SOLIS HEALTH PLANS

CAQH Credentialing Application

In order to expedite the credentialing process, please assure to complete and sign the attached CAQH Application. Attestation including the attestation of accuracy and the consent and release sections. Please be sure to also provide the information requested below and submit a copy of the documents listed, as applicable:

Practioner Name:	**Degree:**
Specialty:	**County:**
Official Address: **City/State:** **ZIP Code:**	
Office Phone #: **Office Fax #:** **Office E-mail Address:**	

Please provide the following:		
SSN:	**DOB:**	**State License #:**
DEA:	**NPI #:**	**Medicaid ID:**
Medicare #:		

Additional Required Items:

- W9
- Florida Medicaid Managed Care Treating Provider Registration (required for providers without a Medicaid Program ID # that will be treating SHP Medicaid members)
- Signed SHP Medical Malpractice Insurance Statement
- Signed and completed ownership/controlling interest form
- 1 peer reference letter or completion of 1 SHP peer reference letter (attached)

FOR PLAN USE ONLY - to be completed by Provider Relations Department

- Site Inspection Evaluation Form completed and enclosed, when applicable
- CAQH Credentialing Application Attestation is complete and signed
- Required supporting documentation meets plan criteria and all documents are current.

QUESTION	YES	NO
Provider has requested that the Plan utilize the CAQH Application. *If "Yes", please provide CAQH Application number.*		
Provider has notified and authorized CAQH to release information to SHP.		

Signature of Solis Provider Representative

Date

CAQH Credentialing Application Attestation

PLEASE ANSWER THE FOLLOWING QUESTIONS (This section must be completed by the practitioner)

QUESTION	YES	NO
I certify that all information that I have provided to CAQH as of today is accurate, complete and true. (If "No", please include clarification/details of any changes or discrepancies on a separate signed and dated sheet and attach it to this form).		
Provider has notified and authorized CAQH to release information to SHP.		

If you are a PCP without admitting privileges in a SHP hospital, please indicate the name and contact name of the SHP network provider whom you have made arrangements with, for the admission of your patients in the SHP network hospital, this may include the plan's contracted hospitalist providers. Please indicate which of the options below is applicable to you.

☐ **I will be utilizing the following provider for hospital admissions:**

Provider Full Name: Specialty:	Degree:
Office Phone Number:	Fax:

☐ **I will be utilizing the Plan's contracted Hospitalist Group.**

I understand that:

A. Any misrepresentations, misstatement or omission of a relevant fact in connection with this application may result in denial of my application or termination of my participation in the Managed Care Organization;
B. It is my responsibility to promptly advise Solis Health Plan ("the Plan") in writing within 30 days of any changes or additions to the information contained in this application;
C. All of the information contained in this application, or its attachments, is subject to the Plan's investigation and review and;
D. This is an application only and my submission of this application does not automatically result in participation with the Plan.

CAQH Credentialing Application Attestation

NOTICE: The National Practitioner Data Bank will be queried if you apply. If your application is rejected for reasons relating to professional conduct or professional competence, which reasons include misrepresenting, misstating, or omitting a relevant fact in connection with your application, the rejection may be reported to the National Practitioner Data Bank.

I authorize the Plan to provide 'Minimum Data' to the Council for Affordable Quality Healthcare ("CAQH") for the purposes of obtaining updated documents and information necessary for my credentialing. Minimum Data includes my name; office addresses and phone numbers; office fax number; office e-mail address; and at least one of the following: Social Security number, date of birth, state license number, or Drug Enforcement Agency number.

I authorize the Plan to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been or am currently associated, and with others, including without limit past and present malpractice carriers, who may have information bearing on my professional competence, character and ethical qualifications. I further represent consent to the inspection by agents, employees, contractors, affiliates or other representatives of the Plan of all documents that may be materials to an evaluation of my professional competence, character and ethical qualifications.

I release from liability the Plan and all representatives of the Plan for their acts performed in good faith and without malice or negligence in connection with evaluating my application and my credentials and qualifications, and I release from any liability any and all individuals and organizations who provide information to the Plan in good faith and without malice or negligence concerning my professional competence, character and ethics.

I consent to the release and exchange of information as allowed by law relating to any application, investigation, disciplinary action, suspension or curtailment of participation status, membership and/or privileges of any type to or from the Plan.

Name (Please print):	CAQH #:
Signature of Applicant:	Date:

Must be signed in ink. EACH SUBMISSION REQUIRES AN ORIGINAL SIGNATURE AND CURRENT DATE. Rubber stamped signatures are not acceptable. Practitioners have the right to review information obtained to evaluate their credentialing status.

CAQH Supplemental Information

Practitioner Information

Race/Ethnicity (Voluntary)	
Check all that apply:	
	American Indian/Alaskan Native
	Asian
	Black/African American
	Caucasian/White
	Hispanic/Latino
	Multi-Racial
	Native Haiwaiian and other Pacific Islander

Languages		
Is practitioner fluent in language(s) other than English (including sign language)?	YES	NO
If yes, list languages:		

Cultural Competency		
Has practitioner undergone cultural competence training?	YES	NO

Office Appointment/Availability

Office Information		
Are you accepting new patients?	YES	NO
Do you offer evening appointments?	YES	NO
Do you offer weekend appointments?	YES	NO
Is the office wheelchair accessible?	YES	NO
Is the office accessible from public transportation?	YES	NO

Hours of Operation				
Monday	From:	AM/PM	To:	AM/PM
Tuesday	From:	AM/PM	To:	AM/PM
Wednesday	From:	AM/PM	To:	AM/PM
Thursday	From:	AM/PM	To:	AM/PM
Friday	From:	AM/PM	To:	AM/PM
Saturday	From:	AM/PM	To:	AM/PM
Sundau	From:	AM/PM	To:	AM/PM

CAQH Supplemental Information

Primary Care Physician		
Is the office able to offer appointments in:		
Less than 30 calendar days for preventative care?	Yes	No
Less than 7 calendar days for routine care?	Yes	No
Within 24 hours for urgent appointments?	Yes	No

Behavioral Health Practitioner		
Is the office able to offer appointments in:		
6 hours for non-life-threatening emergencies?	Yes	No
48 hours for urgent care?	Yes	No
10 business days for initial/routine care?	Yes	No

Attestation and Release of Information Form

Modifications Will Not Be Accepted

By submitting this authorization and release of information I understand and agree as follows:

I understand and acknowledge that, as an applicant for participating status with Solis Health Plans for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

I further understand and acknowledge that Solis Health Plans or designated agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of Solis Health Plans as part of the verification and credentialing process.

I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to Solis Health Plans their staffs and agents.

I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of Solis Health Plans or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies of Solis Health Plans I agree to abide by the policies, procedures, and or contractual agreements of Solis Health Plans from whom I am seeking initial or recredentialing.

I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of Solis Health Plans where I have membership and/or participation status before initiating judicial action.
I understand that completion and submission of this application/Attestation/Authorization and Release does not automatically grant me membership or participating status with Solis Health Plans.

I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Attestation and Release of Information Form

Question	Yes/No
Do you have more than 3,000 patients (defined as seen a minimum of (3) times per year) in your practice, including all populations; Medicaid FFS, MSM Network, MHO, Health Plan, Medicare and commercial.	
Are you eligible to become Medicaid provider?	

I certify the information in this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been made. A photocopy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

Print Name:	Date:
Signature (stamped signature is not acceptable):	
CAQH #:	

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