Sentara Health Plans

SENTARA HEALTH PLANS
ORGANIZATIONAL PROVIDER ENROLLMENT APPLICATION

Please complete this form and include copies of the following documents:

- ☐ CMS Certified Letter
- ☐ W-9 (Address listed must match Remit address desired)
- ☐ Most Recent CMS Site Survey, only if non-accredited
- ☐ Accreditation Certificate or Letter, if applicable
- ☐ Certificate of Insurance (Professional & General Liability)
- ☐ State License
- ☐ Virginia - State License Addendum
- ☐ Virginia - ARTS Attestation & Roster

ORGANIZATION TYPE

CHECK ALL THAT APPLY

- ☐ ABA Clinic
- ☐ Adult Day Care Center
- ☐ Ambulatory Surgery Center (ASC)
- ☐ Ambulance (Ground/Air)
- ☐ Assisted Living Facility
- ☐ Behavioral Health Clinic
- ☐ Birthing Center
- ☐ Case Management Agency
- ☐ Clinic
- ☐ Communication Device Supplier
- ☐ Community Health
- ☐ Community Mental Health Clinic (CMHC)
- ☐ Comprehensive Outpatient Rehab Facility (CORF)
- ☐ Consumer Directed Services Agency
- ☐ Consumer Directed Personal Care
- ☐ Consumer Directed Service Facilitator
- ☐ Diagnostic Radiology Facility (Free Standing)
- ☐ Dialysis Center
- ☐ Durable Medical Equipment Supplier
- ☐ Early Intervention Center
- ☐ Emergency Center (Free Standing)
- ☐ Emergency Response System Install Company
- ☐ Emergency Response System Install and Monitoring Company
- ☐ Emergency Response System Install and Medication Monitoring Company
- ☐ Environmental Modification
- ☐ Federally Qualified Health Clinic (FQHC)
- ☐ Hearing Center
- ☐ Home Health Agency
- ☐ Home Delivered Meals
- ☐ Health Department
- ☐ Home Infusion
- ☐ Hospice Care
- ☐ Hospital-Critical Access
- ☐ Hospital-General Acute Care
- ☐ Hospital-Long Term Acute Care
- ☐ Hospital-Pediatric
- ☐ Hospital-Physical Rehabilitation
- ☐ Hospital-Psychiatric
- ☐ Infusion Center
- ☐ Long Term Acute Care (LTAC)
- ☐ Mammography Facility (Free Standing)
- ☐ Mental Health Clinic
- ☐ Methadone Clinic
- ☐ Mobile Radiology
- ☐ Orthotics/Prosthetics Supplier
- ☐ Patient Centered Medical Home
- ☐ Pharmacy
- ☐ Private Duty Nursing
- ☐ PT/OT/ST Center
- ☐ Reference Lab
- ☐ Residential Treatment Adult
- ☐ Residential Treatment Child
- ☐ Rural Health Clinic (RHC)
- ☐ Skilled Nursing Facility
- ☐ Sleep Disorders Center
- ☐ Specialty Lab
- ☐ Substance Abuse Center
- ☐ Transportation
- ☐ Urgent Care Center
- ☐ Ventilator Skilled Nursing Facility
- ☐ Other

(Specify):_____

Revised: 1-13-25

ORGANIZATION SERVICES

CHECK ALL THAT APPLY

- ☐ Adult Companion Services
- ☐ Adult Day Care
- ☐ Alcohol/Chemical Dependency-Inpatient
- ☐ Alcohol/Chemical Dependency-Outpatient
- ☐ Applied Behavioral Analysis/Therapy
- ☐ Aquatic Therapy
- ☐ Assertive Community Therapy
- ☐ Assisted Living Unit
- ☐ Assistive Technology
- ☐ Behavioral Therapy
- ☐ Birthing Rooms
- ☐ Bone Density
- ☐ Brain Injury Services
- ☐ Car Service
- ☐ Cardiac Cath Lab
- ☐ Case Management
- ☐ Chore Services
- ☐ Chores/Housekeeping
- ☐ Community Integration Counseling
- ☐ Community Transitional Services
- ☐ Companion Services
- ☐ Consumer Directed Personal Care
- ☐ Consumer Directed Service Facilitator
- ☐ Counseling
- ☐ Crisis Stabilization
- ☐ CT Scans
- ☐ Day Treatment-Partial Hospitalization-Adults
- ☐ Day Treatment-Partial Hospitalization - Pediatrics
- ☐ Diagnostic Radiology
- ☐ Dialysis Unit
- ☐ Early Intervention Infant Services
- ☐ Early Intervention Care Coordinator
- ☐ Emergency Dept – Adult
- ☐ Emergency Dept – Pediatric
- ☐ Environmental Modifications
- ☐ Equine Therapy
- ☐ Family Planning
- ☐ Functional Family Therapy
- ☐ Hand Therapy
- ☐ Home Delivered Meals
- ☐ Home Health
- ☐ Home Delivered Meals
- ☐ Homemaker Services
- ☐ Hospice Services
- ☐ Infusion Services
- ☐ Intensive Community Treatment
- ☐ Intensive – In-Home
- ☐ Intensive – Inpatient
- ☐ Intensive – Outpatient
- ☐ Intensive Psychiatric Rehab Treatment
- ☐ Laboratory
- ☐ Lithotripsy
- ☐ Mammography
- ☐ Massage Therapy
- ☐ Medical Equipment
- ☐ Medication Administration
- ☐ Medication Assisted Treatment
- ☐ Medication Management
- ☐ Memory Care
- ☐ Mental Health Case Management
- ☐ Mental Health Inpatient
- ☐ Mental Health Intensive Outpatient
- ☐ Mental Health Outpatient
- ☐ Mental Health Skill Building
- ☐ Mobile Radiology
- ☐ Moving Assistance
- ☐ MRI
- ☐ Music Therapy
- ☐ Neonatal ICU
- ☐ Occupational Therapy
- ☐ Opioid Treatment Program
- ☐ Outpatient Infusion/Chemo Center
- ☐ Outpatient Surgery
- ☐ Oxygen Supplies
- ☐ Palliative Care
- ☐ Peer Support Services - Group
- ☐ Peer Support Services - Individual
- ☐ Personal Care
- ☐ PET Scan
- ☐ Pet Therapy
- ☐ Physical Therapy
- ☐ Power Mobility Devices
- ☐ Psychiatric Inpatient Unit
- ☐ Psychiatric Outpatient
- ☐ Psychosocial Rehabilitation
- ☐ Psychotherapy-Family
- ☐ Psychotherapy-Group
- ☐ Psychotherapy-Individual
- ☐ Radiation Oncology
- ☐ Rehabilitation Inpatient
- ☐ Respite Care
- ☐ Sleep Disorder Center
- ☐ Social Day Care
- ☐ Social Day Care Transportation
- ☐ Speech Therapy
- ☐ Structured Day Program
- ☐ Swing Bed Unit
- ☐ Taxi Service
- ☐ Telehealth
- ☐ Therapeutic Day Treatment (non-school based)
- ☐ Therapeutic Day Treatment (school-based)
- ☐ Therapeutic Day Treatment (after school)
- ☐ Transitional Assistance Services
- ☐ Transportation Service
- ☐ Trauma Center
- ☐ Treatment Foster Care Case Mgmt
- ☐ Ultrasound
- ☐ Urgent Care
- ☐ Vaccination Services
- ☐ Ventilator Services
- ☐ Wheelchair Supplier – Manual
- ☐ Wheelchair Supplier - Power
- ☐ Whirlpool Therapy
- ☐ Wound Care
- ☐ X-Ray
- ☐ Other

(Specify):_____

Legal Business Name as Reported to the IRS:		
Business Location DBA Name *(NOT your billing agent, staffing company, or managing organization):*		
Primary Business Location Address Line 1:		
City/Town:	State:	ZIP Code +4:
Telephone Number:	Fax Number *(if applicable):*	
Office Accessibility for this location: ☐ Wheelchair Accessible ☐ Public Transportation within one mile Languages Spoken in this office: _____		
Email Address *(if applicable):*		
Days of Operation:	Hours of Operation:	
Mailing/Correspondence Address, if different from location(s):		
Business Location DBA Name *(NOT your billing agent, staffing company, or managing organization):*		
Secondary Business Location Address Line 2: ***(For additional locations please submit a listing with all information)***		
Remittance Location (if different from main and secondary location):		
City/Town:	State:	ZIP Code +4:
Telephone Number:	Fax Number *(if applicable):*	
Office Accessibility for this location: ☐ Wheelchair Accessible ☐ Public Transportation within one mile Languages Spoken in this office: _____		
Email Address *(if applicable):*		
Office Primary Contact:	Phone Number:	

REGULATORY	
Billing NPI:	Tax ID #:
Group NPI or API:	
State License #:	License Expiration Date:
Medicaid ID #:	Medicare ID #:

GENERAL LIABILITY		
Name of Insurance Company:		
Insurance Policy Number:	Effective Date: *(mm/dd/yyyy):*	Expiration Date: (*mm/dd/yyyy):*
Policy Limits Per Incident:	Policy Limits Aggregate:	

PROFESSIONAL LIABILITY		
Name of Insurance Company:		
Insurance Policy Number:	Effective Date: *(mm/dd/yyyy)*	Expiration Date: (*mm/dd/yyyy):*
Policy Limits Per Incident:	Policy Limits Aggregate:	

ACCREDITATION	
☐ Enrolling Organization is <u>not</u> Accredited – Please include most recent CMS Site Survey Report with application, if applicable ☐ Enrolling Organization is Accredited:	
Name of Accrediting Organization:	
Date of Last Accreditation*:*	Expiration of Current Accreditation*:*

The submissions of a **Disclosure of Ownership, Controlling Interest and Management Statement** is a federal regulation requirement under 42 CFR Part §455, applicable to all providers that participate in state-based health care programs, such as Medicaid & CHIP, and provide services pursuant to a contract between a Medicaid Managed Care Organization (MCO) and a State Medicaid agency Providers are required to disclose to the U.S. Department of Health and Human Services, the State Medicaid Agency, and to Managed Care Organizations that contract with a State Medicaid Agency.

As required, upon receipt of the completed Disclosure, Sentara will review the data and run the names of all the entities and individuals disclosed against several Federal Databases. These Federal Databases include a review and comparison of the disclosed information against any data available in the following databases and/or published lists:

- Office of Inspector General List of Excluded Individuals/Entitles (OIG LEIE)
- General Services Administration's System for Award Management (SAM)
- Any other applicable State exclusion list including other state Medicaid programs

Required information to be disclosed includes:

1) The identity of all owners and others with a controlling interest of 5% or greater;
2) Certain business transactions as described in 42 CFR §455.105;
3) The identity of managing employees, agents and others in a position of influence or authority; and
4) Criminal conviction information for the provider, owners, officers, directors, agents and managing employees. The information required includes, but it is not limited to, name, address, date of birth, social security number (SSN) and tax identification (TIN).
Disclosure of this information, including SSNs for affected parties is required per 42 CFR § 455.104.

This Disclosure is required with the initial contract and shall be updated periodically as follows:

- At minimum, every three (3) years during recredentialing; and
- Any time there is a change to the information

Please attach a separate sheet if necessary to provide complete information. Failure to submit the accurate, complete information requested in a timely manner may lead to the termination or denial of enrollment into the network as specified in 42 CFR 455.416.

DISCLOSURE OF OWNERSHIP CONTROLLING INTEREST AND MANAGEMENT STATEMENT

ORGANIZATION INFORMATION

Check one that most closely describes you: ☐ Individual ☐ Group Practice ☐ Disclosing Entity
Name of Individual, Group Practice, or Entity:
DBA Name:
Address:
Federal Tax Identification Number:

SECTION I

List the name, title, address, date of birth (DOB) and Social Security Number (SSN) for each individual having an ownership or control interest in this provider entity of 5% or greater. List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership or control interest of 5% or greater. *Per 42 CFR 455.104, list the name, title, address, date of birth (DOB) and Social Security Number (SSN) of any general manager, business manager, administrator, director, or other individual who exercises operational or managerial control of the disclosing entity. Please attach a separate sheet if necessary.*

Name of individual or entity	Title	Address	DOB	SSN (if listing an individual) TIN (if listing an entity)

SECTION II

Are any of the individuals listed above related to each other? ☐ Yes ☐ No

If yes, list the individuals named above who are related to each other (spouse, sibling, parent,child). (42 CFR 455.104)

Names	Type of relation

SECTION III

Are there any subcontractors that the Disclosing Entity has direct or indirect ownership of 5% or more? ☐ Yes ☐ No

If yes, list the name and address of each person with an ownership or controlling interest in any subcontractor used in which the disclosing entity has direct or indirect ownership of 5% or more. (42 CFR 455.104)

Name of individual or entity	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

SECTION IV

Has any person who has an ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare, or Title XX Program?
☐ Yes ☐ No

If yes, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN

SECTION V

Business Transactions: Has the disclosing entity had any financial transaction with any subcontractors totaling more than $25,000 or any significant business transactions with any subcontractors? ☐ Yes ☐ No

If yes, list the ownership of any subcontractor with whom this provider has had business transactions totaling more than $25,000 during the previous twelve month period; and any significant business transactions between this provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5-year period. (42 CFR 455.105).Attach a separate sheet if necessary.

Name Supplier/Subcontractor	Address	Transaction Amount

SECTION VI

Have you identified your status (under Organization Information) as a Disclosing Entity? ☐ Yes ☐ No

If yes, for Disclosing Entities, list each member of the Board of Directors or Governing Board, including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest

Name/Title	DOB	Address	SSN	% Interest

ATTESTATION, RELEASE & HOLD HARMLESS

QUESTIONNAIRE – If the answer to any of the questions is **yes**, please provide details on a separate sheet.

Please answer the following questions by checking the appropriate box:	**YES**	**NO**
1. Have criminal proceedings ever been initiated against your Company or its authorized representative(s)?		
2. Has an officer of the facility ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense?		
3. Has the facility ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?		
4. Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I affirm that information provided in or attached to this application including the questions above are current, correct, and truthful.

RELEASE AND HOLD HARMLESS

By applying for or renewing participation, the following conditions are accepted as legally binding. These conditions shall remain in effect for the duration of any term of provider participation:

To the extent permitted by law, applicant shall release and hold harmless from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures, which are made, taken, or received in good faith by the Company or its authorized representatives relating to the following:

A. Applications for participation
B. Periodic reappraisals undertaken for renewal thereof0

Authorization is given to the Company and its authorized representatives to consult with any third party who may have information bearing on services as an Organizational Provider entity.

Authorized Signature (e-signature or wet signature) **Date**

Name (Print/Type) **Title**

Addendum A
Virginia

VIRGINIA STAFFING ATTESTATION – QMHP PROFESSIONALS ONLY

"Qualified Mental Health Professional- Adult or QMHP-A" means a qualified mental health professional who provides collaborative mental health services for adults.

Services are rendered by appropriately qualified individuals as defined in Chapter II of the CMHRS Manual. The QMHP-A, QMHP-C, or QMHP-Trainee (QMHP-E) staff rendering services are appropriately qualified and registered with the Board of Counseling in accordance with 12VAC35-105-20 and 18VAC115-80-10.

☐ YES ☐ NO

Authorized Signature of Staff Member Attesting **Date**

Name (Print) **Title**

VIRGINIA STAFFING ATTESTATION – BRAVO SERVICES ONLY

Services rendered by appropriately qualified individuals as defined by the Department of Medical Assistance Services (DMAS). Your facility's staff rendering services must be appropriately licensed/certified and registered with the appropriate board or certifying body per DMAS.

☐ YES ☐ NO

Please list all required staff (based on service provided) to include degree, title, and/or certification. All applicable licenses /certifications listed must be attached to this application for each person you have listed. Provide a separate sheet with the required information if additional space is required.	
Name:	Position/Title:
Name:	Position/Title:
Name:	Position/Title:
Name:	Position/Title:
Name:	Position/Title:

Authorized Signature of Staff Member Attesting **Date**

Name (Print) **Title**

VIRGINIA SERVICE AREA FOR ARTS AND CMHRS

☐ **Virginia Statewide** (or check applicable Counties and Cities)

VIRGINIA COUNTIES				
☐ Accomack	☐ Chesterfield	☐ Greensville	☐ Middlesex	☐ Rockbridge
☐ Albemarle	☐ Clarke	☐ Halifax	☐ Montgomery	☐ Rockingham
☐ Alleghany	☐ Craig	☐ Hanover	☐ Nelson	☐ Russell
☐ Amelia	☐ Culpeper	☐ Henrico	☐ New Kent	☐ Scott
☐ Amherst	☐ Cumberland	☐ Henry	☐ Northampton	☐ Shenandoah
☐ Arlington	☐ Dickenson	☐ Highland	☐ Northumberland	☐ Smyth
☐ Augusta	☐ Dinwiddie	☐ Isle of Wright	☐ Nottoway	☐ Southampton
☐ Bath	☐ Essex	☐ James City	☐ Orange	☐ Spotsylvania
☐ Bedford	☐ Fairfax	☐ King and Queen	☐ Page	☐ Stafford
☐ Bland	☐ Fauquier	☐ King George	☐ Patrick	☐ Surry
☐ Botetourt	☐ Floyd	☐ King William	☐ Pittsylvania	☐ Sussex
☐ Brunswick	☐ Fluvanna	☐ Lancaster	☐ Powhatan	☐ Tazewell
☐ Buchanan	☐ Franklin	☐ Lee	☐ Prince Edward	☐ Warren
☐ Buckingham	☐ Frederick	☐ Loudoun	☐ Prince George's	☐ Washington
☐ Campbell	☐ Giles	☐ Louisa	☐ Prince William	☐ Westmoreland
☐ Caroline	☐ Gloucester	☐ Lunenburg	☐ Pulaski	☐ Wise
☐ Carroll	☐ Goochland	☐ Madison	☐ Rappahannock	☐ Wythe
☐ Charles City	☐ Grayson	☐ Mathews	☐ Richmond	☐ York
☐ Charlotte	☐ Greene	☐ Mecklenburg	☐ Roanoke	

INDEPENDENT VIRGINIA CITIES				
☐ Alexandria	☐ Covington	☐ Harrisonburg	☐ Norfolk	☐ Salem
☐ Arlington	☐ Danville	☐ Hopewell	☐ Norton	☐ South Boston
☐ Bedford	☐ Emporia	☐ Lexington	☐ Petersburg	☐ Staunton
☐ Bristol	☐ Fairfax	☐ Lynchburg	☐ Poquoson	☐ Suffolk
☐ Buena Vista	☐ Falls Church	☐ Manassas	☐ Portsmouth	☐ Virginia Beach
☐ Charlottesville	☐ Franklin	☐ Manassas Park	☐ Radford	☐ Waynesboro
☐ Chesapeake	☐ Fredericksburg	☐ Martinsville	☐ Richmond	☐ Williamsburg
☐ Clifton Forge	☐ Galax	☐ Newport News	☐ Roanoke	☐ Winchester
☐ Colonial Heights	☐ Hampton			

Continued on next page …

☐ **North Carolina Statewide** (or check applicable Counties and Cities)

NORTH CAROLINA COUNTIES				
☐ Alamance	☐ Chowan	☐ Guilford	☐ Mitchell	☐ Rutherford
☐ Alexander	☐ Clay	☐ Halifax	☐ Montgomery	☐ Sampson
☐ Alleghany	☐ Cleveland	☐ Harnett	☐ Moore	☐ Scotland
☐ Anson	☐ Columbus	☐ Haywood	☐ Nash	☐ Stanly
☐ Ashe	☐ Craven	☐ Henderson	☐ New Hanover	☐ Stokes
☐ Avery	☐ Cumberland	☐ Hertford	☐ Northampton	☐ Surry
☐ Beaufort	☐ Currituck	☐ Hoke	☐ Onslow	☐ Swain
☐ Bertie	☐ Dare	☐ Hyde	☐ Orange	☐ Transylvania
☐ Bladen	☐ Davidson	☐ Iredell	☐ Pamlico	☐ Tyrrell
☐ Brunswick	☐ Davie	☐ Jackson	☐ Pasquotank	☐ Union
☐ Buncombe	☐ Duplin	☐ Johnston	☐ Pender	☐ Vance
☐ Burke	☐ Durham	☐ Jones	☐ Perquimans	☐ Wake
☐ Cabarrus	☐ Edgecombe	☐ Lee	☐ Person	☐ Warren
☐ Caldwell	☐ Forsyth	☐ Lenoir	☐ Pitt	☐ Washington
☐ Camden	☐ Franklin	☐ Lincoln	☐ Polk	☐ Watauga
☐ Carteret	☐ Gaston	☐ McDowell	☐ Randolph	☐ Wayne
☐ Caswell	☐ Gates	☐ Macon	☐ Richmond	☐ Wilkes
☐ Catawba	☐ Graham	☐ Madison	☐ Robeson	☐ Wilson
☐ Chatham	☐ Granville	☐ Martin	☐ Rockingham	☐ Yadkin
☐ Cherokee	☐ Greene	☐ Mecklenburg	☐ Rowan	☐ Yancey
INDEPENDENT NORTH CAROLINA CITIES				
☐ Asheboro	☐ Fayetteville	☐ Hickory	☐ Monroe	☐ Shelby
☐ Asheville	☐ Gastonia	☐ High Point	☐ New Bern	☐ Statesville
☐ Burlington	☐ Goldsboro	☐ Jacksonville	☐ Raleigh	☐ Thomasville
☐ Charlotte	☐ Greensboro	☐ Kannapolis	☐ Rocky Mount	☐ Wilmington
☐ Concord	☐ Greenville	☐ Kinston	☐ Salisbury	☐ Wilson
☐ Durham	☐ Havelock	☐ Lumberton	☐ Sanford	☐ Winston-Salem
INDEPENDENT NORTH CAROLINA CITIES				
☐ District of Columbia	☐ Kentucky	☐ Maryland	☐ Tennessee	☐ West Virginia