MLTSS PROVIDER ENROLLMENT APPLICATION

To begin the contracting and credentialing process, please complete this application in its entirety and submit it with all appropriate documentation. Applications that do not include all of the requested information will not be processed.
Note, for multiple locations operating under separate NPI numbers or separate tax identification, a separate application for each NPI and tax ID combination is needed.
Completion and acceptance of this enrollment form by MCO is not a guarantee of network participation. MCO policies and procedures will govern appeals if available, related to network participation.
If you have not registered with TennCare, we cannot accept your application. Providers must have a valid Tennessee Medicaid ID number in order to contract with TennCare Managed Care Organization(s). To register with TennCare, visit tn.gov/tenncare > Providers > Provider Registration.

Documents required and should be provided to MCO in conjunction with this application:

- Copy of Applicable State Licensure required for services delivered. (If no state license is required, submit a copy of city/county general business license.)
- Copy of State licensing agency's most recent audit/inspection approval letter or applicable survey
- W-9
- Form 147C IRS (Contact the IRS at 800-829-4933 for a copy, if needed)
- Proof of General and/or Professional Liability Certificate of Insurance (Minimum Coverage of $500,000)(CLS, CLS Family 750,000)
- Automobile Liability coverages of $1,500,000 for ECF Choices, CLS, & CLS Family Model only.
- Workman Compensation & Employers Liability $750,000 minimum coverage for ECF CHOICES, CLS & CLS Family Model only.
- Copy of Provider Self-Assessment showing 100% compliance with the HCBS Settings Rule OR TennCare/MCO approved Transition Plan showing provider's willingness and ability to come into full compliance with the HCBS Settings Rule for ADC, ACH, ACLF or CLS. Services marked (*) on page 4.

Please submit your completed application to your MCO:

For BlueCare: ChoicesProviderRelations@bcbst.com

For United Healthcare Initial Application/Service additions: tn_ltc_networkmail@uhc.com

For United Healthcare Re-credentialing Application: hcbscredentialingteam@uhc.com

For Wellpoint Initial Application/Se rvice additions: tnltssprovidercontracting@amerigroup.com

For Wellpoint Re-credentialing Application: WLPcred@wellpoint.com

provider.wellpoint.com/tn/
Medicaid services provided by Wellpoint Tennessee, Inc. We comply with the applicable federal and state civil rights laws, rules, and regulations and do not discriminate against members or participants in the provision of services on the basis of race, color, national origin, religion, sex, age, or disability. If a member or a participant needs language, communication, or disability assistance or to report a discrimination complaint, call **833-731-2154**. Information about the civil rights laws can be found at **tn.gov/tenncare/members-applicants/civil-rights-compliance.html**.

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Start Date **Form Completion Date**

☐ Choices

General Information

MCO

☐ BlueCare ☐ Amerigroup ☐ United HealthCare

App. Type

☐ New Provider ☐ Additional Services Requested/Counties Requ
☐ Re-Credentialing ☐ Address Change/Additions

Provider Information

Legal Name (Should match W-9 or IRS's 147C letter or Online Snapshot) **DBA Name** (if applicable)

MedicaidID **TaxID** **NPI** **Medicare ID**

Medicaid Certified ☐ Yes ☐ No

Minority Business ☐ Yes ☐ No

Minority Bus. Certified ☐ Yes ☐ No

Ethnicity Served
☐ African American
☐ Hispanic American
☐ Women
☐ Native American
☐ Asian American

Group Email Address (Auto enrollment for electronic communication) **Agency Website URL**

Provider Primary Address

Street Address **City** **State** **ZipCode**

Phone Number **Fax Number** **Credentialing Contact** **Contact Title**

Email Address

Provider Primary Mailing Address

Street Address **City** **State** **ZipCode**

Phone Number **Fax Number** **Credentialing Contact** **Contact Title**

Email Address **Referral Email Address**

Payment / Remit Address

Billing Fax Number **Billing Contact** **Billing Contact Title** **Billing ZipCode**

Billing Contact Email Address **Street Address, City, State, ZipCode**

EVV (Required for Respit, Personal Attendant & Supported Home Care)

EVV Contact **EVV Contact Title** **EVV Contact Fax Number**

EVV Contact Email Address

Hours of Operation

☐ 24 Hours ☐ Hours of Operation Mon Fri Tue Sat Wed Sun Thur

Emergency Contact Information

Emergency Phone Number **Emergency Contact** **Emergency Contact Title** **E-mail Address:**

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In the Primary Practice Location, Billing/ Payment Contact Information and Correspondence Information are required. In addition you must list all "Additional Practice Locations" where services are provided."

Provider Additional Locations (Same TaxID/NPI as Primary Address)

Location 1

Street Address	City	State	ZipCode

Phone Number	Fax Number	Administrator Full Name

Location 2

Street Address	City	State	ZipCode

Phone Number	Fax Number	Administrator Full Name

Location 3

Street Address	City	State	ZipCode

Phone Number	Fax Number	Administrator Full Name

Location 4

Street Address	City	State	ZipCode

Phone Number	Fax Number	Administrator Full Name

Choices Services

- [ ] Assistive Technology
- [ ] Enabling Technology
- [ ] Home Modifications/Repair
- [ ] Pest Control
- [ ] Nursing Home
- [ ] Skilled Nursing Facility

Medicare ID: _____

- [ ] Adult Day Care
- [ ] Home Delivered Meals
- [ ] Personal Care/Attendant Care
- [ ] PERS
- [ ] Respite Care — In-Home
- [ ] Respite Care — Inpatient

- [ ] Adult Care Home*
- [ ] Assisted Living Facility*
- [ ] CLS*(DIDD license)
  - [ ] CLS Level One
  - [ ] CLS Level Two
  - [ ] CLS Level Three
  - [ ] CLS Family Model

Services Provided by Subcontractors (CHOICES)

Subcontractors listed above should only apply to the services listed on the application.

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Counties Covered by Services

☐ East ☐ Middle ☐ West ☐ StateWide ☐ Katie Beckett

	CHOICES		CHOICES		CHOICES		CHOICES
Anderson	☐	Fentress	☐	Lauderdale	☐	Roane	☐
Bedford	☐	Franklin	☐	Lawrence	☐	Robertson	☐
Benton	☐	Gibson	☐	Lewis	☐	Rutherford	☐
Bledsoe	☐	Giles	☐	Lincoln	☐	Scott	☐
Blount	☐	Grainger	☐	Loudon	☐	Sequatchie	☐
Bradley	☐	Greene	☐	Macon	☐	Sevier	☐
Campbell	☐	Grundy	☐	Madison	☐	Shelby	☐
Cannon	☐	Hamblen	☐	Marion	☐	Smith	☐
Carroll	☐	Hamilton	☐	Marshall	☐	Stewart	☐
Carter	☐	Hancock	☐	Maury	☐	Sullivan	☐
Cheatham	☐	Hardeman	☐	McMinn	☐	Sumner	☐
Chester	☐	Hardin	☐	McNairy	☐	Tipton	☐
Claiborne	☐	Hawkins	☐	Meigs	☐	Trousdale	☐
Clay	☐	Haywood	☐	Monroe	☐	Unicoi	☐
Cocke	☐	Henderson	☐	Montgomery	☐	Union	☐
Coffee	☐	Henry	☐	Moore	☐	Van Buren	☐
Crockett	☐	Hickman	☐	Morgan	☐	Warren	☐
Cumberland	☐	Houston	☐	Obion	☐	Washington	☐
Davidson	☐	Humphreys	☐	Overton	☐	Wayne	☐
Decatur	☐	Jackson	☐	Perry	☐	Weakley	☐
DeKalb	☐	Jefferson	☐	Pickett	☐	White	☐
Dickson	☐	Johnson	☐	Polk	☐	Williamson	☐
Dyer	☐	Knox	☐	Putnam	☐	Wilson	☐
Fayette	☐	Lake	☐	Rhea	☐		

Additional Questions

Did the provider complete cultural competency training?	☐ Yes	☐ No
Is the provider an Indian healthcare provider?	☐ Yes	☐ No
Does this office meet (Americans with Disabilities Act) accessibility requirements?	☐ Yes	☐ No
Does provider have interpretation services?	☐ Yes	☐ No

If Yes, please indicate what type:

Does provider have any other cultural or linguistic services (including ASL) ☐ Yes ☐ No

If Yes, please indicate what type:

If Yes, please indicate which language:

Handicap accessible:	☐ Building	☐ Transportation	☐ Parking	☐ Restroom	☐ Equipment	☐ Exam Rooms
Services for disabled:	☐ Building	☐ Transportation	☐ Parking	☐ Restroom	☐ Equipment	☐ Exam Rooms
Accessible by public transportation:	☐ Building		☐ Parking	☐ Restroom	☐ Equipment	☐ Exam Rooms

Credentialing Questions

Has the provider had any professional liability claim judgments or settlements? ☐ Yes ☐ No

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Has the license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed? ☐ Yes ☐ No

Has the business been denied participation, suspended from or denied renewal from Medicare or Medicaid? ☐ Yes ☐ No

Has the business ever had its professional liability coverage canceled or not renewed? ☐ Yes ☐ No

Has the business been denied accreditation by its selected accrediting body or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body? ☐ Yes ☐ No

If the answer is "Yes" to any of the above questions, please submit additional details.

Attestation and Information Release Authorization

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify MCO of any changes thereto. I understand that this application does not entitle me to participation in MCO. By applying for appointment as an MCO participating provider, I authorize the plan, its medical director and appropriate representatives to consult with administrators and members of other institutions where I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I hereby further consent to the inspection by MCO, its medical director and appropriate representatives of all records and documents, excluding medical records of non-MCO plan members that may be material to an evaluation of any professional qualifications and competence to carry out the requested duties, as well as my moral and ethical qualifications for participating provider status with MCO. I consent and agree that MCO will complete a criminal history background check to determine if I or any subcontracted providers have any history of felony convictions, including adjudication withheld on a felony, plea or nolo contendere to a felony, or entry into a pretrial for a felony. I agree to obtain any consents or approvals required for my subcontracted providers to undergo such background checks. I hereby release MCO and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individuals and organizations from any liability that provide information to MCO or its staff in good faith and without malice concerning my professional competence, ethics, character and other qualifications, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the Ancillary Agreement between MCO and my group or myself, as such terms may be applicable to me.

I understand that as an applicant for participation in MCO, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from MCO, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing committee if they so request. I further understand that I may appeal the committee's decision, either in writing or by appearance before the Credentialing committee if they so request.

Authorized Signature

Printed Name (Owner/Registered Authorized Agent)

Signature (Owner/Registered Authorized Agent)

Date

Title (Owner/Registered Authorized Agent)