Vaya Health

Credentialing Initiation Form: Licensed Practitioner

Use this form to initiate the Vaya Health credentialing process. Completion of this form is required in addition to the CAQH Application.

Vaya Health (Vaya) is responsible for processing all applications for credentialing submitted by applicants seeking to become a member of its closed network. Vaya is responsible for making its own decisions about credentialing approval, enrollment, network membership and contracting.

This form and required attachments must be submitted via secure electronic transmission to: CredentialingTeam@vayahealth.com. Alternatively, this form and attachments may be submitted to:

Credentialing Team
Vaya Health
200 Ridgefield Court
Asheville, NC 28806

INSTRUCTIONS

All licensed practitioners seeking to provide clinical services to Vaya Health Plan members must be credentialed. This includes licensed practitioners (LPs) who bill through an agency, group practice or facility and Licensed Independent Practitioners (LIPs) seeking a direct contract with Vaya. The credentialing process for practitioners includes submission of this CIF and attachments, completion of a CAQH application, verification of credentials and review of the application by the Vaya Credentialing Committee. The Credentialing Committee will make a final determination about any applicant's credentials. The credentialing effective date may not be earlier than the date a complete application was received by Vaya. For LPs, the billing effective date cannot be earlier than the credentialing effective date. ***The provision of services prior to receiving notification of approved credentials is at the sole risk of the agency/ applicant.*** For LIPs, the billing effective date may not be earlier than the effective date of the contract between the credentialed applicant and Vaya.

This CIF must be completed in its entirety, with all questions addressed and required information submitted. Any required attachments should be easily identifiable and submitted with the CIF in sequential order. Previous versions of this CIF will not be accepted. A clean CIF includes a signed attestation and all required information and documentation in order for the credentialing verification to be completed, i.e., that Vaya has determined no further information is required and that all information provided is complete, accurate and contains no conflicting information. Vaya will notify applicants if the CIF is incomplete. A CIF is considered to be incomplete if:

- All spaces in the CIF have not been completed. (Please indicate "N/A" or "None" if the question is not applicable.)
- The Attestation and Consent for Release are not signed and dated.
- The text has been altered, highlighted, struck through or obstructed through the use of correction fluids.
- The responses are illegible.
- Any of the required documents or pages are missing.

Note: An individual NPI number is now required for all practitioners, including associates.
To apply for a new NPI number, visit https://nppes.cms.hhs.gov/NPPES/Welcome.do.

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Name: _____ _____ _____ _____
First *Middle* *Last* *Maiden (if applicable)*

Are you applying as (check one):

☐ An employee of an agency, group practice or facility?
If yes, enter agency name: _____

Start date with current agency, if applicable: _____

☐ Licensed Independent Practitioner? ***(Note: Independent practitioners must receive prior approval from Vaya to submit this form.)***

Individual NPI number: _____ **TIN (tax ID #):** _____ **CAQH number:** _____

License number: _____ **Primary taxonomy number:** _____

Provider type:

☐ MD	☐ Clinical psychologist	☐ Adv. practice psychiatric CNS (APPCNS)
☐ DO	☐ Physician's assistant (PA)	☐ Psychiatric mental health NP (PMHNP)
☐ LPC/LCMHC	☐ Neuropsychologist	☐ Out-of-state license type:
☐ LCSW	☐ Psychological associate	_____
☐ LMFT	☐ LCAS	

For specialized consultative IDD services only:

☐ Physical therapist (PT)	☐ Occupational therapist	☐ Speech therapist
☐ BCBA	☐ Certified therapeutic recreational therapist	☐ Nutritionist

Contact person: _____ **Contact email:** _____
Contact phone: _____ **Practitioner agency email:** _____
Practitioner direct email: _____

Home address: _____ _____ _____ _____
Street *City* *State* *ZIP Code*

Site address: _____ _____ _____ _____
Street or P.O. Box *City* *State* *ZIP Code + 4 (required)*

Site county: _____

Mailing address: _____ _____ _____ _____
(if different) *Street or P.O. Box* *City* *State* *ZIP Code + 4 (required)*

Employment gaps: Please explain any gaps in employment longer than six months in the last five years. Use a separate sheet if necessary.

_____

5% OWNERSHIP OR CONTROL DISCLOSURE

Do you have ownership or control interest of 5% or more in other organizations that bill Medicaid for services?

☐ Yes ☐ No *(If you answered yes, complete the following information for each relevant entity.)*

Entity's legal name:	Federal tax ID #:	Medicaid #

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PRACTICE INFORMATION

Help us communicate to members, staff and others what they need to know about you. *Credentialing cannot be initiated without receipt of this form. Check all that apply to your scope of practice/expertise (proof may be requested).*

General categories:	**Ages:**	
☐ Mental health	☐ Young child (ages 3-5)	☐ Older child (ages 6-12)
☐ Intellectual/developmental disabilities	☐ Adolescent (ages 13-20)	
☐ Substance use	☐ Adult (ages 21-64)	☐ Geriatrics (age 65+)

General and applied approaches:

☐ ADHD	☐ Conduct disorders	☐ Group therapy	☐ Posttraumatic stress
☐ Alcohol and other drug use	☐ Co-occurring MH/SU issues	☐ HIV/AIDS	☐ Psychological testing
☐ Anger management	☐ Dementia	☐ Learning disabilities	☐ Psychotic disorders
☐ Anxiety disorders	☐ Dialectical behavior therapy	☐ Mood disorders	☐ Sex offender treatment
☐ Applied behavioral analysis	☐ Eating disorders	☐ Neurodegenerative disorders	☐ Sexual behavior problems
☐ Autism spectrum	☐ Faith-based counseling	☐ Neuropsychological disorders	☐ Trauma-focused treatment
☐ Behavior therapy	☐ Family systems	☐ Parent training	☐ Traumatic brain injury
☐ Biofeedback	☐ Forensic screening/ evaluation*	☐ Personality disorders	☐ Women's issues
☐ Cognitive behavior therapy	☐ Lesbian/Gay/ Nonbinary/Transgender	☐ Play therapy	☐ Other (please specify): _____

Clinician certification/expertise (may require verification):

☐ Addiction psychiatry fellowship, board or ASAM certification	☐ Addiction treatment (LCAS, CSAC, CCS)	☐ Child psychiatry fellowship or board certification	☐ Forensic psychology/ psychiatry * (N.C. state certification required to complete forensic screenings and evaluations)

☐ Caucasian	☐ Black or African-American	☐ American Indian/Alaska Native
☐ Asian/Pacific Islander	☐ Hispanic/Latino	☐ Other (please specify): _____

Language(s) other than English in which you are able to communicate fluently:

☐ Spanish	☐ American Sign Language	☐ Other (please specify): _____
☐ Available interpreter types: _____		

Race/ethnic background (information is voluntary and can be used publicly):

☐ Caucasian	☐ Black or African-American	☐ American Indian/Alaska Native
☐ Asian/Pacific Islander	☐ Hispanic/Latino	☐ Other (please specify): _____

Do you have any current contracts with other Medicaid managed care organizations (including LME/MCOs or out-of-state MCOs), or have you had any such contracts in the past three years?

☐ Yes ☐ No *If yes, please identify the MCO(s):* _____

Please indicate the method you will use to perform electronic billing:

☐ Web-based billing via high-speed internet connection

☐ HIPAA-compliant transaction sets (837 transactions and 835 remittances)

Note: You must be able to send 837 transactions and receive 835 remittances OR participate in the LME/MCO web-based billing portal as a condition of participation.

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Check "yes" or "no". For each question answered "yes," provide a detailed explanation on a separate page and any documentation supporting your explanation. The explanation should describe the circumstances that led to the event. Failure to disclose will result in the denial of the application.	**YES**	**NO**
A. Have you ever been excluded from providing publicly-funded healthcare services or otherwise identified on the List of Excluded Individuals/Entities maintained by the U.S. Health and Human Services Office of Inspector General, the U.S. System for Award Management list or the Exclusion list maintained by N.C. DHHS?	☐	☐
B. Have you ever had an overpayment in excess of $50,000.00 identified by Medicare or a Medicaid program in any state, or have you been employed by an organization that had an overpayment in excess of $50,000.00 identified by Medicare or a Medicaid program in any state, even if the overpayment has been paid in full?	☐	☐
C. Have you ever had civil monetary penalties levied by Medicare, Medicaid or other state or federal agency or program, including the N.C. Division of Health Service Regulation (DHSR), or been employed by an organization that had civil monetary penalties levied by Medicare, Medicaid or other state or federal agency or program, including the N.C. Division of Health Service Regulation (DHSR), even if the fine(s) has/have been paid in full?	☐	☐
D. Do you owe money to Medicare, any state Medicaid program (including North Carolina Medicaid) or any LME/MCO that has not been paid?	☐	☐
E. Have you ever been found to have violated federal or state laws, rules or regulations governing North Carolina's Medicaid program or any other state Medicaid program, or any other publicly funded federal or state healthcare or health insurance program, and been sanctioned accordingly?	☐	☐
F. Have you ever been convicted of any criminal offense related to the neglect or abuse of a patient in connection with the delivery of any healthcare goods or services?	☐	☐
G. Have you ever been convicted of any criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?	☐	☐
H. Have you ever been convicted of any criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility or other financial misconduct?	☐	☐
I. Have you ever been charged with, arrested for or convicted of a misdemeanor or felony, including but not limited to Driving Under the Influence (DUI) or Driving While Impaired (DWI), or any minor traffic violations?	☐	☐
J. Have you ever been convicted of any criminal offense in a country outside the jurisdiction of the United States?	☐	☐
K. As of the date of this application, do you have any pending charges related to the above categories of "A" through "J"?	☐	☐

ARRANGEMENTS FOR 24-HOUR/7-DAY COVERAGE:

Please provide a name and telephone number of the on-call designee or an explanation of 24-hour/7-day coverage:

Name: _____ **Phone number:** _____

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Please attach the following documents (all applicants):

- ☐ Resume and/or curriculum vitae that includes all training and professional history following graduation from medical, dental or other professional school
- ☐ Copy of the Certificate of Insurance (COI) for current Professional Liability insurance with minimum $1,000,000 occurrence/ $3,000,000 aggregate policy coverage amounts

Please attach the following documents(if applicable):

- ☐ Collaborative Practice Agreement (NPs and PAs)
- ☐ Supervision Agreement (Practitioners w/associate license)

Do you have 100% ownership of this practice? ☐ Yes ☐ No

If your answer is no, complete the following information for each relevant individual/entity with 5% or more direct or indirect ownership or control interest. Any individuals listed below must complete the release form provided on page 7 of this document.

Entity legal name	Federal tax ID #	Medicaid #

Please attach the following documents (LIP only):

- ☐ W-9 form
- ☐ Copy of the Certificate of Insurance (COI) for current General Liability insurance with minimum $1,000,000 occurrence/ $3,000,000 aggregate policy coverage amounts; must include the Waiver of Subrogation and Additional Insured naming Vaya Health
- ☐ Copy of the Certificate of Insurance (COI) for current Automobile Liability and Workers' Compensation insurance policy coverage in the required amounts OR a signed and dated attestation that you are not required to hold such coverage. For Automobile Liability, the COI must include the Waiver of Subrogation and Additional Insured naming Vaya Health.

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ATTESTATION AND SIGNATURE

All information included in this Credentialing Initiation Form, provided in my CAQH application or submitted as an attachment or supplemental information (collectively, "application"), is true, accurate and complete to the best of my knowledge and belief as of the date of signature below. I understand that any misstatement or failure to disclose may constitute grounds for denial of the application, revocation of credentials or termination of a resulting participating agreement.

By applying for participation in the Vaya Health Provider Network, I signify my willingness to appear for an interview in regard to my application. I further authorize Vaya Health (Vaya) to consult with any individuals at any organization with which I am currently or have previously been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in the credentialing application or any associated documents. I further authorize Vaya to collect any information necessary to verify the information in the credentialing application. Upon request, I will obtain and provide to Vaya materials pertaining to my qualifications and competence, including materials relating to complaints filed, any disciplinary action, suspension or action to curtail my clinical privileges. I further consent to the inspection by representatives of Vaya all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that as an applicant, I have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Vaya for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability all individuals and organizations that provide information to Vaya in good faith and without malice concerning this application, and I hereby consent to the release and verification of information relating to any disciplinary action, suspension or curtailment of clinical privileges to Vaya. **I understand, agree and acknowledge that denial of this application does not constitute grounds for appeal in any forum.**

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Vaya may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank. If I am accepted for participation in the Vaya Health Provider Network, I hereby consent to inspection by Vaya of my health records relating to Vaya enrollees as necessary for its peer and utilization review purposes as permitted by federal and state laws, rules and regulation.

In the event that this application for credentialing is approved, I agree to notify Vaya within five (5) business days of any changes to the information requested on the initial application, or within such timeframes identified in the Vaya Health Network Participation Agreement and/or Vaya Health Provider Operations Manual.

Signature of Practitioner: _____ **Date:** _____

Vaya Health

Authorization, Consent and Release

to Perform Criminal Background and Exclusion Checks pursuant to the Fair Credit Reporting Act (FCRA) and the Federal Driver's Privacy Protection Act (DPPA)

This form must be completed by every practitioner, owner and managing employee identified on the Credentialing Initation Application.

Name of agency, group practice, facility or hospital submitting application: _____

Last name: _____ **First name:** _____ **Middle initial:** _____

Maiden and/or other last names used: _____ **Gender:** ☐ Male ☐ Female ☐ Non-binary ☐ Transgender

Driver's license no.: _____ **State issued:** _____ **Expiration date:** _____

Date of birth: _____ **Social Security Number:** _____

Please list all counties and states where you have resided for the past five years:

County and state:	From month/year:	To month/year:

By signing below, I authorize Vaya Health ("Vaya"), its staff, authorized representatives and/or its agent, Accurate Background, to conduct background investigations as part of an application for credentialing or re-credentialing submitted by the organization listed above, whether the records are of a public, private or confidential nature. These investigations are limited to searches of motor vehicle records and criminal history information on file in local, state or federal agencies; searches of local, state or federal records necessary for participation in public healthcare programs, including, but not limited to, the U.S. Health and Human Services Office of Inspector General List of Excluded Individuals and Entities (LEIE), the Medicare Exclusion Databases (MED), the System of Award Management (SAM), the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System; and verification of education, employment history and professional liability/licensure history as applicable. Vaya does not perform searches of commercial or retail credit agencies.

I understand that these searches will be used to determine eligibility for credentialing and participation in the Vaya Closed Network, that information obtained pursuant to this authorization is confidential and that disclosure of this information will be limited only to those persons or entities to whom such disclosure is necessary or authorized for purposes of credentialing verification. Therefore, I authorize and consent for full release of records (either orally or in writing) to Vaya, its staff, authorized representatives and/or its agent, Accurate Background. In addition, I release and discharge Vaya, its staff, authorized representatives and its agent and associates to the full extent permitted by law from any claims, damages, losses, liabilities, costs expenses or any other charge or complaint filed with any agency arising from retrieving and reporting this information. I understand that according to the federal Fair Credit Reporting Act, I am entitled to know whether credentialing was denied based upon the information obtained and to receive, upon written request, a copy of the background report. After reading this document, I fully understand its contents and authorize the background investigation. This authorization shall expire one (1) year from the date signed below, or, if the applicant is approved for participation in the Vaya Health Provider Network, upon termination of such participation.

I hereby certify that all information provided in this authorization and release is true, correct and complete.

Signed this _____ day of _____, 20_____

Applicant (print name): _____

Applicant signature: _____