is direct or indirect). Provide the entity's name and federal tax identification number.** *See Instructions for Completing the Disclosure of Ownership and Control Interest Statement. List any additional names and addresses under Remarks on the Disclosure of Ownership and Control Interest Statement. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.*		
	Name:	**Address:**	**Federal Tax ID:**

(c)	**Do you currently have a creditor with a security interest in a debt that is owed by you?** **Is the creditor(s) security interest protected by at least 5 percent of your property?**	☐ Yes ☐ No ☐ Yes ☐ No

List each creditor with a security interest in a debt that is owed by you if the creditor's security interest is protected by at least 5 percent of your property.

Last Name/Company Name:	First Name:	Percent of Security Interest:

(d) Type of Entity: *Select only one - must match entity on W9*

☐ Individual/sole proprietor ☐ C Corporation ☐ S Corporation ☐ Partnership

☐ Limited liability company. **(***Enter the tax classification [C=C corporation, S=S corporation, P=partnership*]) _____

☐ Trust/estate ☐ Other *(specify)* _____ _____

(e) If the disclosing entity is a corporation, list names, addresses of the directors and EINs for corporations in remarks.
Attach additional pages if needed.

Remarks:

IV.	**Ownership**	
(a)	**Has there been a change in ownership or control within the last year?**	☐ Yes ☐ No
	If **Yes**, *give date:*	
(b)	**Do you anticipate any change of ownership or control within the year?**	☐ Yes ☐ No
	If **Yes**, *give date:*	
(c)	**Do you anticipate filing for bankruptcy within the year?** *(see provider agreement for additional information)*	☐ Yes ☐ No
	If **Yes**, *give date:*	
(d)	**Are any of the new owners related to any of the former owners?**	☐ Yes ☐ No
(e)	**Did any former owners transfer their ownership interest to any new owners in anticipation of or following the assessment of a civil monetary penalty?** *If yes, please list the name of the former owners below.*	☐ Yes ☐ No

Last Name:	First Name:	Middle Initial:

V.	**Management**	
	Does the provider identified in Section I. above comprise or include a facility that is operated by a management company, or a facility that is leased in whole or in part by another organization?	☐ Yes ☐ No
	If **Yes**, *give date of change in operations:*	

VI.	Staffing	
(a)	**Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?**	☐ Yes ☐ No

VII.	Affiliation		
(a)	**Is the provider identified in Section I. above chain affiliated?**		☐ Yes ☐ No
	If **Yes**, *provide the name, address, and Federal Tax ID number of the chain's corporate/home office:*		
	Name	Address	Federal Tax ID

VIII.	Capacity			
(a)	**Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last two years?** *(For Hospitals only)*			☐ Yes ☐ No
	If **Yes**, *give:*	**Year of change:**	**Current Beds:**	**Prior Beds:**

IX.	Disclosure of Relationship		
(a)	**Please disclose any of the following familial relationships between principals and/or the provider (Husband, Wife, Natural or Adoptive Parent, Natural or Adoptive Child, Natural or Adoptive Sibling):**		
	Provider/Principal 1:	**Has a Relationship as:**	**To Provider/Principal Name 2:**