COASTAL CARE SERVICES, INC.®

PROVIDER NAME: _____

CREDENTIALING REQUIREMENTS FOR PHARMACY PROVIDERS	
PLEASE CHECK AND SUBMIT COPIES OF THE FOLLOWING	
	Mission Statement & Organizational Chart
	W9 Form
	Occupational License(s)
	Pharmacy License(s) / Home Health License
	DEA Certificate(s)
	Medicare / Medicaid Certification Letter
	Accreditation Certificate
	Most Recent Regulatory Department of Health/AHCA Surveys – Required if not Accredited
	Fire Rescue Permit (if applicable)
	Professional & General Liability Insurance Coverage – Declaration Page
	Proof of Workers Compensation Insurance Coverage or Proof of Exemption – Declaration Page
	Background Screening & Monitoring Policy & Procedure (including Level 2 & OIG/SGA)
	Signed Background Screening Affidavit
	Fraud Waste and Abuse Policy and Procedure
	Signed FWA Attestation
	List of Licensed Employee(s) and License Number(s)
	After Hours Procedure
	Quality Assurance Plan
	Emergency Procedures / Disaster Recovery Plan
	Drug Free Workplace Policy and Procedure
	Notice of Privacy Practices

PLEASE NOTE: IF YOU HAVE MULTIPLE FACILITIES AND LICENSES, BUT ONE TAX ID #, COMPLETE ONLY ONE APPLICATION. IF EACH LICENSED ENTITY IS UNDER A DIFFERENT TAX ID #, PLEASE COMPLETE ONE APPLICATION FOR EACH ENTITY.

IF YOUR ORGANIZATION PROVIDES HOME HEALTH CARE AND/OR HOME MEDICAL EQUIPMENT SERVICES, PLEASE CONTACT US FOR ADDITIONAL FORMS.

PLEASE SUBMIT COPIES OF YOUR POLICIES AND PROCEDURES AND FORMS THAT RELATE TO THE FOLLOWING IF PHARMACY IS NOT ACCREDITED:	
• Admission Process • Client's Right and Responsibilities • Client Satisfaction Measurement Tool	• Informed Consent • Patient Handbook • Right to Refuse Care
PLEASE HAVE AVAILABLE FOR REVIEW AT TIME OF SITE VISIT	
• Complaint / Grievance Policy • Licenses for all Professional Licensed Personnel	• Personnel Policy and Procedures • Policy & Procedure Manuals • Utilization Review Plan

PLEASE RETURN TO:
Coastal Care Services, Inc. - Network Management Department
7875 NW 12 Street, Suite 200Miami, FL 33126

Pharmacy Provider Credentialing Application

Name:

Primary Address: *****

**** Please note checks will be sent to this address***

City: State: Zip Code:

Telephone #: Fax #:

Toll Free Telephone #: Toll Free Fax #:

Billing Department Contact: _____

Email Address: _____ Fax #: _____

Multiple Facilities: _____ NO _____ YES *If YES, And Under Same Tax ID # Complete Attachment A*

If under separate Tax ID copy and complete one application for each location.

If Yes, Do You Have Centralized Intake? ___ NO ___ YES Phone Number _____ Fax Number _____

E-mail Address: _____ Web Site: _____

Federal Tax I.D. #: National Provider Identifier #:

Date When Company Began Operations:

Are you a Minority Business? _____ NO _____ YES
If Yes, are you Certified? _____ NO _____ YES Expiration Date: _____

Pharmacy Manager: License # Administrator:

Hours of Operations: Posted ___ NO ___ YES 24 Hours Availability _____ NO _____ YES

Medicare Provider: _____ NO _____ YES Number_____ # of Years _____

Medicaid Provider: _____ NO _____ YES Number_____ # of Years _____

If not participating, does your facility plan to participate? ____ NO ____ YES Date: _____

Pharmacy License #: Expiration Date:

DEA #: Expiration Date:

Please indicate your staff's multilingual and multicultural capabilities (e.g. languages spoken) other than English:
___ Spanish ___ Creole Other _____

STAFFING

Please indicate number of licensed personnel employed by your Pharmacy:
___RPH ___CPHT ___ Other _____

Please **list** licensed personnel employed by your agency/organization (use separate sheet of paper if necessary):

Name: _____ License #: _____ Expiration Date: _____

Name: _____ License #: _____ Expiration Date: _____

Name: _____ License #: _____ Expiration Date: _____

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OPERATIONS

1. Which managed care companies do you presently do business with? _____
   _____
   _____
   _____
2. May we contact these managed care companies for a reference? _____ NO _____ YES
3. How many managed care patients are currently active? _____
4. What is your average daily census of Medicare patients receiving services? _____
5. What is your average daily census of Medicaid patients receiving services?_____
6. What is your average daily census of Commercial patients receiving services?_____
7. What is your active census of IV Therapy patients? _____

SCOPE OF SERVICES

Please check services which you provide

	YES	NO		YES	NO
Infused Therapies			Pump, Stationary		
Non-Infused Therapies			Pump, Synchromed		
Pump, Ambulatory			Supplies		
Pump, Disposable					

If you checked YES but there are limitations or provide other services not listed please describe below. _____

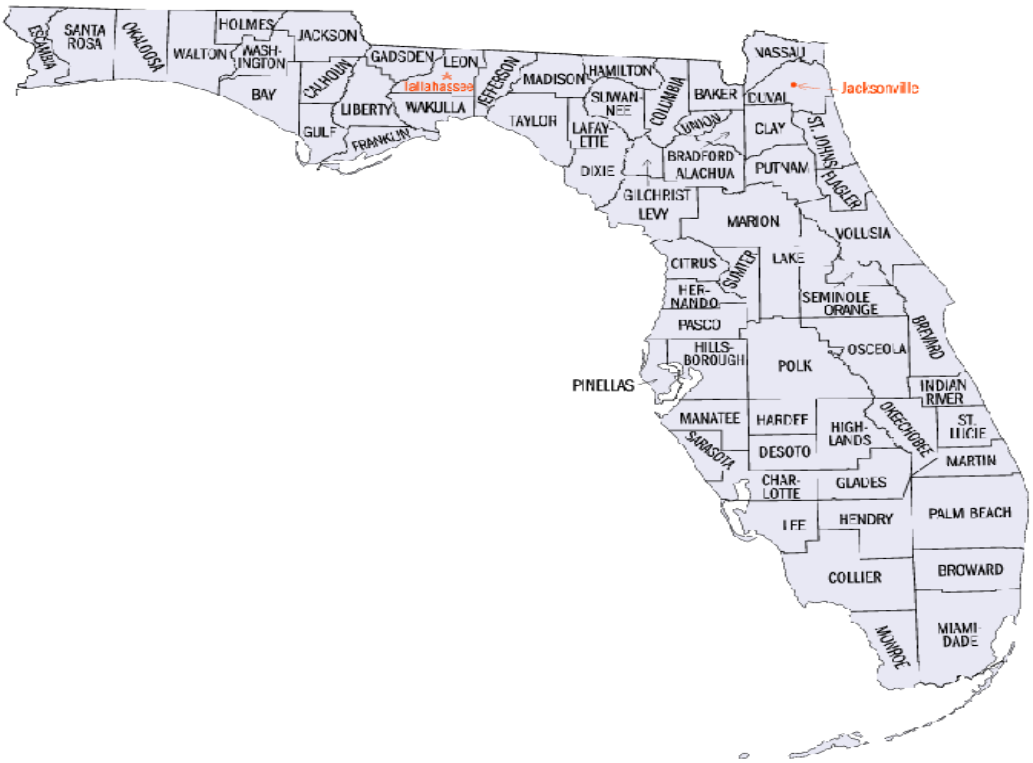
_____

_____

PROVIDER NAME: _____

LOCATION / ADDRESS: _____

If Multiple Locations Please Copy This Page and Submit One Per Location.



PLEASE INDICATE THE COUNTIES IN WHICH EACH FACILITY CAN AND DOES PROVIDE SAME DAY SERVICES!

GEOGRAPHICAL AREAS OF COVERAGE IN FLORIDA

☐ Alachua	☐ Franklin	☐ Lee	☐ Pinellas
☐ Baker	☐ Gadsden	☐ Leon	☐ Polk
☐ Bay	☐ Gilchrist	☐ Levy	☐ Putnam
☐ Bradford	☐ Glades	☐ Liberty	☐ Santa Rosa
☐ Brevard	☐ Gulf	☐ Madison	☐ Sarasota
☐ Broward	☐ Hamilton	☐ Manatee	☐ Seminole
☐ Calhoun	☐ Hardee	☐ Marion	☐ St. Johns
☐ Charlotte	☐ Hendry	☐ Martin	☐ St. Lucie
☐ Citrus	☐ Hernando	☐ Miami-Dade	☐ Sumter
☐ Clay	☐ Highlands	☐ Monroe	☐ Suwannee
☐ Collier	☐ Hillsborough	☐ Nassau	☐ Taylor
☐ Columbia	☐ Holmes	☐ Okaloosa	☐ Union
☐ Desoto	☐ Indian River	☐ Okeechobee	☐ Volusia
☐ Dixie	☐ Jackson	☐ Orange	☐ Wakulla
☐ Duval	☐ Jefferson	☐ Osceola	☐ Walton
☐ Escambia	☐ Lafayette	☐ Palm Beach	☐ Washington
☐ Flagler	☐ Lake	☐ Pasco	

PLEASE INDICATE ANY LIMITATIONS SPECIFIC TO THE GEOGRAPHICAL AREA IN WHICH YOU PROVIDE SERVICES: _____

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ACCREDITED ORGANIZATION	NUMBER OF YEARS OF ACCREDITATION	EXPIRATION DATE
		_____ / _____ / _____
Please submit copies of all certificates of accreditation, per Provider location		

If not accredited, does the organization plan to achieve accreditation in the future? _____NO _____YES

If Yes, what is the expected date of review? _____

What accreditation will be sought? _____

INSURANCE INFORMATION		
Professional Liability Carrier:	Coverage:	Expiration Date: _____ / _____ / _____
General Liability Carrier:	Coverage:	Expiration Date: _____ / _____ / _____
Worker's Compensation Carrier:	Coverage:	Expiration Date: _____ / _____ / _____
Please submit a copy of each insurance policy declaration page indicating current status and coverage amount		

*** WORKER'S COMPENSATION COVERAGE IS A REQUIREMENT FOR PARTICIPATION IN CCS' NETWORK REGARDLESS OF EXEMPT STATUS.**

PROFESSIONAL REFERENCES **Please submit two professional references from managed care or insurance companies**	
Company:	Company:
Address:	Address:
Telephone:	Telephone:
Contact Person:	Contact Person:

COMPLIANCE QUESTIONNAIRE	YES	NO
Does your organization have a formal quality assurance program?		
Does your organization have a formal infection control plan?		
Does your organization have a formal safety plan?		
Does your organization comply with all OSHA guidelines (as applicable)?		
Does your organization have policies and procedures for patient grievance and resolution?		
Are the credentials, certifications and/or licenses of personnel involved in the care and/or treatment of patients verified by your organization prior to employment or contract?		
Are the credentials, certifications and/or licenses of personnel involved in the care and/or treatment of patients re-verified by your organization at least every three years or at expiration?		
Does your organization have a formal emergency-preparedness plan designed to provide continuity of necessary operations in the event of disaster or emergency?		
Does your organization comply with current employment/labor laws?		
Does your organization have a formal program or process for the maintenance of a drug free working environment?		
Does your organization comply with all guidelines of the American with Disabilities Act?		
Do you question prospective employees/independent contractors as to any previous involvement in professional/malpractice litigation?		
Do you run background checks on all personnel (employed and/or contracted) who enter a patient's home?		
Are you able to provide same day urgent services 24 hours a day / 7 days a week?		

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PROVIDER DATA RECORD	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?		
Are there any actions contemplated or pending against this organization by any government agency, professional group, institution, or other entity?		
Has your organization's professional liability coverage ever been restricted, limited, denied or cancelled?		
Has any insurance carrier ever made an out-of-court settlement or paid a judgment on a professional liability claim on your organization's behalf?		
At present or during the last five years, has this organization been part of any legal proceedings?		
Do you have any litigation pending?		
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?		
Has your organization ever lost its accreditation status?		
Does any staff member of your organization have a history of chemical dependency or substance abuse or currently abuses drugs and alcohol?		
If you have answered YES to any of the above questions, please provide details on a separate sheet of paper		

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CONSENT AND RELEASE FORM FOR _____

(Please Print Provider/Organization's Name

1. I hereby attest that the applying facility has given me the authority and responsibility to execute contractual agreements and to provide credentialing and re-credentialing information on the facility's behalf. I understand that a credentialing process is the process established by medical institutions, insurance companies, and other health care providers to identify the capacity, quality, professionalism and ethical conduct, among other important criteria, of its contracting providers; and that I must possess significant knowledge about the facility that I represent in regards to the issues questioned in this application to accurately and responsibly complete and sign this application.

2. I hereby attest that all information provided in or attached to this application is complete and correct to the best of my knowledge. I fully understand that any misstatements in or omissions from this application or its attachments, whether intentional or not, constitute cause for participation denial or termination.

3. I understand and agree that the applying facility has the burden of producing adequate information for proper evaluation of the facility and for resolving any doubts about such qualifications.

4. I agree to provide updated information for credentialing matters as such information becomes available.

5. I hereby give authorization to Coastal Care Services, Inc. (CCS) to request, collect and evaluate information regarding this facility's competence, conduct, ethics, malpractice history, and any other matter bearing on the facility's qualifications to perform the services being contracted. This includes, but is not limited to, information from health care providers, certification and licensing entities, monitoring agencies, attorneys, State and Federal agencies, organizations with databases of information regarding companies providing patient care services and any entity with information related to information provided in or attached to this application. I furthermore authorize for the release of this information to CCS. Whether such information is private, public, privileged or confidential. I hereby release from any liability all entities and individuals providing this information in good faith.

6. I hereby release CCS any other organization contracted or affiliated to CCS and any individual acting on behalf of any of these entities from any liability arising from any action taken related to this facility's participation in CCS whether such action is directly related to the applying facility, its owners or leaders.

7. I hereby release from liability and hold harmless all individuals and organizations and their respective directors, employees or agents for acts made in good faith and without malice in connection with the evaluation of my facility's competence and qualifications.

8. I understand and agree that CCS may be required to provide information about the entity that I represent and/or about the relationship between CCS and the entity that I represent to State and Federal entities, to databanks, monitoring agencies and other contracting organizations. I hereby authorize for the release of such information and release from any liability all entities and individuals providing this information in good faith.

9. I understand that records kept by CCS relating to the applying facility may be subject to review by State and Federal entities, monitoring and accrediting organizations, and other organizations contracted or applying to contract with CCS I hereby authorize for such reviews and release from any liability all entities and individuals participating in such reviews.

10. I understand that as a condition for participation, CCS may review this facility's records and conduct an inspection of the site. I hereby consent to these reviews and agree to fully cooperate for such reviews to be done timely and accurately.

11. I further acknowledge and agree that communications and/or documents which are required in writing in order to comply with applicable laws and regulations shall be considered to be in compliance with any such laws and regulations, if transmitted, acknowledged and/or executed through the use of mail (e-mail), electronic data interface, (EDI), internet or other electronic transmission.

12. I hereby acknowledge that this Consent and Release Form will be valid for a period of three (3) years from the date it is signed by me, and that a photocopy or fax will serve as an original.

_____
Provider Name

_____
Applicant's Signature

_____
Print Name

_____
Title

_____
Date

FOR INTERNAL OR OFFICE USE ONLY

_____
CHAIRPERSON

_____
DATE

____ APPROVED **_____ YEARS**

____ DENIED

COMMENTS _____

_____

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Location 1		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location		
License # _____ Medicare # _____ Medicaid # _____		
Director of Nursing / Pharmacy Manager: _____ License # _____		
Location 2.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location		
License # _____ Medicare # _____ Medicaid # _____		
Director of Nursing / Pharmacy Manager: _____ License # _____		
Location 3.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location		
License # _____ Medicare # _____ Medicaid # _____		
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Location 4.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location		
License # _____ Medicare # _____ Medicaid # _____		
Director of Nursing / Pharmacy Manager: _____ License # _____		

ATTACHMENT A – If More Than Four Locations Please Copy This Page

Disclosure of Ownership Form

List the Owner(s) and Operator(s) TIN:_____

**Denotes Required Field*

Name*	Title	Relationship*	SSN*	License #	% Owner*

NOTE: Select one or more from the following list when indication each owner and operator's relationship to the applicant: Owner, Officer, Director, Financial Records Custodian, Medical Records Custodian, Shareholder, Sub-Contractor, EFT Authorized Individual, Partner, Manager, or Family (Specify Relationship i.e. Spouse, Parent, Sibling, or Child).

Have you, or any of the individuals listed above:	**YES**	**NO**
1. **Been convicted of a felony, had adjudication withheld on a felony, no contest to a felony, or entered into a pretrial agreement for a felony**? If yes, list the name(s) of the individual(s) and provide a copy of the administrative complaint and final disposition. Name:_____		
2. Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state? If yes, list the names(s) of the individual(s) and the date of the action. Provide a copy of the final disposition. Attach documentation from the proper authorities that approved the reinstatement of the license. Against Whom?_____ Date _____		
3. Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state? If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation. Name:_____Provider Number:_____		
4. Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state? If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation. Name:_____Provider Number:_____		

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Have you, or any of the individuals listed above:	**YES**	**NO**
5. Owes money to Medicaid or Medicare that has not been paid? If yes, list the name(s) and provider number(s) of the individual(s) and provide a copy of the documentation. Name:_____Provider Number:_____		
6. Have ownership in any other Medicaid enrolled business? If yes, list the name and Medicaid provider number of the other Medicaid enrolled business and the names of all owners of five percent or more of the business. Attach additional pages if necessary. Name of Other Business:_____ Provider Number: _____ Name of Owner(s):_____		

I certify that all information provided by me in my attestation is true, correct, and complete to the best of my knowledge and belief, and that I will notify Coastal Care Services, Inc. or its Agents within 10 days of any material changes to the information I have provided in my attestation. I understand and agree that any material misstatement of omission in the attestation may constitute grounds for withdrawal of the application for consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation.

_____
Signature

_____
Name (Please Print)

_____
Date

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