Join Our Network: Provider Contracting and Credentialing Guide

PRSS Enrollment

The federal act requires providers who serve Medicaid patients through managed care organization (MCO) networks to enroll directly in the state Medicaid program.

Here are the steps:

The provider must notify Sentara Health Plans of their DMAS approval/approval date and request participation with Sentara Medicaid by submitting a **Provider Update Form**.

When the **Provider Update Form** is received by Sentara Health Plans, the provider will be updated to par for Sentara Medicaid, effective as the DMAS approval/enrollment date.

Claims submitted for date of service (DOS) on or after the provider's Sentara Medicaid effective date will be processed/reimbursed as in the network.

Step 1:
Determine the type of request appropriate for you. There are two options available:

1. a contracting request
2. a credentialing request

Click this link to determine which request applies to you.

Step 2:
Once your request is submitted, a contract manager will contact you to discuss your contract and provide credentialing instructions. The approval and loading time can take 30 to 45 days to complete.

Step 3:
Welcome to Sentara Health Plans! Once your contract and credentialing process are approved, you will officially be a Sentara Health Plans partner.

Join Our Network

Noncontracted providers, group practices, or facilities that have not joined Sentara Health Plans will need to complete the **Request for Participation Form** available on the Sentara Health Plans website under Join Our Network.

Credentialing
The Sentara Health Plans credentialing process allows healthcare professionals to join the Sentara Health Plans provider network. It also ensures that providers who are contracted with Sentara Health Plans meet the healthcare industry standard. To request credentialing, please submit a **Provider Update Form**.

Sentara® Health Plans

For more information, visit **sentarahealthplans.com/providers.**

Contracting Scenarios

LTSS/Sentara Community Plan Provider Services

Sentara Health Plans delegates and provides oversight for credentialing and re-credentialing of Sentara Community Plan LTSS providers to HEOPS-Centipede per requirements. Sentara Community Plan ensures that HEOPS-Centipede credentials and re-credentials providers per DMAS and Sentara Community Plan requirements and ensures that all providers comply with provisions of the CMS Home and Community-based Settings Rule.

Phone: **1-855-359-5391**

Email: **joincentipede@heops.com**

New Provider Joining Sentara Health Plans or an Existing Provider Joining a New Group

1. New provider and existing provider requests with new noncontracted groups are submitted through a **Request for Participation Form** located on the provider portal.
2. Your **Request for Participation Form** is routed to network management for review.
3. If your request is approved, a contract manager will contact you regarding contract and credentialing instructions.
4. You will receive an email from Sentara Health Plans confirming that the provider and contract has been set up with an effective date.

Credentialing Scenarios

1. Confirm the Sentara Health Plans contract is completed. To receive or request credentialing instructions, the Sentara Health Plans contract must be completed and approved.
2. New provider requests or existing provider requests with existing contracted groups are submitted through the **Provider Update Form**. This form will include the practitioner CAQH number. All credentialing requests for new providers who are joining existing groups must be submitted through this form.
3. The application loading process completion may take up to 30 days.
4. Once the application loading process is completed, you will receive a letter from the credentialing department confirming your provider update approval.

Facility/Ancillary Provider

1. New facility/ancillary requests are submitted through a **Request for Participation Form** located on the provider portal.
2. The **Request for Participation Form** is routed to network management. A network manager will send the contract and credentialing packet to the provider.
3. Please contact your assigned network educator at **contactmyrep@sentara.com** to inquire about the contracting process.

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Billing While Credentialing Is Pending

According to VA Law § 38.2-3407.10:1 of the Code of Virginia, Sentara Health Plans may reimburse providers for services while their credentialing application is pending. An application is considered pending once the application has been deemed complete/clean by Sentara Health Plans to advance within the credentialing process. Reimbursement for services rendered during the pending application period is contingent upon approval of the provider's credentialing application by the Sentara Health Plans Credentialing Committee.

New provider applicants, to submit claims to Sentara Health Plans pursuant to the law, shall provide written or electronic notice to covered members in advance of treatment that they have submitted a credentialing application to Sentara Health Plans stating it is in the process of obtaining approval.

It is recommended that your notice includes the following information:

Notice of Provider Credentialing and Re-credentialing

Your health insurance carrier is required to establish and maintain a comprehensive credentialing verification program to ensure that its physicians, mental health professionals, and other providers meet the minimum standards of professional licensure or certification.

Written supporting documentation for (i) physicians, (ii) mental health professionals who have completed their residency or fellowship requirements for their specialty area more than 12 months prior to the credentialing decision, or (iii) other providers shall include:

- *current valid license and history of licensure or certification*
- *status of hospital privileges, if applicable*
- *valid U.S. Drug Enforcement Administration certificate, if applicable*
- *information from the National Practitioner Data Bank, as available*
- *education and training, including postgraduate training, if applicable*
- *specialty board certification status, if applicable*
- *practice or work history covering at least the past five years*
- *current, adequate malpractice insurance and malpractice history covering at least the past five years*

Your health insurance carrier is in the process of obtaining and verifying the above information in order to determine if your physician, mental health professional, or other provider will be credentialed or not.

H. The provisions of this section shall not apply to coverages issued by a Medicare Advantage plan, but shall apply to health maintenance organizations that issue coverage pursuant to Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid).

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Provider Malpractice Important Note

Virginia providers must maintain malpractice coverage in amounts not less than the medical malpractice caps currently in effect under section 8.01-581 of the **Virginia Code**.

Nonprescribing providers (including behavioral health providers) must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.

In all states except Virginia, providers must maintain the coverage amount required under the applicable state law governing minimum medical malpractice coverage. If the state does not have a requirement for minimum medical malpractice coverage, the provider must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.

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