Facility and Ancillary Re-credentialing

iCircle Services of the Finger Lakes appreciates your continued interest in providing care for our members as a contracted provider. Re-credentialing is required every three years to re-verify your licenses, certifications, insurance and ownership information. It also allows you to update your demographic and contact information that we use in our Provider directory and make available to our members. If any section of the application does not apply to your organization please indicate that by using N/A. Please use the following checklist to ensure you have provided all of the information and documentation required to process this application. Once complete, please return this application with your signed contract to the address below.

Required Documentation:

☐ Copy of Federal, State, and/or Local license (OPCERT or License)

☐ Accreditation Certificate(s) as applicable

- ☐ If not accredited please submit a copy of your most recent DOH survey

☐ Copy of any other State/Federal licensure (CLIA, DPS, DEA, etc.)

☐ Copy of Certificate of Insuance with General Liability Coverage minimum amount $1M/$3M with current coverage dates

☐ Proof of enrollment in New York State Medicaid

☐ Proof of enrollment with Medicare, if applicable

☐ W9. Please sign and date the form with the IRS registered legal entity name and billing address. Please only use your assigned TIN or SSN. This information MUST match the name on the Participating Provider Agreement

☐ Disclosure of Ownership and Control Interest statement (attached separately)

Applications may be returned to:

- Mail – iCircle Services, 860 Hard Road, Webster, New York 14580 Attention: Credentialing
- Email – Credentialing@icirclecny.org

Demographic Information

Legal Entity Name (line 1 W9):		DBA name (line 2 W9)	
Tax ID number:	Billing NPI:	Date of Application:	
Additional NPI with service type (if applicable)	Additional NPI with service type (if applicable)	Additional NPI with service type (if applicable)	
License #:	Medicaid ID # **(required)**:	Medicare ID # :	

*Physical Address :	**Street Address** (*street level only, no PO Box)**:**			STE:
	City:	County:	State:	ZIP Code:
	Office Phone:	Office Fax:	Handicap accessible (**required**): ☐ Yes ☐ No	
	Email:		Public Transportation: ☐ Yes ☐ No	
Remit Address:	**Address:**			STE:
	City:	County:	State:	ZIP Code:
	Office Phone:	Office Fax:	Email:	
Billing Address:	**Address (**iCircle requests the billing address be populated here and on the W9)**:**			STE:
	City:	County:	State:	ZIP Code:
	Office Phone:	Office Fax:	Email:	
Credentialing Contact:	Name:	Telephone:	Email:	
Billing Contact:	Name:	Telephone:	Email:	
Authorization Contact:	Name:	Telephone:	Email:	
Preferred Method to Receive Service Authorizations ***Fax*** ☐ ***Email*** ☐		Office Fax:	*Email:*	

Office Hours:	**From**	**To**
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

*If you have multiple locations please submit a roster of locations including all of the information requested above.

Important Notice: *Failure to legibly complete all sections of this application or provide all documentation may result in delays.*

iCircle_20190926,20191011, 20200106, 07202020 , 03292021, 20240621

Please list all services you are currently contracted to provide to our members:

_____

_____

I would like Provider Relations to contact me about contracting for additional services (describe):

_____

Counties served – Please check a box for each county your organization currently serves			
☐ Albany	☐ Allegany	☐ Bronx	☐ Broome
☐ Cattaraugus	☐ Cayuga	☐ Chautauqua	☐ Chemung
☐ Chenango	☐ Clinton	☐ Columbia	☐ Cortland
☐ Delaware	☐ Dutchess	☐ Erie	☐ Essex
☐ Franklin	☐ Fulton	☐ Genesee	☐ Greene
☐ Hamilton	☐ Herkimer	☐ Jefferson	☐ Kings
☐ Lewis	☐ Livingston	☐ Madison	☐ Monroe
☐ Montgomery	☐ Nassau	☐ New York	☐ Niagara
☐ Oneida	☐ Onondaga	☐ Ontario	☐ Orange
☐ Orleans	☐ Oswego	☐ Otsego	☐ Putnam
☐ Queens	☐ Rensselaer	☐ Richmond	☐ Rockland
☐ St. Lawrence	☐ Saratoga	☐ Schenectady	☐ Schoharie
☐ Schuyler	☐ Seneca	☐ Steuben	☐ Suffolk
☐ Sullivan	☐ Tioga	☐ Tompkins	☐ Ulster
☐ Warren	☐ Washington	☐ Wayne	☐ Westchester
☐ Wyoming	☐ Yates	☐ **ALL NYS COUNTIES**	

If you do not provide all services in all counties selected above please provide further explanation:

_____

_____

Attestation Questionnaire (any Yes responses should be fully explained with explanation attached separately)	
1. ☐ **Yes** ☐ **No**	Has the facility ever had or currently have pending any legal actions excluding medical malpractice?
2. ☐ **Yes** ☐ **No**	Has the facility ever been convicted of a crime, excluding misdemeanors?
3. ☐ **Yes** ☐ **No**	Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4. ☐ **Yes** ☐ **No**	At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now under way?
5. ☐ **Yes** ☐ **No**	At any time, has the facility been assessed a penalty, conviction, or suspension or is the facility currently under investigation by the Medicaid or Medicare programs?
6. ☐ **Yes** ☐ **No**	At any time, has any third party payors ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality of care issues?
7. ☐ **Yes** ☐ **No**	Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (i.e. Medicaid/Medicare)?

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or revocation of participation. Further, I give permission to verify the organizational providers credentials and by doing so hereby authorize release of the requested information concerning the organizational providers licensing, certification and accreditation. I further acknowledge, (i) that the organization will be bound by the terms of iCircle Services of the Finger Lakes, Inc. Credentialing plan; (ii) that this is our attestation of compliance with all background screening laws and regulations applicable to our services, employees, and/or volunteers, if any. More specifically I attest to compliance with Level II background screening in accordance with State requirements; and (iii) iCircle Services of the Finger Lakes, Inc. will be notified within ten (10) days of any material changes to the information in attestations. I also hereby attest that my organization has read and understands the CMS Compliance and Fraud, Waste, and Abuse (FWA) Training and agrees to abide by the laws and regulations therein upon the initial term of my contractual status and annually thereafter.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Provider Name/City/State: _____

Signature: _____ **Date:** _____

Print Name & Title _____