Magellan Complete Care
ORGANIZATION PROVIDER APPLICATION

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Complete entire application for primary site and Pages 6-7 only for additional locations.

- **For entities with more than 15 locations, please complete this single application for one location, and contact Magellan at MCCVAProvider@magellanhealth.com to request a spreadsheet template to expedite credentialing of your additional locations.**
- **Current copies of all supporting documents must be submitted with this application (licenses, insurance certificates, accreditation/certification/site visit reports, etc.) as referenced throughout the application.**

Return this application by: E-Mail: MCCVAProvider@magellanhealth.com **Fax**: 888-656-5098 **or**
Mail: Magellan Complete Care of Virginia, Provider Network Dept**,** 3829 Gaskins Road, Richmond, VA 23233

SECTION A CORPORATE ENTITY / MAIN SITE	
MAIN SITE IDENTIFYING INFORMATION	
Legal Name:	TIN Number:
Other name(s) organization is known by (or d/b/a):	
Website Address *If your agency does not have a website, list N/A*:	
If the organization is a subsidiary of, in partnership with, or otherwise administratively or organizationally linked with a health system, please identify the entity by name below:	
Name of entity:	

MAILING ADDRESS			
Mailing Address:			
City:	County:	State:	Zip:
Contact Person (for credentialing correspondence):		Title:	
Telephone: ( )	Fax: ( )	Email:	

BILLING INFORMATION				
Billing Legal Name:		Billing TIN Number:		
Billing Address:				
City:		County:	State:	Zip:
Billing Contact Person:			Title:	
Telephone: ( )		Fax: ( )	Email:	

QUALITY OF CARE		
Does this facility have a Policy and Procedure addressing Advanced Directives in accordance with the Federal Patient Self Determination Act?	☐ YES	☐ NO
Does this facility have a quality improvement plan?	☐ YES	☐ NO
Does this facility have a patient satisfaction survey process?	☐ YES	☐ NO
Does each service location follow the policies and procedures as defined by the facility's primary service location?	☐ YES	☐ NO

SECTION B SERVICE LOCATION

SPECIFIC SERVICE DELIVERY LOCATION

Location Name:			
Street Address (No P.O. Box please):			
City:	County:	State:	Zip:
Telephone: ( )	Fax: ( )	Appointment Telephone: ( )	

Is this location physically accessible for patients and visitors with disabilities?	☐	YES	☐	NO
Does this location have telecommunications for the deaf capability?	☐	YES	☐	NO
Is this location located within one block of a public transportation stop?	☐	YES	☐	NO

Indicate business hours:

Business Hours:	MON	TUE	WED	THU	FRI	SAT	SUN
Start Time:	____	____	____	____	____	____	____
End Time:	____	____	____	____	____	____	____
By Appointment	☐	☐	☐	☐	☐	☐	☐

AFTER HOURS ACCESSIBILITY FOR PATIENTS IN TREATMENT

☐ Answering Machine	☐ Answering Service	☐ Beeper	☐ Not Available
After Hours Telephone: ( )			

LICENSE INFORMATION – please submit copies

Please list only those that apply to this service location. *For Medicare, please provide the Inpatient sub-provider ID number (i.e., "99S999") where applicable.* ***Please do not enter practitioner licenses****, only licenses that are applicable to the Organization itself.*

STATE	TYPE	NUMBER	LICENSING BODY	EXPIRATION DATE
1.				
2.				
3.				

CERTIFICATIONS/MEMBERSHIPS/PROVIDER IDENTIFIERS – please submit copies as applicable.				
CERTIFICATION/MEMBERSHIPS			**NUMBER**	**EXPIRATION DATE**
Accept Medicare Assignments?	☐ Yes	☐ No		
Accept Medicaid Assignments?	☐ Yes	☐ No		
National Provider Identifier (NPI):	☐ Yes	☐ No		N/A
CLIA Certification?	☐ Yes	☐ No		
Enter additional certifications:				

BED COUNTS – Please provide the number of beds, in each category. Please list only those that apply to this service location.					
TYPE	**NUMBER**	**TYPE**	**NUMBER**	**TYPE**	**NUMBER**
Coronary Care Unit (CCU)		Long Term Care (LTC)		Residential Treatment-Mental Health	
Crisis Stabilization Unit		Medical-Surgical		Residential Treatment-Substance Abuse	
Inpatient Mental Health		Medicare Certified Beds		Skilled Nursing Facility (SNF)	
Inpatient Substance Abuse		Neonatal ICU (NICU)		Surgical ICU	
Intensive Care Unit (ICU)		Pediatric ICU (PICU)		Other (List):	

ACCREDITATION INFORMATION - Please include copy of current accreditation documentation. By completing this accreditation section, you are attesting to the accreditation status of all levels of care at this service location.					
ACCREDITING BODY	**EXP DATE**	**ACCREDITING BODY**	**EXP DATE**	**ACCREDITING BODY**	**EXP DATE**
TJC		CARF		HFAP/AOA	
AAAASF		CCAC		UCAOA	
AAAHC		CHAP		OTHER (LIST):	
AAUCM		COA		NONE (NON-ACCREDITED)	
ACHC		DNV/NIAHO			

INSURANCE INFORMATION Please also submit copy of insurance coverage, for verification, for both general and professional liability.	
PROFESSIONAL LIABILITY ☐ Independent Carrier ☐ Self-Insured ☐ State Tort Liability Act	**GENERAL LIABILITY** ☐ Independent Carrier ☐ Self-Insured ☐ State Tort Liability Act
Current Carrier Name:	Current Carrier Name:
Policy Number:	Policy Number:
Policy Effective Date:	Policy Effective Date:
Policy Expiration Date:	Policy Expiration Date:
Per Occurrence Limit:	Per Occurrence Limit:
Aggregate Limit:	Aggregate Limit:

SERVICE LOCATION: Provider Designation. Please check all that apply for this specific location only.
Please also submit copy of insurance coverage, for verification, for both general and professional liability.

Type	Description	Type	Description
☐ 04	Health Department	☐ 14	Nursing Facility (☐ *Intermediate* ☐ *Skilled)*
☐ 05	Hospice	☐ 16	Outpatient Rehabilitation (☐PT ☐OT ☐ST)
☐ 06	Long Term Services & Supports (LTSS)	☐ 17	Durable Medical Equipment (DME) and Supplies
☐ 07	Outpatient Mental Health – Traditional Services	☐ 18	Radiology
☐ 08	Addiction, Recovery, & Treatment Services (ARTS)	☐ 19	Home Health
☐ 09	Community MH Rehabilitative Services (CMHRS)	☐ 20	Laboratory
☐ 10	Hospital - Psychiatric	☐ 26	Federally Qualified Health Center (FQHC)
☐ 11	Hospital – General (☐ *Pediatric)*	☐ 27	Community Services Board (CSB)
☐ 12	Hospital – Physical Rehabilitation	☐ 28	Rural Health Clinic (RHC)
☐ 13	Urgent Care	☐ 24	Other (please describe):

DISCLOSURE QUESTIONS: PLEASE PROVIDE SUPPORTING DOCUMENTATION FOR ANY "YES" ANSWERS.

A. Has the organization or program or members of the organization's/program's staff been named in any malpractice action within the last five (5) years? ☐ YES ☐ NO

B. Has the organization or program or any of the organization's or program's staff members' malpractice insurance been canceled, non-renewed, restricted or special rated within the last five (5) years? ☐ YES ☐ NO

C. 1. Has any government agency investigated, suspended, revoked or taken any other action against the organization or program or any of the organization's or program's staff members' licenses to practice within the last five (5) years? ☐ YES ☐ NO

2. At any time, has any license, specialty board certification or eligibility been revoked, reduced, denied, or suspended by the issuing entity or voluntarily given up by the organization or program or members of the organization's or program's staff, within the last five (5) years or are any actions which could possibly lead to such actions now under way? ☐ YES ☐ NO

D. Has the organization or program or members of the organization's or program's staff had any legal actions brought against them within the last five (5) years or are there any legal actions currently pending against them? ☐ YES ☐ NO

E. Has the organization or program or members of the organization's or program's staff been expelled or suspended from receiving payment under the Medicare and/or Medicaid Program within the last five (5) years? ☐ YES ☐ NO

F. At any time, have any memberships in a professional organization been revoked, reduced, denied, or suspended by others or voluntarily given up by the organization or program or members of the organization or program's staff, within the last five (5) years or are there any actions that may lead to such conclusions now under way? ☐ YES ☐ NO

G. Has the organization or program or members of the organization's or program's staff been removed, sanctioned or suspended from membership in a professional association for violation(s) of its ethical code of practice within the last five (5) years? ☐ YES ☐ NO

SECTION C DECLARATIONS AND CONSENT

The Applicant hereby warrants and represents that all information supplied to Magellan Health, including, but not limited to, licensure, insurance and malpractice history, is true, accurate, and complete. The Applicant further understands that any information entered in this document by Applicant which subsequently is found to be false could result in removal from the network and/or termination of any agreement with Magellan and/or its affiliated companies (Magellan). The Applicant agrees to maintain professional and general liability coverage as stated in this document.

The Applicant grants permission and consent for Magellan, and/or its designee, to obtain and verify information contained on the application and consents to the release by any person, organization, or other entity to Magellan, and /or its designee, of all information that may be reasonably relevant to an evaluation of, including, but not limited to, the Organization's ability to render clinical services, character and moral and ethical qualifications. The Applicant expressly waives any privilege, confidentiality right or privacy right to which the Organization may be entitled. The Applicant agrees to hold harmless any such person, organization or other entity from any cause of action based on the release of such information, in good faith, to Magellan and /or its designee pursuant to this consent. The Applicant releases Magellan and its designees from any liability for any reports, records, recommendations, claims information and claims history, or any other information related to the Organization that are provided to Magellan or its designee by a third party, including otherwise privileged and confidential information given in good faith and related to the credentialing process. The Organization further understands that participation as a provider for Magellan is dependent upon successful completion of the credentialing process. A photocopy of this authorization shall be deemed equivalent to the original.

Applicants serving Medicaid/Medicare population(s): Applicant agrees to comply with applicable state and federal regulations, rules, policies, and procedures relating to servicing Medicaid/Medicare members.

I certify that I am authorized to make the above warranties, representations, authorizations and releases on behalf of this provider organization and to sign this application on behalf of this organization.

Name of Provider Organization (*Please print*)	Name of Authorized Representative (*Please print*)
Date	**Signature of Authorized Representative**

ADDITIONAL SERVICE LOCATION SUPPLEMENT: Submit one copy for each additional service location.

SECTION A CORPORATE ENTITY / MAIN SITE	
MAIN SITE IDENTIFYING INFORMATION	
Legal Name:	TIN Number:

SECTION B DEMOGRAPHIC INFORMATION			
MAILING ADDRESS: ☐ SAME AS CORPORATE ENTITY ☐ SAME AS SERVICE ADDRESS			
BILLING ADDRESS: ☐ SAME AS CORPORATE ENTITY ☐ SAME AS SERVICE ADDRESS			
SPECIFIC SERVICE DELIVERY LOCATION			
Location Name:			
Street Address (No P.O. Box please):			
City:	County:	State:	Zip:
Telephone: ( )	Fax: ( )	Appointment Telephone: ( )	

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