

PROVIDER NAME: _____

CREDENTIALING REQUIREMENTS FOR PHARMACY PROVIDERS	
PLEASE CHECK AND SUBMIT COPIES OF THE FOLLOWING	
	Mission Statement & Organizational Chart
	W9 Form (Cannot be a PO Box)
	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
	Errors & Omissions Insurance Coverage
	Professional & General Liability Insurance Coverage – Declaration Page
	Proof of Workers Compensation Insurance Coverage or Proof of Exemption – Declaration Page
	Signed Abuse, Neglect, and Exploitation Policy & Training Attestation Provided
	Signed Cultural Competency Training Attestation
	Signed Background Screening Attestation
	Signed FWA Attestation
	List of Licensed Employee(s) and License Number(s)
	Emergency Procedures / Disaster Recovery Plan
	CAQH Form and Policy and Procedure
<p>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.</p>	

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:	
<ul style="list-style-type: none"> • Admission Process • Client’s Right and Responsibilities • Client Satisfaction Measurement Tool 	<ul style="list-style-type: none"> • Informed Consent • Patient Handbook • Right to Refuse Care
PLEASE HAVE AVAILABLE FOR REVIEW AT TIME OF SITE VISIT	
<ul style="list-style-type: none"> • Complaint / Grievance Policy • Licenses for all Professional Licensed Personnel 	<ul style="list-style-type: none"> • Personnel Policy and Procedures • Policy & Procedure Manuals • Utilization Review Plan

PLEASE RETURN TO:
Coastal Care Services, Inc. - Network Management Department
1200 NW 78 Avenue, Suite 100, Doral, 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: _____

Electronic Medical Records: _____ NO _____ YES

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

Age Restrictions : _____ NO _____ YES *If yes, Please list age limitations: _____*

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: _____

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? _____

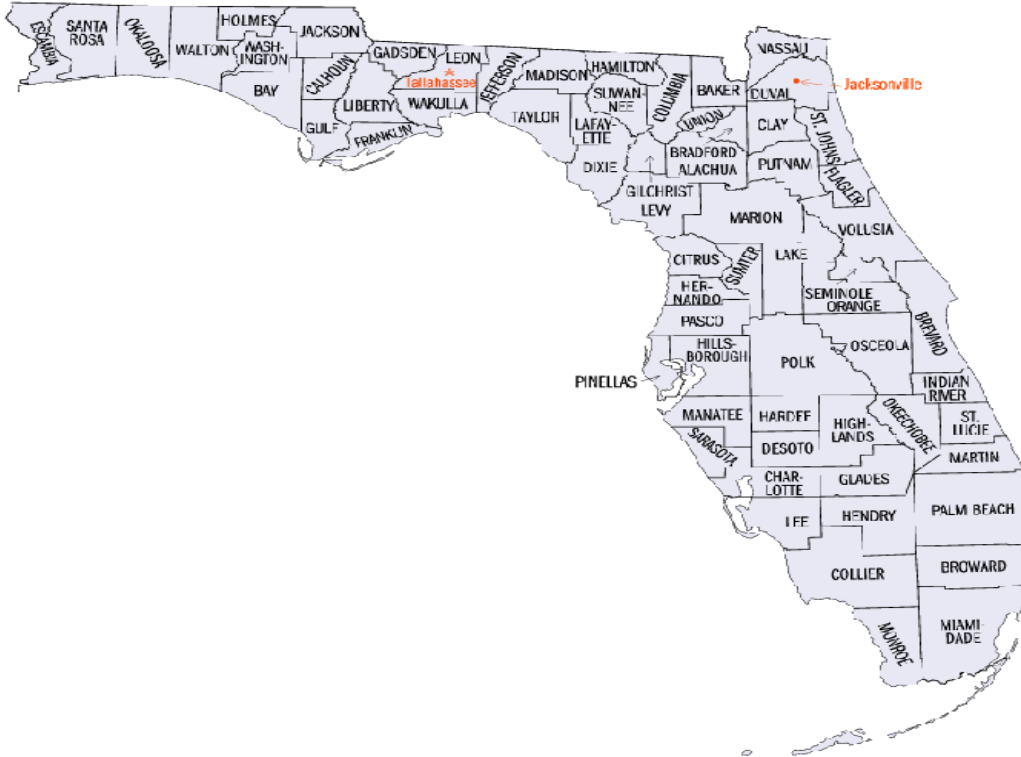
SCOPE OF SERVICES					
Please check services which you provide					
	YES	NO		YES	NO
Infused Therapies			Pump, Stationary		
Non-Infused Therapies			Pump, Synchronomed		
Pump, Ambulatory			Supplies		
Pump, Disposable					

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

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

ACCREDITED ORGANIZATION	NUMBER OF YEARS OF ACCREDITATION	EXPIRATION DATE
		____ / ____ / ____
Please submit copies of all certificates of accreditation, per Provider location		
<p>If not accredited, does the organization plan to achieve accreditation in the future? ____NO ____YES</p> <p>If Yes, what is the expected date of review? _____</p> <p>What accreditation will be sought? _____</p>		

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?		

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		

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 _____

Location 1		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
<i>If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location</i>		
License # _____	Medicare # _____	Medicaid # _____
Director of Nursing / Pharmacy Manager: _____		License # _____
Location 2.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
<i>If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location</i>		
License # _____	Medicare # _____	Medicaid # _____
Director of Nursing / Pharmacy Manager: _____		License # _____
Location 3.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
<i>If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location</i>		
License # _____	Medicare # _____	Medicaid # _____
Director of Nursing / Pharmacy Manager: _____		License # _____
Location 4.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
<i>If Multiple Counties Are Covered Please Copy And Complete Page 4 Of This Application For Each Location</i>		
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 indicating 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
<p>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.</p> <p>Name: _____</p>		
<p>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.</p> <p>Against Whom? _____ Date _____</p>		
<p>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.</p> <p>Name: _____ Provider Number: _____</p>		
<p>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.</p> <p>Name: _____ Provider Number: _____</p>		

Have you, or any of the individuals listed above:	YES	NO
<p>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.</p> <p>Name: _____ Provider Number: _____</p>		
<p>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.</p> <p>Name of Other Business: _____</p> <p>Provider Number: _____</p> <p>Name of Owner(s): _____</p>		

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