PROVIDER NETWORK APPLICATION FORM

Organization/Service Type:

- ☐ INPATIENT PSYCHIATRIC SERVICES
- ☐ COMMUNITY LIVING SUPPORTS/RESPITE
- ☐ SPECIALIZED RESIDENTIAL
- ☐ SUBSTANCE USE DISORDERS
- ☐ PSYCHIATRIC
- ☐ SPECIALTY HEALTH SERVICES (OT, PT, SLP, RD)
- ☐ PRIMARY CARE
- ☐ VOCATIONAL SERVICES
- ☐ OUTPATIENT MH SERVICES (THERAPY, CSM, AUTISM)
- ☐ OTHER (PLEASE SPECIFY) : ____________

LEGAL NAME OF ORGANIZATION: ____________

Mailing/Billing Address: ____________

____

Phone Number: ____________ Fax: ____________

(Complete additional sheets for multiple sites)

SITE NAME: ____________

Site Address: ____________

____

Site Telephone # : ____________ Fax # : ____________

Name of Contact Person at this site: ____________

E-Mail Address : ____________ Handicap Accessibility: ☐Y ☐N

Service Hours: ____________

Services Provided at this Location: ____________

National Provider Identifier (NPI) Number: ____________

Federal Tax ID Number: (if applicable) ____________

Are you exempt from Federal Income Tax? ☐Yes ☐No

If Yes, please attach copy of tax exempt certificate

CORPORATE CONTACT DATA:

NAME & DOB OF CEO/OWNER: (FOR BACKGROUND CHECK)

FIRST	MIDDLE	LAST	DATE OF BIRTH

TITLE: ____________

PHONE NUMBER: ____________

Montcalm Care Network
611 N. State St.
Stanton, MI 48888
Phone: 989-831-7520/Fax: 989-831-7578

NAME OF BILLING PERSON: ______________________
TITLE: ______________________
PHONE NUMBER: ______________________

NAME OF CONTRACT MANAGER: ______________________
TITLE: ______________________
PHONE NUMBER: ______________________
EMAIL ADDRESS: ______________________

THIRD PARTY REIMBURSEMENT PROVIDER NUMBERS (IF APPLICABLE):
Please list any third party reimbursement numbers
Type: ☐ Medicare *Provider Number:* ______________________
☐ Medicaid *Provider Number:* ______________________

List of Third Party /
Commercial Insurances Accepted: ______________________

PROVIDER TRAININGS:
*** Submit policies, procedures & training records. See checklist on last page of application.*

PROFESSIONAL CERTIFICATION / ACCREDITATION
***If accredited, attach a copy of the last survey report issued by the organization's accrediting or certifying body (whichever is applicable)*

CERTIFIED OR ACCREDITED BY: ______________________ **EXPIRATION DATE:** ______________________
______________________ ______________________
______________________ ______________________

MEDICAL DIRECTOR PROFILE (IF APPLICABLE)**:**
Name: ______________________
Hospital Affiliations: ______________________
Medical Training: ______________________
Board Certification: ______________________

RECIPIENT RIGHTS ADVISOR NAME: ______________________

ALTERNATIVE LANGUAGE RESOURCES *(Please identify any non-English languages spoken by service providers)***:**______________________
____

LICENSURE (IF APPLICABLE):
Attach copies of all licenses pertaining to this application, both individual practitioner and agency licensures. See Checklist

LICENSE TYPE:	LICENSE #:	EXPIRATION DATE:

INSURANCE INFORMATION:
***Attach a copy of the current certificate of insurances carried. See checklist on last page of application.*

FOR LICENSED INDEPENDENT PRACTIONERS ONLY:

FULL NAME: (FIRST)____________________(MIDDLE)________________(LAST)____________________

(FOR BACKGROUND CHECK) DATE OF BIRTH: ____________________

PERSONAL:

Are you prevented from lawfully becoming employed in this country because of Visa or Immigration Status? ☐ Yes ☐ No

(PROOF OF U.S. CITIZENSHIP WILL BE REQUIRED PRIOR TO ENTERING INTO A CONTRACT)

EDUCATION AND EXPERIENCE:

***Attach a current resume/curriculum vitae & original transcripts. See Checklist.*

IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS YES, GIVE FULL DETAILS ON A SEPARATE SHEET:

1. Have you ever had a state license or state certification revoked and/or suspended? ☐ Yes ☐ No
2. Have you ever refused membership on a hospital medical or allied health staff? ☐ Yes ☐ No
3. Has your request for any specific privileges ever been suspended, diminished, revoked or voluntarily or involuntarily not renewed? ☐ Yes ☐ No
4. Have your privileges at any hospital ever been suspended, diminished, revoked or voluntarily or involuntarily not removed? ☐ Yes ☐ No
5. Have you ever been denied membership or renewal thereof, or been subject to disciplinary action in any professional organization? ☐ Yes ☐ No
6. Are you currently engaged in the use of illegal controlled substances? ☐ Yes ☐ No
7. Do you have a mental or physical condition which in any way may impair or limit your ability to practice medicine with reasonable skill and safety with or without reasonable accommodation? ☐ Yes ☐ No
8. Have you ever been convicted of a crime (felony or misdemeanor)? If Yes, please explain and give dates of conviction(s): ☐ Yes ☐ No
9. Do you have any felony charges pending against you? If Yes, please explain: ☐ Yes ☐ No
10. Have you ever had a recipient rights violation substantiated against you? ☐ Yes ☐ No

Criminal background checks may be conducted on prospective providers of Montcalm Care Network. New providers may not be added to the provider network until verification is received through primary source of information.

SANCTIONS: Have you or your organization ever been sanctioned by Medicaid, Medicare, or the Office of the Inspector General? ☐No ☐Yes If Yes, Date of Sanction:_________ Date of Reinstatement: _______

Have judgments or settlements been made against you in professional liability cases or are there any pending? *(If yes, give full details on a separate sheet.)* ☐No ☐Yes

REFERENCES: *List three references (include full name, address and phone number)*

1. ____
2. ____
3. ____

CHECKLIST: *Copies of the following pieces of documentation must be submitted with this application as indicated.*

	AFC/ Licensed Residential	***Independent Practitioner***	***Provider Agency***
Tax Exempt Certificate	√		√
Policies/Procedures on Staff Training Requirements	√		√
Proof of Staff/Provider Trainings *(PCP, RR, LEP, Cult Div, G&A, HIPAA, Med Admin, Gentle Teaching)*	√	√	√
Certifications/Accreditations *(include copy of last survey/review report issued by accrediting/certifying body with certification/accreditation dates)*	√	√	√
Licensures *(both individual & agency)*	√	√	√
Insurances *(show carrier name, policy number, policy limit, and effective & expiration dates)* • ***Professional Liability***	√	√	√
• ***General Liability***	√		√
• ***Workers Compensation***	√		√
• ***Auto*** *(if transporting consumers)*	√	√	√
• ***Property*** *(if services provided on site)*	√	√	√
• ***Other (indicate: ______________________)***	√	√	√
Resume/Curriculum Vitae		√	
Original Transcripts		√	

ATTESTATION: I fully understand that any misstatements in, or omissions from, this application may constitute cause for denial of membership to the provider network of Montcalm Care Network. All information submitted by me in this application is true to the best of my knowledge and belief. I certify that the customers listed above have given consent to serve as a reference for the purposes of this application.

I verify that all professional staff and other health services staff who deliver direct services to our clients are current and in good-standing with their respective licensing and/or certifying board or agency. I also verify that those employees, who do not yet have their license and/or certification, have a plan and are working to obtain the appropriate license and/or certification. I also verify relevant legal background checks were made as well as educational credentials.

I understand that any contractual relationship with Montcalm Care Network may be subject to termination if I fail to comply with any of the regulations or policies specified.

I understand that a criminal background check may be conducted based on the information provided in this application and agree to said background check.

DECLARING THAT THE STATEMENTS MADE IN THIS APPLICATION ARE TRUE, I HEREBY MAKE APPLICATION AND REQUEST TO BECOME A PART OF THE MCN PROVIDER NETWORK:

Signature of Applicant   Date

Printed Name of Applicant:____

10/1/15