PreferredOne®

Provider Selection Criteria for PreferredOne Participating Practitioners

General Criteria

1. Practitioner must serve a specialty and/or geographic need for the good of the PreferredOne product for which they are applying.

2. Practitioner must have a current unrestricted/unconditional license/registration in each state services are provided and certification as required.

3. If a practitioner has hospital admitting or attending privileges, the practitioner must have privileges and be a member in good standing of the medical staff at a PreferredOne participating hospital. The existence of any restrictions on privileges must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

4. Practitioner must accept PreferredOne fee schedules.

5. Practitioner must have arranged for 24-hour coverage, 7 days per week.

6. Practitioner must accept patients from all purchasers of the specific PreferredOne products applied for.

7. Practitioner must agree to maintain referrals and admissions at all times within the existing provider network except as authorized by the Medical Director or designee.

8. Practitioner must maintain professional liability (malpractice) insurance in amounts as established from time to time by PreferredOne Boards of Directors.

9. The presence of any past disciplinary or corrective action or current investigation by the State Licensing, Certifying or Registering Board or any other regulatory authority (i.e. Medicare, Medicaid, etc.) having jurisdiction over the practitioner must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

10. The existence of any pending or past professional liability claims must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

11. Practitioner agrees to authorize review organizations to release to PreferredOne and information relating to practitioner's professional competence or conduct. Practitioner may present his/her own information also.

12. Practitioner agrees to participate in and cooperate fully with all procedural terms and requirements of the PreferredOne Network Management Services Program that monitors provider performance in terms of chart review (both inpatient and outpatient) for the purpose of identifying quality issues.

13. Practitioner must disclose any restricted/conditioned licensure/registration in each state services are provided. The information will be examined and acted upon as deemed necessary by the Credentialing Committee.

14. A practitioner must be able to document his/her:
    - Training, experience, and demonstrated competence
    - Adherence to the ethics of their profession, good reputation, and character
    - Physical & emotional health status
    - Ability to work with others

15. Practitioner agrees to promptly inform PreferredOne of any changes in licensure, disciplinary actions, professional liability actions, or practice circumstances.
16. Practitioner agrees to inform PreferredOne if charges are pending or if currently charged with or ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense.

17. Practitioner must have an absence of a physical or mental condition that would adversely affect the practitioner's ability with or without accommodation, to provider appropriate care to patients and must be able to perform the essential functions in the practitioner's area of practice without posing a health or safety risk to patients.

Specific Criteria for Nurse Practitioner

1. (A) Nurse Practitioner must have active certification as a Nurse Practitioner by an accredited national professional nursing organization accredited by the National Commission for Certifying Agencies (NCCA).

2. (B) Nurse Practitioners will provide services through a PreferredOne contracted medical group.

3. (C) Nurse Practitioners providing services outside of PreferredOne contracted medical group will be handled on a case by case basis.

4. A Nurse Practitioner applying for network participation must meet the criteria of **A and B** or **A and C**.

Specific Criteria for Nurse Midwife

1. Nurse Midwives who prescribe medications must have a current valid DEA and/or CDS in each state where care is provided. If the Nurse Midwife does not hold a DEA/CDS license or it is pending, there must be documented process for allowing a participating practitioner with a valid DEA/CDS certificate to write all prescriptions.

2. Certified Nurse Midwife must be certified through the American College of Nurse Midwives.

3. Independent Certified Nurse Midwives must have a Joint Prescribing and Collaborative Practice Agreement with a participating OB/Gyn.

PreferredOne®

Pre-Application for Providers

This pre-application serves to provide us with general information regarding your practice and professional background. **This form must be completed for each practitioner in the clinic and returned along with a completed "New Clinic/Facility Information Form"**. Incomplete pre-applications will be immediately pended. Thank you for your interest. Please print or type.

Name:	**Degree/License:**
NPI #:	

1. Please list all current State Licensure numbers:

State Licensure:	**Number:**	**Expiration Date:**
State Licensure:	**Number:**	**Expiration Date:**

2. Please list your professional liability carrier:

3. Are you currently a PreferredOne Provider with a different practice? ☐ **Yes** ☐ **No**
If yes, will you continue to practice at this location? ☐ **Yes** ☐ **No**

4. Please list any Special/Unusual Skills or Services?

5. Who provides on-call coverage for your practice?

6. Please list supervising physician name:

7. Are you affiliated with any physicians or other professionals?

☐ **Yes** ☐ **No**	**If Yes, please list:**

I affirm that the foregoing are True Statements and Facts ☐

Signature:	**Date:**

(If filling out this form electronically, please just check the above box and type in your name and date)

PreferredOne®

Provider Assurance Statement for Telemedicine

Provider Name	NPI

This Assurance Statement is an addendum to the Provider Agreement.

Telemedicine definition

Telemedicine is the delivery of health care services or consultations through electronic communication while the patient at one site and the licensed health care provider at a distant site. Effective January 1, 2018, PreferredOne covers medically necessary services and consultation by a licensed health care provider through telemedicine in the same manner as if the service or consultation was delivered in person. (Minn. Stat. 256B.0625, Subd. 36).

Applicant Assurance Statement

By initialing each requirement and signing below, I, the above-named applicant, attest to compliance with the following and acknowledge that I will maintain documentation proving compliance with these requirements:

_____ I have written policies and procedures specific to telemedicine services that I review and update regularly.

_____ I have policies and procedures that adequately address patient safety, before during and after the telemedicine service is rendered.

_____ I have established quality assurance process related to telemedicine services which includes all applicable Health Insurance Portability and Accountability Act (HIPPA) requirements.

_____ My agency has documentation of each occurrence of a health care service provided by telemedicine that includes all of the following

- The type of service provided
- The time the service began and the time the service ended
- A description of the provider's basis for determining that telemedicine is an appropriate and effective means for delivering service to the recipient
- The mode of transmission of the telemedicine service
- The location of the originating and the distant site

APPLICANT NAME (authorized representative)	APPLICANT SIGNATURE	Date

Fax the signed Applicant Assurance Statement with your completed PreferredOne Provider Enrollment Application packet & other required documents to 763-847-4010

PreferredOne®

New Clinic/Facility Information Form

Corporate Name: **List in PreferredOne Directory?** ☐ **Yes** ☐ **No**	**Clinic/Facility Name:**
Administrator Name & Phone:	**Billing Manager Name & Phone:**

Billing/Remit Information	**Physical Site Information** *(Site 1)*	**Physical Site Information** *(Site 2)*
Claims Form Type: ☐ **HCFA** or ☐ **UB92** **Tax ID** (as filed with IRS)**:**		
Billing Name:	**Clinic Name:**	**Clinic Name:**
NPI:	**NPI:**	**NPI:**
Address:	**Address:**	**Address:**
City/State/Zip:	**City/State/Zip:**	**City/State/Zip:**
Phone: **Fax:**	**Phone:** **Fax:**	**Phone:** **Fax:**
Email:	**Email:**	**Email:**
Website:	**Hours:**	**Hours:**
Billing ID *(Internal use only)***:**	**PGID** *(Internal use only)***:**	**PGID** *(Internal use only)***:**

Provider/Facility Information							*(Internal use only)*			
List in Directory? (Y or N)	**NPI**	**Name (First, MI, Last)**	**Degree**	**Specialty**	**License Number**	**Site Number (1, 2, etc.)**	**Effective Date**	**Term Date**	**Prov/Fac ID Episodes**	**Facets ID**

(Internal use only)

Comments/Instructions

System Updated					
☐ **Episodes**	**Date:**	**Initials:**	☐ **Facets**	**Date:**	**Initials:**
☐ **Provider Guide**	**Date:**	**Initials:**	☐ **NetworksPro**	**Date:**	**Initials:**
			Tracking Number:		

MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

☐ Initial Credentialing ☐ Re-credentialing

APPLICATION INSTRUCTIONS

- ALL fields must be completed unless otherwise directed
- Additional instructions are ***bolded*** in *italics* on the application
- Submit completed application along with **all** required documentation

APPLICATION NOTES

- For the purposes of this application, "facility" is defined as a hospital; home health agency; skilled nursing facility; ambulatory surgery center; and inpatient, residential, and ambulatory behavior health facility
- As required by the facility contract and accrediting agencies, a completed application is required at the time of contracting and at least every 3 years thereafter
- Failure to complete this application in its entirety, including submission of required documentation may delay or suspend network participation
- The Minnesota Uniform Facility Credentialing Application may be used by other organizations

ATTACHMENTS

THE PROCESSING OF YOUR APPLICATION WILL BE DELAYED IF ALL REQUIRED INFORMATION IS NOT SUBMITTED

☐	Copy of all **current** State and/or local licenses required to operate as a health care facility
☐	State / local license not required [**Explanation Needed**]
☐	Signed copy Medicare certification documents from CMS
☐	Copy of facility's **current** Commercial General Liability insurance certificate (not required by HealthPartners and UCare)
☐	**Current** copy of facility's Professional liability insurance certificate covering all facility employees (not required by HealthPartners and UCare)
☐	Copy of **current** accreditation letter or certificate
☐	**Current** copy of your onsite governmental licensing agency survey including facility's corrective action plan if deficiencies were cited, OR cover letter/e-mail from licensing agency stating facility is in substantial compliance with licensing standards

Submitting Instructions

- **Modification to the wording or format of this application will invalidate the application.**

- **Complete the application in its entirety and E-Mail application to the applicable Health Plan**

☐ **BlueCross Blue Shield: credentialing@bluecrossmn.com**

☐ **Hennepin Health: HHCredentialing@hennepin.us**

☐ **HealthPartners: qualityrecredentialing@healthpartners.com**

☐ **Medica: www.medica.com/providers/join-our-provider-network/join-the-network**
Or contact the Provider Service Center at 1 800-458-5512

☐ **PreferredOne: credentialing@preferredone.com**

☐ **UCare: credentialinginfo@ucare.org**

MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

1. FACILITY IDENTIFICATION

CORPORATE IDENTIFICATION INFORMATION

LEGAL BUSINESS NAME *(as reflected on W-9)*	**FEDERAL TIN/TAX ID** *(application cannot be processed without valid 9 digit TIN)*
BUSINESS ADDRESS *(if different than facility address)*	**TYPE-2 NPI** *(application cannot be processed without valid 10-digit NPI)*
ORGANIZATION CLASSIFIED AS: ☐ Corporation ☐ Partnership ☐ Not-For-Profit Corp ☐ Sole Proprietorship ☐ Other (Specify)	**Is facility owned in whole or in part or managed by a hospital or health care system/facility?** ☐ Yes, owned in whole or in part by ☐ Yes, managed by ☐ No, not affiliated with a hospital or health care system/Facility

FACILITY INFORMATION

FACILITY DOING BUSINESS AS NAME *(as reflected on W-9)*

STREET ADDRESS:		**CITY:**	**STATE:**	**ZIP CODE:**
COUNTY:	**PHONE:**	**FAX:**	**WEBSITE:**	

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone, Fax)*

APPLICATION CONTACT PERSON *(Name, Title, Email, Phone, Fax)*

MAILING/CORRESPONDENCE ADDRESS

☐ Check here if all correspondence can be directed to the facility location directly above. Otherwise, complete the section below.

NAME

EMAIL

COUNTY

OFFICE ADMINISTRATOR *(Name, Title, Email, Phone, Fax)*

APPLICATION CONTACT PERSON *(Name, Title, Email, Phone, Fax)*

2. MEDICAL DIRECTOR OR EQUIVALENT

A Medical Director or equivalent must clearly be identified and must be licensed in good standing.

Name: ☐ MD ☐ DO Specialty:

License Number: NPI Number:

Phone Number: Email Address:

3. FACILITY TYPE

One box must be checked based on licensure status. If your provider type is not listed below, do NOT complete this application

	MEDICAL
☐	Ambulatory Surgery Center - Free Standing
☐	Home Health Care Agency - Providing skilled nursing services
☐	Hospital - All Types including Psychiatric (# of Medicare certified beds:)
☐	Skilled Nursing Facility / Nursing Home (# of Medicare certified beds:)
	BEHAVIORAL HEALTH
☐	Adult Licensed Residential Crisis
☐	Children's Residential Facility - Mental Health Treatment
☐	Children's Residential Facility - Substance Abuse Treatment
☐	Eating Disorders Residential Facility
☐	Mental Health Residential Treatment, IRTS, or Residential Crisis
☐	Partial Psych/Partial Hospitalization - Free standing only
☐	Substance Abuse Treatment - Outpatient and / or Residential / Inpatient
☐	Outpatient Treatment Program

FOR HOSPITALS ONLY

Does your Facility provide any of the following services?

Critical Access Hospital	☐ Yes	☐ No	Cardiac Surgery Program	☐ Yes	☐ No
Outpatient Dialysis	☐ Yes	☐ No	Physical Therapy	☐ Yes	☐ No
Critical Care Services - Intensive Care Unit (ICU)	☐ Yes	☐ No	Occupational Therapy	☐ Yes	☐ No
Diagnostic Radiology	☐ Yes	☐ No	Outpatient Infusion / Chemotherapy	☐ Yes	☐ No
Mammography	☐ Yes	☐ No	Speech Therapy	☐ Yes	☐ No
Genetic Counseling and Testing	☐ Yes	☐ No	Laboratory Services	☐ Yes	☐ No
Cardiac Catheterization Services	☐ Yes	☐ No			

4. FACILITY LICENSURE

Attach a copy of each Facility license for this facility. Do not submit Practitioner licenses. Residential Behavioral Health facilities must submit State license and Board & Lodging/Supervised Living license.

Licensing Agency	License Number	Effective date	Expiration Date

5. MEDICARE STATUS

Is this facility/program/agency Medicare certified? ☐ YES ☐ NO

If Yes: Medicare number: Date of initial Certification:

☐ Check here if facility is not eligible for Medicare certification.

6. ACCREDITATION

The Facility being credentialed must be listed in the accreditation

☐	**AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities**
☐	**AAAHC - Accreditation Association for Ambulatory Health Care**
☐	**ACHC - Accreditation Commission for Health Care**
☐	**CARF - Commission on Accreditation of Rehabilitation Facilities**
☐	**CCAC - Continuing Care Accreditation Commission**
☐	**CHAP - Community Health Accreditation Program**
☐	**COA - Council on Accreditation**
☐	**DNV / NIAHO - Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations**
☐	**HFAP - Healthcare Facilities Accreditation Program**
☐	**TJC - The Joint Commission (Formerly known as JCAHO)**

1. Date of last full site survey by accrediting body:

2. Site survey is scheduled:

3. Effective date of accreditation: through

Facility is not currently accredited. *Complete Non Accredited Facility Section below.*

7. NON ACCREDITED FACILITY

Complete this section if facility is not accredited.

Medical Facility: Has your State completed an onsite licensing review or has CMS certification survey within the past 36 months?

☐ **YES - Date of most recent onsite survey:**

Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.

☐ **NO -** ***Successful completion of a health plan onsite visit will be required to complete re/ credentialing.*** **You will be contacted by health plan to schedule the visit.**

If your State has not had a Services Site survey within the past 36 months, please note when your next site survey is scheduled:

Behavioral Health Facility: Has your State completed an onsite licensing site review within the past 36 months?

☐ **YES- Date of most recent onsite survey:**

Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.

☐ **NO –** ***Successful completion of a health plan onsite visit will be required to complete re/credentialing.*** **You will be contacted by health plan to schedule the visit.**

If you have not had a State site survey within the past 36 months, please note when your next site survey is scheduled:

8. HEALTH PLAN SITE VISIT:

Does your branch or satellite location(s) follow the same policies and procedures as your main facility?

☐ Yes - Fill out the attached Policy and Procedure Attestation on the page 7.

☐ No - When the health plan contacts you to schedule the health plan site visit, it will be determined if site visits are required for the branch/satellite locations.

POLICY ATTESTATION

Please list any other facilities under the same name and/or tax id number as name of facility, specialty and location listed on this application.

If your facility follows the same policies and procedures as your main facility, the **Health Plan** may limit a site visit to the main facility so long as the policies and procedure are the same.

Attestation:

I, the undersigned authorized agent, hereby attest and certify that (name of facility, specialty and location) shares the same policies and procedures as: (list all facilities, specialty and locations)

Facility Name	Specialty	Location	TIN	NPI

_____ _____/_____/_____

Signature of Authorized Representative Date Signed

_____ _____

Printed Name Title

9. CREDENTIALING PROGRAM

Indicate how credentialing is ensured for all health care professionals employed or contracted at the facility:

☐ Credentialing procedures are performed internally

☐ Credentialing procedures are outsourced/delegated to:

Name : Phone Number:

10. INSURANCE COVERAGE (*This information is not needed for approval for the following HealthPartners and UCare*)

1. This facility is covered by **Commercial General** liability insurance in the minimum amount of

$ per occurrence and $ aggregate? (Excess liability/Umbrella coverage can count toward the

$ aggregate amount.)

☐ YES - ***Attach copy of insurance certificate.*** We prefer the Acord® Certificate of Liability Coverage form.

☐ NO - ***Please obtain the required amount of coverage before submitting this application.***

Facility is covered by Government insurance. – ***Attach documentation detailing coverage.***

2. Is this facility covered by **Professional** liability insurance in the minimum amount of $1 million per occurrence and $3 million aggregate? Policy must state it covers all facility employees. (Excess liability/Umbrella coverage can count toward the $3 million aggregate amount.)

☐ YES - ***Attach copy of insurance certificate.*** We prefer the Acord® Certificate of Liability Coverage form.

☐ NO - ***Please obtain the required amount of coverage before submitting this application.***

Facility is covered by Government insurance. - ***Attach documentation detailing coverage.***

NOTE: Hospitals may require additional insurance coverage amounts if the hospital has over 100 beds ($5 million occurance/$5 million aggregate).

MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

FACILITY CREDENTIALING APPLICATION LANGUAGES

●Check all languages spoken by facility/agency/program staff fluently enough to treat patients/clients who speak only that language.

●Indicate if Sign Language and/or an Interpreter Service is available at your facility

☐	AFRIKAANS	☐	HILIGAYNON	☐	OROMO
☐	AKAN	☐	HINDI	☐	PAKASTANI
☐	ARABIC	☐	HINDU	☐	PERSIAN
☐	ARABIC NORTH LEVAN	☐	HMONG	☐	POLISH
☐	ARMENIAN	☐	IBO OF NEGERIA	☐	PORTUGUESE
☐	ASSAMESE	☐	ICELANDIC	☐	ROMANIAN
☐	BENGA	☐	INDONESIAN	☐	RUSSIAN
☐	BENGALI	☐	IOLCANO	☐	SERBIAN
☐	BOSNIAN	☐	ITALIAN	☐	SINDHI
☐	BULGARIAN	☐	KANNADA	☐	SINHALA
☐	BURMESE	☐	KAREN	☐	SLAVIC
☐	CAMBODIAN	☐	KASHMIRI	☐	SLOVENIAN
☐	CANTONESE	☐	KISII	☐	SOMALI
☐	CHILEAN	☐	KISWAHILI	☐	SPANISH
☐	CHINESE	☐	KONKANI	☐	SWAHILI
☐	CHINESE MANDARIN	☐	KOREAN	☐	SWEDISH
☐	CROATIAN	☐	KUNIAN	☐	TAGALOG
☐	CZECH	☐	KURDISH	☐	TAIWANESE
☐	DANISH	☐	LATIAN	☐	TAMIL
☐	DUTCH	☐	LAOTIAN	☐	TELUGU
☐	EGYPTIAN	☐	LATVIAN	☐	THAI
☐	ESAN	☐	LIINGALA	☐	TIGRIGNA
☐	EATONIAN	☐	LITHUANIAN	☐	TSWANA
☐	FARSI	☐	LUGANDA	☐	TURKISH
☐	FILIPINO	☐	LUO	☐	TURKMEN
☐	FINNISH	☐	MALAY	☐	UKRANIAN
☐	FLEMISH	☐	MALATALAM	☐	URDU
☐	FRENCH	☐	MANDARI	☐	VIETNAMESE
☐	GERMAN	☐	MANDINKA	☐	WELSH
☐	GREEK	☐	MARATHI	☐	WOLOF
☐	GUJARATI	☐	NEPALI	☐	YIDDISH
☐	HAITIAN CREOLE FRENCH	☐	NORWEGIAN	☐	YORUBA

OTHER:

☐	AMERICAN SIGN LANGUAGE	☐	INTERPRETER SERVICE UTILIZED BY FACILITY

11. NON -MEDICARE CERTIFIED HOME CARE AGENCY SECTION

Complete this section ONLY if the facility is a Home Care Agency that is not Medicare (CMS) certified. Answer ALL questions.

1. Indicate the age range of clients accepted. to

2. Number of agency employees in each category:

- Registered Nurses (RN):
- Licensed Practical Nurses (LPN):
- Home Health Aide:
- Other

3. Give reason(s) this home care agency has not pursued/been granted Medicare certification.

12. PROVIDER INTEGRITY ATTESTATION OR ELECTRONIC SIGNATURE

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a participating provider.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Signature of Authorized Representative **Printed Name of Authorized Representative**

Date Signed **Authorized Representative's Title**