ANCILLARY GROUP PROVIDER APPLICATION

Thank you for your interest in Health Alliance Plan (HAP) and HAP CareSource. To begin the contracting process, please follow the instructions below. Note:

- Behavioral health providers (Autism Centers, Community Mental Health Centers, Inpatient Addiction Disorder Facilities, Inpatient Mental Health Facilities, Inpatient Psychiatric Hospital, Outpatient Addiction Disorder Facilities, Outpatient Ambulatory Facilities, Outpatient Mental Health Facilities, and Partial Day Hospitals) need to complete the *Coordinated Behavioral Health Management Facility/Center Credentialing Application* on **www.hap.org\providers**, then *Join HAP*.
- Credentialing is required for Ambulatory Surgery Centers, Home Health Facilities, and Skilled Nursing Facilities.
- Pain Management Specialists must be credentialed in pain management specialty and should **not** complete this application. Instead, please complete the *Provider Enrollment Form* on **www.hap.org\providers**, then *Join HAP.*

Instructions

1. Download the application.
2. Complete the appropriate sections for your provider type.
3. Sign and date the application.
4. Submit the following **required** documents with your completed application:
    - Accreditation certificate, if applicable
    - CHAMPS approval letter, if applicable
    - CMS Certificate (Medicare letter/number)
    - Current W-9, signed and dated
    - HAP's Disclosure of Ownership and Control Interest Form
    - EIN/IRS letter
    - General Liability Certificate
    - Malpractice insurance certificate
    - State of Michigan license
    - For labs (proprietary testing only), submit letter of interest detailing the proprietary test
    - Roster (PT/OT/ST providers only)
5. Email completed application and required documents to providernetwork@hap.org. **Put "new ancillary application" in the subject line. Incomplete applications with missing documents will not be processed and returned to the provider.**

Pending approval of your application and credentialing (if appropriate), we will send contracts for your review and signature.

Thank you!

March 2025

Please check the appropriate box for your provider type and refer to sections to complete.

X	Provider Type	Sections To Complete
	Ambulance	1, 6
	Ambulatory Surgery Center (Note: Pain Management Specialists do not complete this application).	1, 2, 6
	Anesthesia Group and/or CRNA Group	1, 3, 6
	DME/Prosthetics & Orthotics	1, 4, 6
	Dialysis	1, 6
	Diagnostic Imaging and Radiology	1, 6
	Federally Qualified Health Center (FQHC)	1, 6
	Home Health Care and Home Help Care	1, 6
	Home Infusion	1, 6
	Hospice	1, 6
	Lab (proprietary testing only)	1, 6
	Local Health Department	1, 6
	Long Term Acute Care	1, 6
	Pathology Groups	1, 6
	PT/OT/ST (**roster required**)	1, 6
	Skilled Nursing Facility	1, 6
	Sleep Disorder Center	1, 6
	Urgent Care	1, 6

Section 1
Must be completed by all providers – all fields required

GENERAL	
Corporation name:	
DBA:	
Tax ID:	Type 2 (group) NPI:
Medicare Certificate Number:	CHAMPS# if applicable:
Name of healthcare system affiliation, if applicable:	

PRIMARY FACILITY ADDRESS INFORMATION **(For additional locations, complete section 6).**	
Office street address:	
City, State, Zip:	
Office phone:	Fax:
Contact person name:	
Contact person email:	

FACILITY/OFFICE HOURS THAT PATIENTS CAN BE SEEN

Mon: Tues: Wed: Thurs: Fri: Sat: Sun:

Do you have an after-hours phone number? ☐ Yes ☐ No

If yes, where do you direct patients after hours?

BILLING (PAY TO) INFORMATION	
Billing street address:	
City, State, Zip:	
Billing phone:	Fax:
Contact person name:	
Contact person email:	

MEDICAL DIRECTOR

Please list the name of your Medical Director

Name and Title	NPI	Specialty

LICENSURE/CERTIFICATIONS/ACCREDITATIONS Please list all licenses/certifications/accreditations and submit copies with this application.	
CMS certification (Medicare)	Exp. date:
State license/certification	Exp. date:
Minority Business Ownership Certificate	Exp. date:
General Liability Certificate	Exp. date:
Malpractice insurance certificate	Exp. date:
Michigan Certification of Need (only required for air ambulance)	Exp. date:
Accreditation name:	Exp. date:
Other:	Exp. date:
Other:	Exp. date:
Other:	Exp. date:
Other:	Exp. date:
Other:	Exp. date:
Other:	Exp. date:
Note: For PT/OT/ST, each therapist must be licensed.	

SANCTIONS		
Have there been any settled malpractice claims, suits, settlements or proceedings involving your organization within the past 5 years?	☐ Yes	☐ No
Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐ Yes	☐ No
Has an officer of your organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse or a sexual offense?	☐ Yes	☐ No

COMPLIANCE AND QUALITY		
Is this facility ADA (American Disabilities Act) Compliant?	☐ Yes	☐ No
Is handicap parking available?	☐ Yes	☐ No
Do you have a quality management plan in place? Submit copies of plan, if appropriate.	☐ Yes	☐ No

PATIENT RESTRICTIONS		
Do you have any age restrictions?	☐ Yes	☐ No
If there are any patients you cannot service, please explain.		

LANGUAGES SPOKEN, OTHER THAN ENGLISH

ACLS/BCLS TRAINING					
Do you require ACLS Training?	☐ Yes	☐ No	Do you require BCLS Training?	☐ Yes	☐ No

PT/OT/ST ONLY
Are you a mobile therapy group (home visits)? ☐ Yes ☐ No

GEOGRAPHIC REGION
Describe proximity to hospitals.

SERVICE AREA BY STATE, COUNTY AND CITY
(For example: MI, Wayne County, Detroit)

IF APPLICABLE, INDICATE NUMBER OF BEDS AVAILABLE FOR THE FOLLOWING PATIENTS				
Medicare patients:	Medicaid:	Pediatric:	Custodial:	Total:
☐ N/A				

Section 2
To be completed by Ambulatory Surgery Center

Important!

- Anesthesiology groups and Certified Registered Nurse Anesthetist (CRNA) groups providing services to HAP and HAP CareSource members at an ambulatory surgery facility must be contracted.
- The facility cannot service members until it is credentialed, contracted, and notified in writing of a contract effective date by HAP and HAP CareSource.

Facility Information

Pain Management
Perform stand-alone interventional non-invasive, pain management injections, unrelated to surgery? ☐ Yes ☐ No

CRNA and Anesthesiology Group Services	
CRNA group name:	
Group NPI:	
Contact person:	
Office phone:	Contact person email:
Anesthesiology group name:	
Group NPI:	
Contact person:	
Office phone:	Contact person email:

SURGICAL PROCEDURES
Please list the top 10 procedure codes (#1 = most frequent) performed at the facility.

Rank	CPT CODE	DESCRIPTION
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Section 3
To be completed by Anesthesia Group and/or CRNA Group

Modifiers
☐ Anesthesia Group ☐ CRNA group List modifiers to be billed (AA, QK, QY, QX, QZ):
Monitored Anesthesia Care (MAC) services performed (QS)
List types of services or indicate N/A.
List anesthesia codes to be submitted for pain management, if applicable.
List the name and NPI of facility where services will be rendered (attach another sheet if necessary). Services must be rendered in a HAP contracted entity. This section cannot be blank.
Name:
NPI:
Name:
NPI:
Name:
NPI:
Name:
NPI:

Section 4
To be completed by DME and Prosthetics & Orthotics

Services/products offered – check all that apply.

- ☐ Diabetic supplies
- ☐ Canes
- ☐ CPAP devices and supplies
- ☐ Continuous Passive Motion machine
- ☐ Custom wheelchairs
- ☐ Electric scooters
- ☐ Hospital beds
- ☐ Medical supplies- ostomy, urologic,etc.
- ☐ Orthotics – collars, wrist splints, air casts, braces, etc.
- ☐ Oxygen supplies and equipment
- ☐ Powerchairs
- ☐ Prosthetics
- ☐ Ventilators, accessories and supplies
- ☐ Walkers
- ☐ Wheelchairs
- ☐ Wound care supplies

Proprietary items (note: Certain items may require certification by a specialist):

Other:

Additional information/comments

Section 5
Additional Locations

Note: **If you have more locations, please attach another sheet and be sure to include the information below.**

FACILITY/OFFICE INFORMATION						
Group NPI:			TIN:			
Office street address:						
City, State, Zip:						
Office phone:				Fax:		
Contact person name:						
Contact person email:						
FACILITY/OFFICE HOURS THAT PATIENTS CAN BE SEEN						
Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:
FACILITY/OFFICE INFORMATION						
Group NPI:			TIN:			
Office street address:						
City, State, Zip:						
Office phone:				Fax:		
Contact person name:						
Contact person email:						
FACILITY/OFFICE HOURS THAT PATIENTS CAN BE SEEN						
Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:
FACILITY/OFFICE INFORMATION						
Group NPI:			TIN:			
Office street address:						
City, State, Zip:						
Office phone:				Fax:		
Contact person name:						
Contact person email:						
FACILITY/OFFICE HOURS THAT PATIENTS CAN BE SEEN						
Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:
FACILITY/OFFICE INFORMATION						
Group NPI:			TIN:			
Office street address:						
City, State, Zip:						
Office phone:				Fax:		
Contact person name:						
Contact person email:						
FACILITY/OFFICE HOURS THAT PATIENTS CAN BE SEEN						
Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:

Section 6
Attestation Statement – To Be Completed by All Providers

I agree to the contents thereof as evidenced by my signature that the information provided in this application is true and complete to the best of my knowledge and that omission or falsification of information may be cause for ineligibility or disaffiliation. I further agree that I have current malpractice insurance, and I have disclosed the history of loss or limitation of privileges or disciplinary activity.

Authorized Representative Signature Date

Printed name

MICHIGAN ASSOCIATION OF HEALTH PLANS STANDARD PROVIDER APPLICATION
CONSENT TO RELEASE OF INFORMATION FORM

Provider understands that this Consent to Release Information is made in connection with contracting, credentialing, recredentialing or reappointment activity of the Plan. Provider further understands that the Plan is responsible for the evaluation of its licensure/certification, experience, and professional conduct. All information submitted by the provider or on its behalf pursuant to this Consent to Release Information is true and complete to the best of its knowledge and belief. Provider fully understands that any misstatement in or omission related thereto may constitute cause for the summary dismissal/denial of such participation in the Plan. Provider understands and agrees that as an applicant for participation with the Plan, Provider has the burden of producing adequate information for proper evaluation of its professional competence, character, ethics and other qualifications and for resolving any doubts about such qualifications.

Provider hereby authorizes the Plan and its representative to contact and/or consult with any persons, entities or institutions (including, but not limited to, hospitals, HMOs, PPOs, other group practices and professional liability carriers) which the Provider has been affiliated with, have used for liability insurance or who may have information relevant to its character and professional competence and qualifications, whether or not such persons or institutions are listed as references.

Provider also authorizes and directs persons contacted by the Plan to provide such information regarding the Provider's character and/or professional competence and qualifications, professional liability insurance and/or malpractice insurance claims history to representatives of the Plan and Provider understands in doing so, Provider is waiving its confidentiality rights to this information. Provider releases and holds harmless from liability all persons, entities, or institutions who, in good faith and without malice, for acts performed in gathering or exchanging information in this credentialing or recredentialing process. This release and hold harmless provision applies to all persons, entities and institutions who will provide and/or receive, as part of the Plan's credentialing or recredentialing process, information which may relate to past or present deficiencies.

Provider further authorizes the release of the above information, or any other information obtained from the application by a credentialing verification organization (CVO) to any health care organization designated by Provider or one that has entered into an agreement with the CVO where Provider currently is applying, or in the future will be applying for participation. Provider also authorizes the CVO or the Plan to allow its file to be reviewed by the organizations' state or national accrediting and licensing bodies.

A photocopy of this consent shall be as effective as an original when presented.

Provider Name

Authorized Representative Signature

Printed Name

Date