Dear Provider,

Thank you for your interest in joining Coastal Care Services, Inc.'s (Coastal) network. In order to expedite the credentialing process, ensure that all sections of the application are completed and copies of all items on the checklist are provided. Any item on the checklist that is not applicable to your organization, please indicate as "N/A."

If you have multiple facilities and licenses under one Tax ID#, complete only one application. If each licensed entity is under a different Tax ID#, an application for each Tax ID# must be completed.

The Credentialing Application and supporting documents may be submitted in the following methods:

- **Mail** to the following address**:**
  Coastal Care Services, Inc.
  Attn: Credentialing Department
  1200 NW 78th Ave, Suite 100
  Doral, FL 33126
- **Email** to ProviderRelations@ccsi.care

If you should have any questions, please contact the provider relations team at 855-481-0505 ext. 1904.

Thank You,

Coastal Care Services, Inc.

PROVIDER NAME:

Provider Type:

☐Home Health Agency ☐ Nurse Registry ☐ Homemaker & Companion
☐ Durable Medical Equipment, Medical Supplies, Respiratory Equipment
☐Home Infusion

CREDENTIALING REQUIREMENTS

CHECK AND SUBMIT COPIES OF THE FOLLOWING
(PLEASE WRITE "N/A" NEXT TO ANY THAT DO NOT APPLY)

	Mission Statement & Organizational Chart
	W9 Form (cannot contain a PO Box Address)
	Occupational License(s)
	License(s), Certification (s), Registration (s) - (State License, DEA, Biomedical Waste, CLIA, etc)
	Oxygen Permit(s) / Retailer and Wholesalers License / Permit
	Medicare and Medicaid Certification Letters
	Accreditation Certificate
	Most Recent Department of Health Survey – ***Required if not Accredited***
	Professional & General Liability Insurance Coverage – Declaration Page
	Proof of Workers Compensation Insurance Coverage or Proof of Exemption – Declaration Page
	Proof of Errors and Omissions Coverage
	Surety Bond (if applicable, ***required for DME***)
	CAQH Form and Policy and Procedure
	Clinical Notes Template ***(HH provides Only)***
	Notice of Medicare Non-Coverage Policy and Procedures and Notice of Medicare Non-Coverage Form # 10123 ***(HH provides only)***
	Staff Roster - List of Licensed Employee(s) and License Number(s) (RN, LPN, CNA, PT, OT, RT, ST, Pharmacists)
	Emergency Procedures / Disaster Recovery Plan
	Disclosure of Ownership Form (attached)
	Signed Attestations (attached)
	Signed Notification of Non-incentive (attached)

PLEASE SUBMIT COPIES OF YOUR POLICIES AND PROCEDURES AND FORMS THAT RELATE TO THE FOLLOWING IF YOUR FACILITY IS <u>NOT ACCREDITED</u>:

• 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

Credentialing Application

Provider Legal Name:		
Provider DBA Name (If Applicable):		
Primary Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
Billing Address (if different from Primary Address – Payments/EOPs will be mailed to this address):		
Billing City:	State:	Zip Code:
Billing Telephone #:	Billing Fax #:	
Billing Department Email :		

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
Administrator:	Administrator License (if applicable):
Hours of Operations: Posted ☐ NO ☐ YES	24 Hours Availability ☐ NO ☐YES

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

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: _____

State License #:	Expiration Date:
Oxygen Retailer Permit#:	Expiration Date:
Compressed Medical Gases Wholesaler Permit #:	Expiration Date:

Age restrictions on patients the provider is willing to service: ☐NO ☐YES

If yes, please list age restrictions:

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

☐Spanish ☐ Creole ☐ Other _____

OPERATIONS

1. Which managed care companies do you presently do business with? _____
   _____
   _____
2. How many locations/distribution centers do you have? _____ (If more than one or at different location, please submit copies of occupational license(s))
3. How do you confirm receipt of services provided?_____
   _____
4. How do you evaluate customer satisfaction? _____
   _____
5. Does your organization offshore and/or sub-delegate any functions that may contain Patient Health Information (PHI)? (This includes but is not limited to - Call Center, Credentialing, Claims, Member Outreach, etc.)
   _____
   _____

ACCREDITATION 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		

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		

PROFESSIONAL REFERENCES

Please submit two professional references from managed care or insurance companies

Company:	Company:
Address:	Address:
Telephone:	Telephone:
Contact Person:	Contact Person:

DME SCOPE OF SERVICES

Please check services which you provide

	YES	NO		YES	NO
Ambulatory Aids			Oxygen Concentrators		
Apnea Monitors			Oxygen, Gaseous		
Bathroom and Toileting Aids			Oxygen, Liquid		
PAP Devices			Osteogenesis Stimulators		
Clinical Respiratory Services			Ostomy Supplies		
Diapers			Peak Flow Meters		
Customized Equipment			Phototherapy (Bilirubin) Equipment		
Diabetic Supplies			Rehabilitation Therapy Services		
Enteral Supplies and Equipment			Power Operated Vehicles		
Heat Lamp and Pads			Specialty Beds/Mattresses		
Hospital Beds, Mattresses and Rails			TENS Units		
Low Air Loss Mattresses			Tracheostomy Supplies		
Lymphedema Pumps			Traction Equipment		
Nebulizers			Trapezes		
Neuromuscular Stimulators			Urological Supplies		
Passive Motion Devices			Ventilators and Related Equipment/Supplies		
Patient Lifts			Wheelchairs		

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

_____
_____
_____

HH SCOPE OF SERVICES

Please check services which you provide

	YES	NO		YES	NO
Enterostomal Nurse			Physical Therapy		
Hi-Tech RN			PICC Line Certified Nurse		
Home Health Aide			Psychiatric Nurse		
Lab Drawing			Private Duty Nusing		
LPN			Respiratory Therapy		
Medical Social Worker			RN		
Occupational Therapy			Speech Therapy		
Pediatric Services			Wound Care		
Attendant/Care Services			Homemaker/Chore Services		
Certified Nurse Assistant			Personal Care Services		
Companion Care			Respite Care, Unskilled		

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

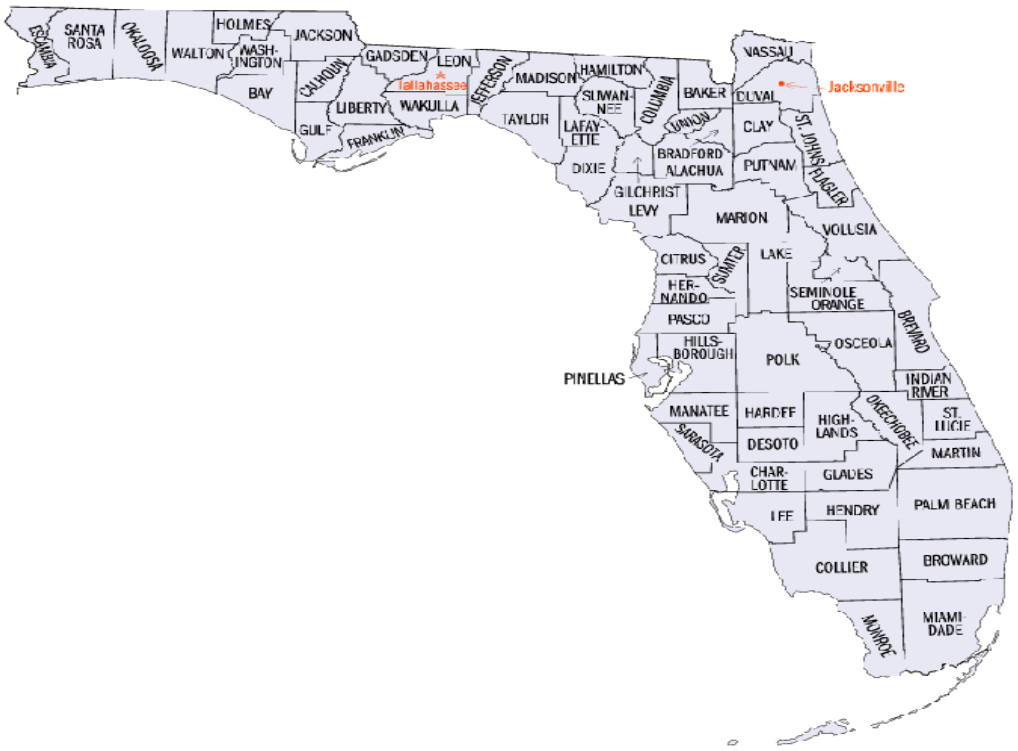
_____
_____
_____

PROVIDER NAME: _____

LOCATION ADDRESS: _____

LOCATION NPI#: _____

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



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:

_____

_____

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 CCSI USE ONLY

_____

CHAIRPERSON

_____

DATE

_____ APPROVED **_____ YEARS**

_____ DENIED

COMMENTS _____

_____

Attachment A

If more than four (4) locations, please copy this page

Location 1.		NPI#
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 6 Of This Application For Each Location		
License # _____	Medicare # _____	Medicaid # _____
Location 2.		NPI#
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 6 Of This Application For Each Location		
License # _____	Medicare # _____	Medicaid # _____
Location 3.		NPI#
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 6 Of This Application For Each Location		
License # _____	Medicare # _____	Medicaid # _____
Location 4.		NPI#
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
If Multiple Counties Are Covered Please Copy And Complete Page 6 Of This Application For Each Location		
License # _____	Medicare # _____	Medicaid # _____

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:_____		

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

ATTESTATIONS

I hereby attest and certify to the following:

Fraud, Waste, and Abuse Training

I attest my organization's business practices have met the Fraud, Waste, and Abuse (FWA) certification requirements through enrollment into the Medicare program or accreditation as a DME/HH/Pharm provider and is deemed to have met the training and education requirements for FWA per 42 C.F.R. §423.504(b)(4)(vi)(c).

_____	_____	_____
Name & Title of Attester	Signature	Date

Compliance of HIPAA Training

I attest my organization conducts HIPAA training within 30 days of hire, or prior to exposure to PHI, whichever is sooner. Thereafter, employees and contractors receive additional HIPAA training annually.

_____	_____	_____
Name & Title of Attester	Signature	Date

Abuse, Neglect, and Exploitation

I attest my organization is compliant with contractual requirements to ensure all employees or contractors that provide direct Patient care or will be entering a patient's residence, have completed an annual training on "Abuse, Neglect, and Exploitation."

_____	_____	_____
Name & Title of Attester	Signature	Date

Verification of Eligibility for Employment

I attest my organization verifies employment eligibility for all employees using E-verify database and/or by approved documents per Form I-9 to ensure they are eligible to work in the United States.

_____	_____	_____
Name & Title of Attester	Signature	Date

Level 2 Background Screening

I attest my organization is compliant with the Agency for Health Care Administration (AHCA) and contractual requirements to ensure all direct care givers have completed and cleared the AHCA required Level 2 background screening and will produce documentation upon request. Our policies meet compliance with the provisions of Chapter 435 and section 430.002, Florida Statutes, regarding level 2 background Screening.

_____	_____	_____
Name & Title of Attester	Signature	Date

Debarment / Exclusion Verification

I attest my organization is compliant with federal requirements to provide documentation of employees screening against the OIG, SAM, GSA and the AHCA website listings prior to hire and monthly thereafter.
If the organization learns of a suspension and/or debarment, it further attests that it will notify Coastal within five (5) days of knowledge of such event. The organization will retain document evidencing these requirements have been met for at least 10 years after completion of services and will make such documentation available for inspection and review by Coastal, upon request.

_____	_____	_____
Name & Title of Attester	Signature	Date

Cultural Competency

As a first tier, downstream or related entity, my organization attests that it has conducted appropriate education and training on Cultural Competency to interact with our culturally diverse members, pursuant to Federal Medicaid Managed Care requirement 42 CFR 438.206 (Availability of Services) that requires Cultural Competency training of staff and providers who interact with members, upon hire and annually thereafter.

_____	_____	_____
Name & Title of Attester	Signature	Date

Notification of Non-Incentive
NOTICE TO PROVIDERS

Coastal Care Services, Inc. Utilization Management Program will oversee the process by which each member receives access to appropriate services with effective and efficient coordination of care to promote an assurance against under-utilization or over-utilization

To ensure that provider compensation is not structured to provide direct financial incentives for the provider or Coastal employees to deny, limit, or discontinue medically necessary services to any member.

Coastal does not specifically reward, encourage or provide financial incentives to practitioners or individuals for issuing denial of coverage or care which result in underutilization.

Provider Name: _____

Print Name: _____

Title: _____

Provider Signature: _____ Date: _____