Enrollment Application
Licensed Independent Practitioners
(DPM, PT, OT, SLP, RD)

Instructions:

Please type or legibly print in black ink and Fax, Mail, or E-mail Enrollment Application along with all required documentation to:

iCircle Care
860 Hard Road
Webster, NY 14580
Attn: Credentialing
Fax: (888) 519 -2816
Email: Credentialing@icirclecny.org

Credentialing Checklist:

Please utilize below checklist before sending to iCircle Services of the Finger Lakes, Inc.

☐ Application

- Complete all sections and especially the required fields. If you are enrolling more than one practitioner for the same group please fill out only page 2-3 for each individual practitioner. Pages 4-6 only need to be filled out once.
- All addresses:
  - Primary Office
  - Remittance
  - Correspondence

☐ W-9 Request for Taxpayer Identification Number (signed and dated)

☐ A Council for Affordable Quality Health Care (CAQH) number is required.
You can self-register on the CAQH website (www.caqh.org). Please ensure that your CAQH information is completed and released to us with the most up-to-date information.

☐ Copy of Certificate of Liability Insurance. Minimum amount of $1 million occurrence and $3 million aggregate. Ensure certificate has effective date, (current) expiration date, and coverage amounts. If any section does not apply to you please indicate by using “N/A”.

We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are not considered in-network.

Credentialing applications are usually processed within **90 days** of receipt. Please ensure that applications are completed in their entirety, signed, and all supporting documentation included as any missing or inaccurate information will delay the enrollment process.

To begin the enrollment process, please complete all information as it applies to your specialty. Information that does not apply to your specialty may be left blank.

Please attach the W-9 form and a copy of the malpractice (liability) insurance. Enrollment will not be processed without this documentation.

Application for Licensed Individual Practitioner Enrollment

Today's Date:	Group Name (if applicable):	
Last Name:	First Name:	Middle Initial:
Date of Birth:	Social Security # ***(required)***:	Gender: ☐ Male ☐ Female
CAQH Provider ID ***(required)***:	Language(s) spoken other than English:	

Individual NPI #:	*DEA Certificate #:*	*License/Registration #:*
Tax ID #:	Group NPI #:	*Licensed State:*
Primary Specialty:	Medicaid #::	*Medicare #*
Second Specialty:	Taxonomy Code:	
Are you board-certified? ☐ Yes ☐ No	*If yes, board name and date:*	

Select only one

*[We will notify you when your application has been approved. Upon notification, you will be considered a participating provider in our network. Prior to receiving this notification, you are **not** considered in network.]*

☐	*Doctor of Podiatric Medicine (DPM)*
☐	*Physical Therapist (PT)*
☐	*Occupational Therapist (OT)*
☐	*Speech Language Pathologist (SLP)*
☐	*Registered Dietitian (RD)*
☐	*Audiologist (AUD)*

Experienced HIV/AIDS Provider: ☐ *Yes* ☐ *No* | *Accepts Medicare:* ☐ *Yes* ☐ *No*

*Please provide the required addresses: Primary Office, Correspondence, Remittance, and Medical Records. Each address can be the same or different, but **must** be identified as a valid United States Postal Service mailing address. If **PO BOX** information is used, the corresponding City, State and ZIP Code for the PO BOX must be provided and no street level information present.*

Primary Office	**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*
Additional Office	**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*
Remittance	**Street Address:**			*STE:*
	City:	County:	State:	*ZIP Code:*
	Office Phone:	Office Fax:	*Email:*	
Billing :	**Street Address** (street level only, No PO Box):			*STE:*
	City:	County:	State:	*ZIP Code:*
	Office Phone:	*Office Fax:*	*Email:*	

Note: If you have already completed your application with CAQH, please ensure that you have authorized all applicable organizations to access your data. Using the CAQH Universal Credentialing Data Source does not grant participation or constitute applying for participation with the health plan. If applicable, contact the health plan directly to request contracting information.

Application for Licensed Individual Practitioner

Hospital Affiliations (Podiatry Only)	Name/Address	Status	Effective Date

Office/Credentialing Contact name:	Phone:
Office/Credentialing Contact email address:	

Application Disclosure & Attestations

A. Abuse, Neglect, and Exploitation Training

All providers, who are mandated reporters of abuse, neglect, and exploitation, must attest that their staff has received the appropriate training. Please complete this Attestation by marking next to the applicable statement.

☐ We are a mandated reporter of Abuse, Neglect, and Exploitation. Our staff has received the appropriate training and update training as applicable. We are current with this requirement.
☐ We are NOT a mandated reporter of Abuse, Neglect, and Exploitation and will update this attestation should we become a mandated reporter.

Additionally, all providers and their employees with direct contact with enrollees must have completed Abuse, Neglect, and Exploitation Training. Please complete this Attestation as evidence of your compliance by marking next to the applicable statement.

☐ Our license requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation and annually. We are current with this requirement.
☐ Our licensure requires that we provide Abuse, Neglect, and Exploitation training to our direct care staff upon orientation only. We are current with the requirement.
☐ Our license does not require Abuse, Neglect, and Exploitation Training; however our policy and procedures require our staff to have this in-service training upon orientation. We are current with this requirement.
☐ Our license does not require Abuse, Neglect, and Exploitation Training and we request information or assistance to provide this annual training to our staff. We will complete this Provider Attestation again when we are current with this training requirement.

Signature: ______________________________ Date: ____________

Application for Licensed Individual Practitioner

B. First-Tier, Downstream, and Related Entity Attestation Form

I 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 have read and agree to comply with all of the iCircle Care written compliance policies and procedures and Standards of Conduct, and will implement and distribute them to all employees and board members of my organization.

I, nor any employees of my organization, have not been convicted of, or charged with, a criminal offense related to health care, nor have I been listed by a federal agency as debarred, excluded or otherwise ineligible for participation in federally funded health care programs.

I, agree to review the HHS OIG List of Excluded Individuals & Entities list at http://oig.hhs.gov/exclusions/exclusions_list.asp and GSA Debarment list monthly for all employees and downstream entities of my organization. I agree to immediately disclose any exclusion, or other event that makes my organization ineligible to perform work related directly or indirectly to Federal health care programs, to iCircle Care.

I have effectively screened my organization's governing bodies and senior leadership for conflicts of interest.

I agree to report suspected violations of any laws and regulations to iCircle Care I understand that any violation of any laws and regulations is grounds for disciplinary action, up to and including termination of my contractual status. I am aware that I am protected from retaliation for False Claims Act complaints, as well as any other applicable anti-retaliation protections.

Unless otherwise noted in the space immediately below, I am not aware of any possible violations of any laws and regulations at this time.

Signature: ______________________________ Date: ______________

Application for Licensed Individual Practitioner

Ownership Disclosure Form (Complete each box if applicable)

Provider Entity Status	Check if Applicable
Sole Proprietorship	☐
Professional Association	☐
Partnership or Limited Liability Company	☐
Corporation- For Profit	☐
Corporation- Not For Profit	☐
Other (Identify)	☐

List names and addresses of all Principals and indicate percent ownership, if applicable. ("Principal" means any shareholder, officer, partner, joint venturer or anyone else having an ownership in or managerial control over the PROVIDER. Attach additional sheets if necessary.)

Officer, Director, or Partner Name	Title	Address	Ownership Percentage

Service Area: Provider agrees to provide the services indicated herein for enrollees in the New York Statewide Program for the following counties.

Please check or circle all that apply ***(only counties that your organization services):***

☐ Albany	☐ Chenango	☐ Franklin	☐ Lewis	☐ Oneida	☐ Queens	☐ Seneca	☐ Warren
☐ Allegany	☐ Clinton	☐ Fulton	☐ Livingston	☐ Onondaga	☐ Rensselaer	☐ St. Lawrence	☐ Washington
☐ Bronx	☐ Columbia	☐ Genesee	☐ Madison	☐ Ontario	☐ Richmond	☐ Steuben	☐ Wayne
☐ Broome	☐ Cortland	☐ Greene	☐ Monroe	☐ Orange	☐ Rockland	☐ Suffolk	☐ Westchester
☐ Cattaraugus	☐ Delaware	☐ Hamilton	☐ Montgomery	☐ Orleans	☐ Saratoga	☐ Sullivan	☐ Wyoming
☐ Cayuga	☐ Dutchess	☐ Herkimer	☐ Nassau	☐ Oswego	☐ Schenectady	☐ Tioga	☐ Yates
☐ Chautauqua	☐ Erie	☐ Jefferson	☐ New York	☐ Otsego	☐ Schoharie	☐ Tompkins	
☐ Chemung	☐ Essex	☐ Kings	☐ Niagara	☐ Putnam	☐ Schuyler	☐ Ulster	

☐ **All New York Counties**

Application for Licensed Individual Practitioner

The undersigned, on behalf of the organization named above, hereby certifies that the above information is true and correct to the best of my knowledge. I further acknowledge, (i) that the organization will be bound by the terms of iCircle Care Network and affiliated MCO Health Plans Credentialing Plan; (ii) that iCircle Care Network and MCO may inquire of third party agencies for the purpose of verifying the information in this application; and (iii) that any material misstatement in or omission from the Application may constitute grounds for denial or revocation of participation.

Business Name: ______________________________

Authorized Signature:______________________________ Date:____________

Print Name & Title: ______________________________

Please return the completed form along with a copy of the W-9 and malpractice (liability) insurance to:

iCircle Care
860 Hard Road
Webster, NY 14580
Attn: Credentialing
Fax: (888) 519 - 2816
Email: Credentialing@icirclecny.org