California Mid-Level Provider Application (NP & PA) Checklist

CONIFER HEALTH SOLUTIONS®

Name:	Specialty:	
	CAQH #	**Mid-Level Prov. App. V.7/97** W:\Credentialing\Credentialing Applications
Completed Practitioner Application Signatures to be within 120 Days-Stamped signatures not acceptable.	☐	☐
Work History Minimum requirement is 5 years of work history in month/year format. If there are any gaps exceeding 6 months, please provide explanation.	☐Pg. 13	☐Pg. 4
Attestation All questions to be answered. If your answer to any of the following questions is "Yes", please provide full details on a separate sheet of paper.	☐Pg. 16-17	☐Pg. 5
Information Release Form to be reviewed, signed and dated.	☒	☐Pg. 6
Addendums **A.** Health Plans and IPA/Medical Groups **B.** Professional Liability Action Explanation **C.** Notice to Practitioners of Credentialing Rights Forms to be completed, signed and dated.		☐
Provider Extender Attestation (Required) **1.** Statement of Agreement by Supervision Provider **2.** Provider Extender Attestation **3.** Delegation of Services Agreement **4.** Supervising Physician Responsibility	☐W:\Credentialing\Credentialing Applications	☐
Supporting Documentation Copies of the following documents are to be included		
• Medical License	☐	☐
• DEA Certificate (if applicable)	☐	☐
• Certificate of Insurance 1 to 3 Million	☐	☐
• Board Certificates (if applicable)	☐	☐
• Curriculum Vitae CV	☐	☐
• W9 W:\Credentialing\Credentialing Applications	☐	☐
Internal use only		
Contract Status Address and TIN on application should match contract locations and TIN.	Check One	
Provider contract semi executed.	☐	
New group contract provider listed on exhibit, and semi executed.	☐	
Existing group contract provider amendment created.	☐	

Providers Signature Date

Provider Practice Signature Date

© 2019 Conifer Health Solutions, LLC

Conifer Value Based Care

Provider Extender Attestation

Provider Extender Name:______________________________

Check One:

- Acupuncturist
- Audiologist
- Certified Nurse Midwife
- Certified Registered Nurse
- Certified Registered Nurse Anesthetist
- Chiropractor
- Physical Therapist
- Physician Assistant-Certified
- Registered Nurse Practitioner

Group Name:______________________________

Physician's Name:______________________________

Practice Address;______________________________

____

I attest to compliance with all Laws, Regulations, Standards and contract provisions governing supervision of my activities as a physician extender by the state licensed physician referenced above; that this state licensed physician provides legally required collaboration, consultation and supervision consistent with my licensure, and that there is written agreement that delineates medical services which I may appropriately provide; and written supervisory guidelines are in place that are appropriately utilized for supervision.

______________________________	______________	______________
Provider Extender Signature	License Number	Date
______________________________	______________	______________
Supervising Physician Signature	License Number	Date

Allied Health Professional Application

Attachment I: Statement of Agreement by Supervising Provider

Name: ____________________________ Employed as: _______________________
Allied Health Professional

Name: ____________________________
Supervising Provider

I, _____________________________, MD/DO/DDS, supervising provider for the above-named Allied Health Professional, do hereby make the following statements of agreement in accordance with the policies/procedures regulating the Allied Health Professional program:

1. I hereby accept full legal and ethical responsibility for the performance of all duties and acts performed by the above-named Allied Health Professional employed by ____.

2. I hereby request approval to allow the above-named Allied Health Professional to perform, outside my immediate supervision, the specific activities and duties, as outlined in the attached supervising guidelines and/or job description of the Allied Health Professional.

3. I agree to immediately notify Conifer Value-Based Care, in writing, in the event my approval to supervise an Allied Health Professional is removed, limited or otherwise altered by action of the Medical Board of California, or in the event of any notification of investigation of my supervision by the Board, or if there is a change in employment status of the Allied Health Professional applying herein.

4. I agree to inform all patients that said Allied Health Professional will participate in the total care of the patient and agree to ensure that the Allied Health Professional will be clearly identified by badge.

5. I agree to comply with all regulations and policies of the Medical Board of California and/or other regulating agencies and Conifer Value-Based Care with respect to the supervision of the Allied Health Professional, specifically including such regulations and policies which have been or may, from time to time, be adopted by said Board and/or other regulating agencies and Conifer Value-Based Care with respect to:

a. Billing for the services of the Allied Health Professional;

b. Requirements for supervision of the Allied Health Professional with respect to the type and scope of services approved by the Medical Board of California for the Allied Health Professional to perform; and

c. Requirement for identification of the Allied Health Professional while rendering services

I understand that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by Conifer Value-Based Care of the performance of services by the Allied Health Professional for the Health Plan.

6. I understand the right of the Allied Health Professional to render medical services under my contract shall be contingent upon my continued membership and contract with Conifer Value-Based Care. If I terminate my membership or contract, or if my membership or contract is suspended, revoked or terminated, the Allied Health Professional's clinical activities shall automatically be changed accordingly. Similarly, if my membership or contract is restricted, the Allied Health Professional's activities shall be restricted accordingly.

7. If applicable, a certificate issued to me by the Medical Board of California indicating my approval to supervise an Allied Health Professional in the type and scope of practice for which this application has been made is attached.

8. I understand that the above-named Allied Health Professional shall have only such authority as is necessary to perform the duties and tasks indicated in this application. Questions of authority shall be referred to me for case-by-case resolution.

________________________________ ________________________
Provider's Signature Date

©2017 Conifer Health Solutions, LLC

CERTIFICATE OF NEW PROVIDER TRAINING

I have received, reviewed and completed the New Provider Training from Health Net,* on behalf of CalViva Health. I understand the essential components of CalViva Health's Medi-Cal plan, including basic information about public health programs available to CalViva Health Medi-Cal members, CalViva Health's quality improvement program, and interpreter services and provider tools to care for diverse populations.

In addition, I understand my responsibilities related to CalViva Health's Medi-Cal managed care program services, policies and procedures, and ways to communicate between providers, members and CalViva Health. I understand how to access and find information about Medi-Cal benefits and services, claims and payment policies, California Children's Services (CCS)-eligible conditions and referral processes, case management services, tools to care for a diverse population, and operations manuals, located on the provider website under *Working with Health Net > Contractual > Policy Library > Go to the Provider Library.*

The training was completed: (Must check one)

☐ Self-guided (Online/hard copy)

☐ Instructor-led (Online/in-person)

Provider name (PRINT) ______________________

Tax identification number (TIN) ______________________

Provider signature ______________________

Date training completed ______________________

Telephone number ______________________

Email address ______________________

In order to complete the enrollment of your contract, sign, date and complete this certification, and submit with your contract documents. Note: Failure to complete this certification may result in a delay in becoming an active provider for CalViva Health and Health Net.

CalViva Health is a licensed health plan in California that provides services to Medi-Cal enrollees in Fresno, Kings and Madera counties. CalViva Health contracts with Health Net Community Solutions, Inc. to provide and arrange for network services. *Health Net Community Solutions, Inc. is a subsidiary of Health Net, LLC. and Centene Corporation. Health Net is a registered service mark of Health Net, LLC. All other identified trademarks/service marks remain the property of their respective companies. All rights reserved.

19-352
FRM029576EO00 (5/19)