

Facility/Ancillary Provider Roster Addendum

Purpose: Please complete this form if you are submitting a roster and not submitting a facility application. This form is intended specifically for roster submissions.

Instructions: For the addendum to be considered complete:

1. All information must be legible. Please print clearly or type all information.
2. Roster must be completed in its entirety.
3. The Sanctions Questions below must be answered and Attestation signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. One addendum form must be completed for each Tax ID Number being submitted on Roster.
6. Fill in the applicable Tax ID Number at the bottom of every page for reference purposes.
7. **If your entity provides any Home- and Community-Based Services (HCBS)**, complete the Iowa Total Care HCBS Waiver Provider Application instead of the Facility/Ancillary Provider Application.

Attach the following to the completed addendum when applicable:

- State operational license**
- Any other applicable state/federal licensures**
(e.g., CLIA, DEA, Pharmacy or Department of Health)
- Accreditation certificate(s) or accreditation letter with dates of accreditation**
(By a nationally recognized accrediting body, e.g., TJC/JCAHO/CARF/COA/ or AOA.)
- Site evaluation results:** If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency.
- W-9** signed and dated.
- Professional/general liability insurance.** Attach a copy of the Certificate of Insurance (COI) detail with amounts and coverages listed. *Minimum requirement: \$1M per occurrence /\$3M per aggregate.*
- Provider Accessibility Initiative (PAI) Survey.** The PAI Survey must be submitted for each service location and can be found at the following link:
iowatotalcare.com/providers/contracting---credentialing/improving-accessibility.html

Legal Information

Entity Legal Name: _____ **Tax ID Number:** _____

Sanctions Questions	
<i>If yes, to any question below, please explain on a separate sheet of paper.</i>	
Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has an officer of your organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse or a sexual offense?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Has the corporation, an officer or board member ever been convicted of a felony?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Provider Responsibility Statement

I hereby understand that as a prospective/current Iowa Total Care provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Iowa Total Care Credentials Committee for their review and approval, and, absent such affirmative approval, Iowa Total Care members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Iowa Total Care. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Iowa Total Care in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Iowa Total Care credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to Iowa Total Care, I hereby fully understand that the information submitted in this application shall be held confidential by Iowa Total Care and provided only to individuals connected with Iowa Total Care on a need-to-know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

Tax ID Number: _____

Statement of Application/Authorization for Release of Information

To evaluate this application for participation in and/or continued participation with Iowa Total Care, the Facility hereby gives permission to Iowa Total Care to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, state regulatory and licensing departments, professional liability and workers compensation insurance carriers. The Facility understands that Iowa Total Care will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of Iowa Total Care.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform Iowa Total Care in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by Iowa Total Care on its own behalf or, if applicable, as an agent for one of its affiliations and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Iowa Total Care programs or any program or one of its affiliations until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photocopy of this original constitutes our written authorization and requests to release all documentation relevant to this application. Said photocopy shall have the same force and effect as the signed original.

Name of Entity: _____ **Date:** _____
Print or type name

Signature of Authorized Representative: _____
A stamped signature is not acceptable.

Title: _____

Tax ID Number: _____

Please email completed documents to NetworkManagement@IowaTotalCare.com.