Kentucky Health Alliance

Aetna, Molina, and WellCare Credentialing Made Easy

aetna® Aetna Better Health® of Kentucky | PASSPORT BY MOLINA HEALTHCARE | WellCare® Beyond Healthcare. A Better You.

Instructions for Enrollment and Credentialing

with the Kentucky Credentialing Alliance for Aetna Better Health of Kentucky, Passport by Molina Healthcare and Wellcare.

To reduce the need for practitioners to complete multiple enrollment and credentialing forms for participation in multiple Medicaid Managed Care Organizations (MCOs), the Kentucky Credentialing Alliance created the following form to ease provider burden. Please complete all applicable forms in their entirety and return to the MCO(s) with which you seek participation. Failure to submit all required information may result in delay or denial of your application.

Practitioners:

All practitioners must complete the attached Provider Enrollment Form. If you participate in the Council for Affordable Quality Healthcare (CAQH), the Provider Enrollment Form is the only form you are required to submit for the enrollment/credentialing process. Please add the appropriate MCO(s) as an authorized plan, giving permission to access the providers CAQH application.

CAQH is a self-reported credentialing data exchange that allows you to keep all your credentialing information in a centralized location. Practitioners should update their CAQH every 90 days. This information can be accessed by a variety of credentialing entities and can save you time when seeking participation with multiple health plans.

If you do not participate in CAQH, you must also complete and submit the Kentucky Application for Provider Evaluation and Re-evaluation (KAPER-1) application available at http://insurance.ky.gov.

Facilities:

Facilities, such as hospitals, surgical centers, home health agencies, etc, are not eligible to participate in CAQH. Facilities are required to fill out the Facility Credentialing & Enrollment Packet and return to the appropriate MCO with the required documentation.

- **For Provider Credentialing contact: Verisys at (502) 656-3401 (Ext) 4617 for additional support.**

- **For questions regarding your contract status and/or your contract effective date, please reach out to your Provider Relations representative. Below is the list of participating MCO plans and contact information.**

Aetna Better Health of Kentucky	**Provider Triage Line** **1-855-300-5528** or **KyProviderUpdates@aetna.com**
Passport Health Plan by Molina Healthcare	**Provider Relation Support** **1-800-578-0775** or **contracting@passporthealthplan.com**
WellCare	**Provider Relation Support** **1-877-389-9457** or **KY_ProviderCorrection@wellcare.com**

Request to Add New Provider

Instructions

Complete this form in its entirety and submit to the contact listed on page 1. Provider will be enrolled in Medicaid lines of business, as reflected in the group's contract. Please make sure to indicate panel status and member capacity for each address in the spaces provided below. An "open panel" will indicate a PCP provider's willingness to accept member assignment from KHA's Credentialing Alliance membership. Panels are only applicable to PCPs.

Does the provider have an executed contract with:	**Aetna Better Health** ☐ **Yes** ☐ **No** **Molina** ☐ **Yes** ☐ **No** **Wellcare** ☐ **Yes** ☐ **No**
Practice website*:	☐ **No website**
Practice email*:	☐ **No email**
Does this practitioner provider face-to-face direct care services to members in an office setting?	☐ **Yes** ☐ **No** **If no, please explain.**

*website and email may be published in payer directory

I. Provider Info

Provider's Full Name (Last, First, Middle)	**Title**	**Start Date**	**CAQH ID #**

Individual NPI #	**Provider Type**	**Date of Birth**	**Gender**	**Medicaid Number -** ☐ **pending**

Primary Specialty	**Secondary Specialty**	**Languages Spoken**
		☐ **English** ☐ **Spanish** ☐ **Other**_____

Primary Taxonomy	**Secondary Taxonomy**	**CDS Issue State**	**CDS License Number**

States License No.	**DEA Number -** ☐ **pending**
KY_____ OH_____ IL_____ TN_____ IN_____ WV_____ VA_____ MO_____ Other_____	KY_____ OH_____ IL_____ TN_____ IN_____ WV_____ VA_____ MO_____ Other_____

Supervising Physician ☐ NA	**Primary Hospital Affiliation -** ☐ **No hospital privileges**	**City, State**	**Affiliation Start Date**
Name:_____			

or Covering Arrangements (admitting physician or hospitalist group)	**Hospital Name (used by admitting physician)**

II. Credentialing Contact Information – Email used for notices regarding credentialing

Credentialing Contact Name	**Phone #**	**Fax #**	**Email**

Credentialing Correspondence Address 1	**Address 2**	**City**	**State**	**Zip**

Practice Contact Name	**Phone #**	**Fax #**	**Email**

Practice Correspondence Address 1	**Address 2**	**City**	**State**	**Zip**

Notes: Please include any additional notes to assist us in processing this request

III. Primary Address Information. Primary address will be listed in directory as long as provider is at this location 16 hours or more (unless opted out of directory below). Covering sites will not be listed in directory. If provider practices at more than one location, please complete section IV. Additional Locations.

Address Type	Tax ID#	Group Name (include DBA)
☐ Primary Office ☐ Covering Only		

Scope of Practice for this site			Address 1	Address 2 (suite)
☐ Primary Care	☐ FQHC	☐ DME		
☐ Specialty Care	☐ RHC	☐ Inpatient Care		
☐ ASC	☐ Behavioral Health	☐ Emergency Care	City, State, Zip ☐ Dir Opt-OUT for this location	
☐ Urgent Care	☐ Home Health	☐ Other		
If specialty care, please designate practice specialty			**Notes:**	

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address TDD hearing equipped?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address accessible by bus route?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does office/service provide skilled medical language interpreter?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services at this site?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Is provider a locum tenens provider?	☐	☐
What is the maximum panel capacity for Medicaid at this site?			Has provider completed cultural competence training?	☐	☐
What are the age limitations for patients seen by provider?			Is provider certified in trauma-informed care (TIC)?	☐	☐
Should this provider be printed in the directory?	☐	☐	Has provider been trained in evidence-based practice?	☐	☐
Is office/service location handicap accessible, including exam rooms?	☐	☐			
Is there a gender restriction at this site? (If yes, please specify)					

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Billing/ Vendor Information *a sample claim must be submitted with this application unless contracted as full cap vendor*			
Name to who checks should be made payable *(if different than Practice/Group name)*			Tax ID #
Billing Address *(location where payments will be sent)*	City	State	Zip+4

Billing Contact Name	Billing Office Telephone #	Billing Office Fax #	Billing Office E-Mail

IV. Additional Locations.

Please list alternate and/or covering-only locations below. Primary address should be listed on the prior page of this packet. If more than two addresses are required, AND the Pay To address is the SAME as that of the primary, please see the Appendix on page 7 to report the additional addresses. Alternatively, additional copies of this page can be made for each additional location.

Alternate Office Sites – Secondary sites where patients can call to make appointment to be seen by physician. If patients cannot make appointments with provider at this location, please designate location as "Covering only."
Covering-only Sites – Other sites that are to be loaded only for the times when provider covers for another provider or sites where provider does not accept appointments regularly. Patients cannot schedule appointment with provider at covering locations.
"Pay To" Name – This should match exactly how the claims are submitted from your billing system to insurance carriers, including abbreviations.

Additional Address. Alternate sites will only be listed in directory if provider is at location 16 hours or more, (unless opted IN to directory to override). If opting IN to directory, provider MUST accept appointments at that location. Covering sites will not be listed in directory. Please see page 7, if more sites are required to be loaded.

Address Type	Tax ID#	Group Name (include DBA)
☐ Primary Office ☐ Covering Only		

Scope of Practice for this site			Address 1	Address 2 (suite)
☐ Primary Care	☐ FQHC	☐ DME		
☐ Specialty Care	☐ RHC	☐ Inpatient Care	City, State, Zip	☐ Dir Opt-OUT for this location
☐ ASC	☐ Behavioral Health	☐ Emergency Care		
☐ Urgent Care	☐ Home Health	☐ Other		

If specialty care, please designate practice specialty

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #

Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	☐	☐	Is address TDD hearing equipped?	☐	☐
Is provider at this site at least 16 hours per week?	☐	☐	Is address accessible by bus route?	☐	☐
Can patients call this site to make appointment with provider?	☐	☐	Does practice provide American Sign Language services at this site?	☐	☐
Is provider accepting new patients at this site?	☐	☐	Does office/service provide skilled medical language interpreter?	☐	☐
Is provider a PCP at this site?	☐	☐	Does provider provide telemedicine services at this site?	☐	☐
Does provider provide EPSDT services at this site?	☐	☐	Does this site participate in KHIE?	☐	☐
If PCP, is provider's panel open at this site for Medicaid?	☐	☐	Is provider a locum tenens provider?	☐	☐
What is the maximum panel capacity for Medicaid at this site?			Has provider completed cultural competence training?	☐	☐
What are the age limitations for patients seen by provider?			Is provider certified in trauma-informed care (TIC)?	☐	☐
Should this provider be printed in the directory?	☐	☐	Has provider been trained in evidence-based practice?	☐	☐
Is office/service location handicap accessible, including exam rooms?	☐	☐			

Is there a gender restriction at this site? (If yes, please specify)

Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Billing/ Vendor Information *a sample claim must be submitted with this application <u>unless</u> contracted as full cap vendor*

Name to who checks should be made payable *(if different than Practice/Group name)*	Tax ID

Billing Address *(location where payments will be sent)*	City	State	Zip+4

Billing Contact Name	Billing Office Telephone #	Billing Office Fax #	Billing Office E-Mail

Evidence Based Practice Form

The Kentucky Department of Medicaid (DMS) requires that all participating behavioral health providers complete a survey upon enrollment and at least annually thereafter. Therefore, the following survey is a required part of our program.

Evidence Base Practice	YES	NO
Assertive Community Treatment	☐	☐
Assessing and Managing Suicide Risk (AMSR)	☐	☐
Cognitive Behavioral Therapy (CBT)	☐	☐
Consumer Operated Programs	☐	☐
Coordinated Care Model for Early Interventions for First Episode Psychosis	☐	☐
Dialectical Behavior Therapy (DBT)	☐	☐
Dual Diagnosis Capability in Addiction Treatment (DDCAT)	☐	☐
Eye Movement Desensitization and Reprocessing (EMDR)	☐	☐
Family Psychoeducational	☐	☐
First Episode Psychosis	☐	☐
Functional Family Therapy (FFT)	☐	☐
Individual Placement and Support (IPS) Supported Employment	☐	☐
Integrated Treatment for Co-occurring Disorders (MH and SUD)	☐	☐
Medication Assisted Treatment	☐	☐
Motivational Interviewing	☐	☐
Multi-Systemic Therapy	☐	☐
NIATx model for addiction treatment	☐	☐
Parent Child Interaction Therapy (PCIT)	☐	☐
Peer Support	☐	☐
Screening, Brief Intervention and Referral to Treatment	☐	☐
Seeking Safety	☐	☐
Supported Employment	☐	☐
Supportive Housing	☐	☐
Trauma Focused Cognitive Behavior Therapy (TF-CBT)	☐	☐
Trauma Informed Therapy	☐	☐
Trauma Recovery and Empowerment Model (TREM)	☐	☐
Treatment for Depression in Older Adults	☐	☐
Wraparound	☐	☐
Other	☐	☐

Behavioral Health Clinical Specialties Codes and Descriptions

Code	Description
AA	ADD/ADHD Counseling
AD	Addictionology (MD's Only)
AI	Adoption Counseling
AF	AIDS/HIV Counseling
AC	Alcohol and Substance Use Counseling (certified)
AS	Alcohol and Substance Use Counseling (self-reported)
AM	Anger Management Counseling
AE	Appointments Available in the Evening
AW	Appointments Available on the Weekends
AB	Autism Applied Behavioral Analysis (ABA)
AG	Autism Social Skills Training
AT	Autism Testing
AR	Autism Treatment
BP	Behavioral Pediatrics (MD)
BF	Biofeedback Counseling
BD	Bipolar Disorder (Manic Depression) Counseling
BR	Borderline Personality Disorder (BPD) Counseling
CD	Conduct/Disruptive Behavior Therapy Counseling
CE	Cultural/Ethnic Counseling
DL	Developmental Disorders Counseling
DB	Dialectical Behavior Therapy
DS	Dissociative Disorder (Multiple Personalities) Counseling
DV	Domestic Violence Counseling
RF	EAP: Assessment/Referral
ED	Eating Disorders Counseling
EC	Eye Movement Desensitization and Reprocessing (EMDR)
CC	Faith-Based Counseling: Christian
FB	Faith-Based Counseling: Other than Christian Only
FY	Family Counseling
FI	Fertility Counseling
FR	First Responder Counseling
GA	Gambling Counseling
GI	Gender Identity Counseling

Code	Description
DR	General Depression Counseling
GR	Grief and Loss Counseling
GT	Group Therapy
HV	Home-Based Behavioral Health Services
LD	Learning Disabilities
ML	Medical Illness Counseling
MC	Marriage/Couples Counseling
BS	Medication Assisted Treatment (MAT) for Substance Use: Buprenorphine/Suboxone
MV	Medication Assisted Treatment (MAT) for Substance Use: Vivitrol
MO	Menopause Counseling
MI	Men's Counseling
DD	Mental Health and Substance Use Counseling (Dual Diagnosis)
NT	Neuropsychological Testing (Psychologists Only)
OC	Obsessive Compulsive Disorder (OCD) Counseling
PM	Pain Management
PA	Panic Disorder Counseling
PH	Phobias Counseling
MH	Postpartum Depression Counseling
PT	Post-Traumatic Stress Disorder (PTSD) Counseling
MJ	Psychiatric Medication Management: Injectable Meds
MM	Psychiatric Medication Management: Oral Meds
PS	Psychological Testing
PD	Psychotic Disorders
SI	Sexual Abuse Counseling
SD	Sexual Health Counseling
SO	Sexual Offender Counseling
GL	Sexual Orientation Counseling
TM	Transcranial Magnetic Stimulation (TMS)
TH	Virtual Counseling Provided (via video)
TO	Virtual Counseling Only (via video)
WI	Women's Counseling

APPENDIX

Additional Address. If Pay To and Correspondence Information are NOT the same as that of the Primary Address, please make copies of page 4 to include this information. If more than 4 addresses are required, please make additional copies of either this page or page 4, as appropriate.

Address Type	Tax ID#	Group Name (include DBA)

Scope of Practice for this site			Address 1	Address 2 (suite)
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☐ Specialty Care	☐ RHC	☐ Inpatient Care	City, State, Zip	☐ Dir Opt-OUT for this location
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