OptimaHealth

4417 Corporation Lane
Virginia Beach, VA 23462

4/1/2020

COVID-19 Application Short Form

☐ Yes ■ No Is this application being submitted to assist with the emergent healthcare needs due to COVID-19?

If no, please complete the following application as usual.

If yes, please complete the questions below, but still complete and submit the following application and checklist requirements.

Check those that apply:

☐ Returning retiree
☐ Early Graduate (with VA license)
☐ Out of State License
☐ Other: _____

Provide your primary work location:

_____

_____

_____

Optima Health
New Provider Application Packet

Thank you for your interest in becoming a participating provider in the Optima Health Network. Please review the following instructions to ensure acceptance of your application.

*(**Ancillary Providers please note**: The CAQH application is not intended for ancillary providers; such as: audiologist, physical, occupational and/or speech therapist. Please follow-up with a network educator directly for information regarding network participation. The CAQH packet is applicable for physicians, nurse practitioners and/or physician assistants working in an ancillary facility; such as a health department.)*

1. **Visit www.CAQH.org to complete an application. Optima Health uses the online Council for Affordable Quality Healthcare (CAQH) application exclusively for all Providers. We require that all of your information be entered and accurate in CAQH. We will be unable to accept your application until it is complete.**
   Please contact the CAQH Provider Help Desk (1-888-599-1771 or providerhelp@ProView.CAQH.org) for assistance with the CAQH application.

2. **Once your CAQH application is complete (with all required attachments), please complete and return all required information on the checklist to Network Management:**

   Via email to: **MedProviderApp@Sentara.com**
   Include your primary city location in the subject of your email.

   Or via Fax to: **1-866-751-7645**

3. **Once we receive a completed application and all required paperwork your paperwork will be forwarded to the Optima Health Credentialing Department** for review, verification, and presentation to the Medical Director and Credentialing Committee for final determination. **The credentialing process typically takes between 60-90 days upon receipt of a complete and accurate application.**

4. Upon approval by the Optima Health Credentialing Committee, you will be notified by your assigned Network Educator of your Optima Health participation effective date. **Providers should not begin scheduling or treating Optima Health members on an in-network basis until they are notified of their Optima Health effective date.**

If you have any questions about the requested information or about the application or credentialing process, please contact Provider Services at 1-800-229-8822. We look forward to working with you.

Sincerely,
Optima Health
Network Management

Enclosures

OptimaHealth

NEW PROVIDER CHECKLIST

This list is provided to assist you through the application process.

Provider Name: _____

CAQH

We require that all of your information be entered and accurate in CAQH. We will be unable to accept your application until it is complete. (For assistance with attaching documents within CAQH, contact their provider help desk at 1-888-599-1771.) This includes, but may not be limited to, the following:

- Your Personal Information and Professional IDs
- All license(s) information
- NPI number
- All practices and locations at which you will be routinely providing services to Optima Health members
- Current W-9 for each newly contracted practice (attached to your CAQH application)
- Current Malpractice Insurance Face Sheet (attached to your CAQH application)
    - For Virginia prescribing* licensees: limits must be at least equal to the current year VA state cap requirements (http://law.lis.virginia.gov/vacode/title8.01/chapter21.1/sections8.01-581.15/) (*Note: if your license affords you the ability to write prescriptions, you must meet these limits regardless of your prescribing habits.)
    - For non-Virginia licensees and non-prescribing practitioners: limits must at least equal $1 million/$3 million

REQUIRED ATTACHMENTS

In addition to your completed CAQH, please be sure to send us all of the following required forms/documents:

- Provider Information Form
- Authorization and Release Form - signature must be dated no more than 6 months old at the time we receive all required documents

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Network Management will forward your application and paperwork to the Optima Health Provider Credentialing Department. A credentialing analyst will reach out to you to request any other required information, which may include:

- The following must also be included in your CAQH Application
    - Board Certification information or date when taking boards
    - Nursing Board Certification information, when applicable
    - All past and current state licenses and DEA information
    - Explanation for any malpractice suits
    - Explanation for gaps in malpractice insurance*
    - Education history, including applicable internship/residency/fellowships
    - Work history for past 10 years
    - Explanation of work history gaps greater than six (6) months*
    - Professional references from two (2) providers with contact phone number*
    - Covering colleagues or partners/associates
    - Foreign languages spoken
    - Listing of Hospital Privileges (if applicable)
    - ECFMG number (if applicable)

- The following must also be attached in CAQH
    - Copy of Curriculum Vitae or Resume in month and year format
    - Copy of the Nursing Board Certificate (ANCC, AANP, NCC, PNCB) when applicable
    - Seven (7) years of malpractice insurance history; Two (2) years for NPs, PAs, CRNAs, CNMs*

You may contact the Optima Health Credentialing Department via email at Optima-CredApps@Sentara.com or via phone at 757-552-7193.

* Information not included on North Carolina CAQH application and must be supplied separately.

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OPTIMA HEALTH
PROVIDER INFORMATION FORM
(all fields are required)

Provider Name: _____ CAQH Number _____

Individual NPI: _____

Provider Type: _____ Provider Specialty: _____

If Family Practice, Geriatrics, Internal Medicine, or Pediatrics, will provider be a PCP with members attached? ☐ Yes ☐ No

If yes, please select panel status listed below:

- ☐ 0 Provider is open and accepting members
- ☐ 1 Not accepting new patients; will continue providing services for existing patients, siblings, and spouses switching plans with verification from physician's office
- ☐ 3 Not accepting new patients; accepting newborns and siblings.
- ☐ 4 Age restriction: Provide ages: _____
- ☐ 5 Non MD: Membership should be paneled to valid MD in practice
- ☐ 7 Covering physician only

Practice Name _____

City of Primary Office _____

Tax Id # _____ Group NPI # _____

Practice Email _____

Vendor Number(s) to be Attached to Provider (if known) : _____

NOTE: If we have any questions about the information in this packet, we will reach out to the provider listed above.
If you would prefer that we contact someone else, please provide their information here:

Full Name _____
Phone # _____
Email Address _____

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Authorization and Release Form

A. General Conditions of Application

In return for my application being considered and processed, I agree to be legally bound by the following terms and conditions:

1. I know that it is my responsibility to produce adequate information so that my application can be properly evaluated. In addition to the information provided in this application, I will provide Sentara Health Plans, Inc. (hereinafter referred to as "the applicable Sentara Affiliated Health Plan(s)") with any additional information that they or their respective representatives may request. Failure to provide any requested information will cause my application to be incomplete, so that it cannot be processed.
2. I will keep this application current by informing the Sentara Affiliated Health Plan(s) through the Optima Health Medical Director, of any changes in the information provided.
3. I will be available for interviews with regard to this application.
4. As applicable and appropriate, I will accept committee assignments and other reasonable duties and responsibilities assigned to me.
5. I will provide timely and continuous care for all my patients.
6. My participation with the applicable Sentara Affiliated Health Plans is dependent upon my continued demonstration of professional competence and cooperation and acceptable performance of all related responsibilities.
7. I have had an opportunity to read a copy of the contract of the applicable Sentara Affiliated Health Plan(s), and I specifically agree to abide by the policies, rules and regulations, and directives that are in force during the time I am appointed.
8. I will abide by the applicable Sentara Affiliated Health Plan(s)' Corporate Compliance Policy and any laws, regulations and standards of conduct applicable to my profession, participation in any federal health program, or activities at the applicable Sentara Affiliated Health Plan(s) and will report any known or suspected violation to the Optima Health Medical Director.
9. All information provided in or attached to this application is accurate and complete. I know that any misrepresentation, misstatement or omission from this application shall constitute cause to stop the processing of my application. If my misrepresentation, misstatement, or omission is discovered after I have been appointed, that discovery may be an automatic relinquishment of my appointment and clinical privileges. Neither situation entitles me to any of the hearing or appeal rights contained in the policies at the applicable Sentara Affiliated Health Plan(s).

B. Information Sharing, Release, and Immunity

1. I understand that the entities to which I am applying for provider status is affiliated with Sentara Healthcare. I also understand that my Confidential Peer Review Information includes information and/or documentation regarding my clinical competence and/or professional conduct that is obtained or produced as part of the credentialing, quality assessment, and/or peer review processes conducted by Sentara Health Plans, Inc., and/or the Sentara Affiliated Health Plan(s). Such sharing is solely for the purposes of credentialing and peer review.

2. The Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, and Sentara Health Plans, Inc. may release to one another, and to the Sentara Healthcare Medical Affairs Committee, Confidential Peer Review Information regarding my practice.
3. Confidential Peer Review Information that is released shall be used solely for credentialing and peer review purposes and all Confidential Peer Review Information will be handled in confidence, in accordance with the protections and privileges afforded to peer review information under state and/or federal law.
4. I accept the following conditions and intend to be legally bound by them:
    a) To the fullest extent permitted by law, I extend immunity to, release from any and all liability, and agree not to sue Sentara Healthcare, the Sentara Healthcare Medical Affairs Committee, Sentara Health Plans Inc., the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation, their respective representatives, or any third parties for any matter relating to appointment, reappointment and clinical privileges, and participation in the Sentara Affiliated Health Plan(s), or my qualifications for the same.
    b) I authorize Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to consult with any third party who may have information bearing on my professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for participation in the Sentara Affiliated Health Plan(s). This authorization includes the right to inspect or obtain communications, reports, records, recommendations or disclosures that may be relevant to such questions. I specifically authorize these third parties to release the information to Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives upon request.
    c) I also authorize Sentara Health Plans Inc., and the Sentara Affiliated Health Plan(s) at which I am granted, or seek, participation and their respective representatives to release such information to other hospitals, health care facilities and managed care entities and their agents, who seek such information for the purpose of evaluating my qualifications pursuant to a request for appointment and clinical privileges and participating provider status or other credentialing matter.
    d) I agree that the hearing and appeal procedures set forth in the Sentara Affiliated Health Plan(s)' policies are my sole and exclusive remedy with respect to any professional review action taken at the Sentara Affiliated Health Plan(s).
5. In the event that the terms and conditions of this release conflict with the terms and conditions of the Coalition for Affordable Healthcare's (CAQH) release, the terms and conditions of this release shall control as they relate to Sentara Healthcare.

_____

Signature of Practitioner

_____

Printed or Typed Name of Practitioner

_____

Date