



1991 Marcus Avenue, Suite M201, Lake Success, NY 11042

1-866-586-8044 • info@agewellnewyork.com • www.agewellnewyork.com

Dear Provider/Facility:

Thank you for your interest in becoming a network provider/facility for AgeWell New York, LLC. In accordance with our commitment to the quality of health care services delivered to our members, we have a well-defined and structured credentialing process in place that you will need to undergo before we may confirm you as a participating provider/facility.

Please see below the following criteria we require and information to become part of our network. Please complete and submit the information requested in this form within ten (10) business days, and return it to us by mail to the following address:

AgeWell New York
Provider Relations
1991 Marcus Avenue
Suite M201
Lake Success, NY 11042

In addition to the information contained in the application, please be sure to include a copy of supporting documents:

- **Completed Application**
- **Attestation Signed and Dated**
- **Copy of License (DOH operating Certificate)**
- **W9 Form**
- **Tax ID Number/NPI Number**
- **Copy of CLIA (If applicable)- All contracted laboratory testing sites are required to maintain certification under the Clinical Laboratory Improvement Amendments (CLIA) or have a waiver of CLIA certification**
- **Professional & General Malpractice Insurance Certificate (Please indicate AgeWell New York as the certificate holder).**
- **Workers Compensation: (Attach Coverage Certificate – indicating AgeWell New York as a Certificate Holder)**
- **Evidence of JCAHO or other accreditation**
- **If the facility is not accredited by JCAHO or other accreditation agency, please send a recent State Survey (i.e.; DOH, CMS) along with a statement of deficiency and a plan of correction**
- **The American with Disabilities Act Attestation signed and dated.**

Thank you again for applying to become a participating provider/facility for AgeWell New York, LLC.



GENERAL INFORMATION:

Facility/ Provider Type: _____

Facility / Organization Name: _____

Service Location Address: _____

Primary Contact Person: _____

Primary Contact Person Email: _____

Primary Telephone #: _____

Primary Fax #: _____

Geographic Areas Served:
 Bronx ___ Manhattan ___ Queens ___ Brooklyn ___
 Suffolk ___ Nassau ___ Westchester ___

Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

NPI #: _____ Tax Identification Number: _____
 (Attach copy of W-9)

On a bus route: Y N Name of bus route(s), if applicable: _____

Is the location accessible to the disabled? Internally: Yes No Externally: Yes No

CERTIFICATION, LICENSURE AND ACCREDITATION:

Medicare Certification/Participant Yes No N/A Medicare Provider Number: _____

Medicaid Certification/Participant Yes No N/A Medicaid Provider Number: _____

NYS Article 28? Yes No N/A

New York State License Number: _____ PFI# _____ Exp Date _____
 (Attach copy of Certificate)

JCAHO or other accreditation? Yes No N/A (Include copy of certificate)



Institutional (Non-Individual) Providers Only

1. In the past ten (10) years, has your institution ever been indicted for criminal activity?
 Y **N** (If "Yes", please attach a separate sheet with a full explanation.)

2. In the past ten (10) years, has your institution ever been subject to any investigation of your business practices (e.g., Attorney General, OMIG?) **Y** **N**

(If "Yes", please attach a separate sheet with a full explanation. Routine normal-course-of-business audits need not be disclosed unless resulting in a payback/recoupment to Medicare, Medicaid or other payors in excess of \$500,000 with respect to any single audit.)

3. In the past ten (10) years, has your institution lost, or had suspended, any accreditation, certification, permit, approval or license relating to your operations, or been placed on probation or sanctioned in any way? **Y** **N**

(If "Yes", please attach a separate sheet with a full explanation.)

4. In the past ten (10) years, has your institution been denied membership or renewal of membership at any health plan, or is such action pending? **Yes** **No**

(If "Yes", please attach a separate sheet with a full explanation.)

5. Do you subcontract for medical services with other organizations or individuals?
 Yes **No**

If yes, please provide their names and addresses and describe your relationship(s):

Do you have a quality improvement process in place? **Yes** **No**
If yes, please attach a brief summary as an attachment.

Do you have a process in place to measure and collect patient satisfaction? **Yes** **No**
If yes, please describe your most recent patient satisfaction measure and instrument used.



CONTACT INFORMATION:

Owner/Principal _____

Title: _____ Phone: _____

Email: _____ Fax: _____

Administration: _____

Title: _____ Phone: _____

Email: _____ Fax: _____

Services/Intake: _____

Title: _____ Phone: _____

Email: _____ Fax: _____

Finance/Billing: _____

Title: _____ Phone: _____

Email: _____ Fax: _____

EDI AND INTERNET:

Electronic Claims Submission Y N

Does this business have internet access? Y N

If no to either, please explain: _____

Skilled Nursing Facilities and Home Health Care Agencies: If you respond "No" to the above question regarding an Advance Directives Policy, please include a copy of the specific section of your institutional policy/process which addresses Advance Directives.

PROFESSIONAL LIABILITY INSURANCE COVERAGE

Do you have Professional Liability (Malpractice) Insurance coverage in force? Yes No

Liability Insurance (Attach Coverage Certificate)

Insurance Carrier: _____

Limits of Liability: _____ Policy Period: _____



GENERAL LIABILITY INSURANCE COVERAGE

Do you have General Liability insurance coverage in force? Yes No

Liability Insurance (Attach Coverage Certificate)

Insurance Carrier: _____

Limits of Liability: _____ Policy Period: _____

In the past ten (10) years, have you ever had any Professional Liability coverage canceled, declined or modified, has any renewal ever been refused, or have you voluntarily given up coverage?

Y N (If "Yes", please attach a separate sheet with a full explanation.)

WORKERS COMPENSATION:

Workers Compensation (Attach Coverage Certificate) _____

LANGUAGES:

Languages spoken by Staff:

Chinese Russian Spanish Korean

Italian French Creole

Other: Please list all that apply: _____

SERVICES:

Please check the applicable services below that describe your service type and circle applicable accreditation or certification. If applicable, please provide copy of certificate.

- | | |
|---|--|
| <input type="checkbox"/> Acute Inpatient Hospital | <input type="checkbox"/> Cardiac Catheterization Program |
| <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Home Health Aides |
| <input type="checkbox"/> Home Care Agency | <input type="checkbox"/> Home Health Nursing |
| <input type="checkbox"/> DME | <input type="checkbox"/> Acute Inpatient Hospital |
| <input type="checkbox"/> Comprehensive Outpatient Rehabilitation Facility | <input type="checkbox"/> Home Maintenance Services |
| <input type="checkbox"/> Outpatient Physical Therapy | <input type="checkbox"/> Medical Social Services |
| <input type="checkbox"/> Outpatient Speech Pathology | <input type="checkbox"/> Nutrition Services |
| <input type="checkbox"/> Outpatient Occupational Therapy | <input type="checkbox"/> Personal Care |
| <input type="checkbox"/> Assisted Living Program | <input type="checkbox"/> Personal Emergency Response Services |
| <input type="checkbox"/> Adult Day Health | <input type="checkbox"/> Respite Care |
| <input type="checkbox"/> Lung Transplant Program | <input type="checkbox"/> Social Day Care |
| <input type="checkbox"/> Cardiac Surgery Program | <input type="checkbox"/> Mammography |
| <input type="checkbox"/> Critical Care Services | <input type="checkbox"/> Inpatient Psychiatric Facility Services |
| <input type="checkbox"/> Outpatient Dialysis | <input type="checkbox"/> Orthotics and Prosthetics |
| <input type="checkbox"/> Surgical Services (Outpatient or ASC) | <input type="checkbox"/> Outpatient Infusion/Chemotherapy |
| <input type="checkbox"/> Diagnostic Radiology | <input type="checkbox"/> Heart Transplant Program |
| <input type="checkbox"/> Heart/Lung Transplant | <input type="checkbox"/> Liver Transplant Program |
| <input type="checkbox"/> Kidney Transplant Program | <input type="checkbox"/> Pancreas Transplant Program |
| | <input type="checkbox"/> Other: _____ |



MISCELLANEOUS:

Is there anything else you would like us to know about your organization? Are there any special services that your organization provides that you would like us to know about?



Declaration

I understand that AgeWell New York, LLC is responsible for the evaluation of our professional competence and qualifications and has the obligation to inquire into license, accreditation and professional conduct. I consent to communication of information and documents between AgeWell New York, LLC and our institution and understand that AgeWell New York, LLC may verify New York State License and Malpractice Coverage.

I hereby affirm that the information provided by our institution to AgeWell New York, LLC is accurate to the best of my knowledge and is furnished in good faith. I understand that willful and substantial omissions or misrepresentations may result in denial or suspension from providing services to AgeWell New York, LLC members.

I present this information and arrange for the submission of other information as part of the credentialing process, in the expectation that this information will be kept confidential and will be released or disclosed only as part of current and future credentialing, peer review and quality assessment process.

I hereby affirm that our institution has a quality management plan and agrees to cooperate with the quality management activities of AgeWell New York, LLC, including giving AgeWell New York, LLC access to medical records to the extent permitted by New York State law. If required, our agency will provide an employee profile showing evidence of employee certification, orientation completion, required inservice, physical examination, and criminal verification check.

I hereby formally apply for our institution to be a member of the AgeWell New York, LLC Facility Provider Network and agree to abide by the AgeWell New York, LLC policies, guidelines and quality assurance and performance improvement plan.

Signature: _____

Date: _____

Name (Print or Type) _____

Title: _____