#1 Reason Providers Can't Be Loaded

WellCare®
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What is CAQH®?

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CAQH® stands for the

“Council for Affordable Quality Healthcare”

- It is an online database that stores provider information.
- Providers grant access to their information to insurance companies which makes acquiring provider information more efficient.
- Instead of contacting the provider office for copies of licenses or other essential credentialing information, insurance companies can pull it directly from the provider’s CAQH® file.

CAQH® Requirements

- Name
- DOB
- SSN
- License number
- DEA (if applicable)
- Are you participating in Medicare/Medicaid? (must be checked “yes”)
- Medicaid and Medicare numbers (if applicable)
- NPI
- Education
- Specialty: **All** providers must complete (missed frequently)
- Board certification: National Boards (missed frequently). Even if the provider is not board certified, it still **must** be completed.

CAQH® Requirements

- Primary address, includes TIN of group, physical location, phone and fax numbers. This information ***must*** match the “add letter” and/or new contract. Each **detail** ***must*** match, including the suite number. **All** CAQH® details ***must*** match the “add letter” and new contract.
- Remittance/Pay To information (consistently incorrect); includes name checks are to be made payable to, and address payments should be sent to. All details ***must*** match.
- Common error: In CAQH® : Is the primary address and payment address the same? Payment remittance and billing address: If you have marked “yes” that the address for the payment remittance address is the same as the office manager for all the locations, it causes the address to be blank when we download the application. We then have to refer to the practice address. If the practice address does not match the vendor address (remittance/pay to address) we have on file for the group, please change the answer to “no”.
- Office Hours. Must match the office hours the provider actually works at the respective location.
- Age Limitation. What are the ages of the patients the provider sees? Our default is 0-130.
- Services and Accessibilities section (***must*** be completed entirely).
- Handicapped accessibility ***must*** be completed.
- Bus route ***must*** be completed.

CAQH® Requirements

- Hospital Affiliation (for PCP only). Surgical specialty ***must*** be indicated.
- Professional Liability Insurance (consistently expired or expiring within 30 days).
- Work History (must be for the last 5 years with no more than a 6-month gap. If there is a gap, there must be an explanation. We can also use education to help fill in the last 5 years). We need to know what they have been doing for the last 5 years.
- Disclosure questions (***must*** be completely filled out).
- Any additional addendum pages.
- Any additional locations (consistently incomplete).

Attestation Date

- We must verify the attestation date on the CAQH® report (page 1) is valid.
- We cannot accept a CAQH® attestation that is more than 90 days from when we review. Credentialing and configuration require at least 90 days to process and the attestation cannot be out of date during this time.

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature*

Name (print)*

DATE SIGNED*

Incomplete & Outdated CAQH®

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- Incomplete and outdated CAQH® information, and/or outdated attestations can significantly delay the credentialing and provider load process.
- We reach out 3 times over the course of 30 days if incomplete and/or outdated information is outstanding.
- If the information is not received within those 30 days, we close out the load as incomplete.
- Provider needs to grant us permission to access their CAQH® information.

Complete & Updated CAQH®

The CAQH® Universal Credentialing DataSource is designed to make the credentialing process easier for providers by gathering data in a single repository.

This single repository may be accessed by participating health plans and other healthcare organizations, and enables providers to easily update their information.

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CAQH

Very Important

CAQH stands for "Council for Affordable Quality Healthcare." It is an online database that stores provider information. Providers grant access to their information to insurance companies. This makes acquiring provider information more efficient. Instead of contacting the provider office for copies of licenses, or other essential credentialing information, insurance companies can go in and pull it directly from the provider's CAQH file.

Important CAQH Requirements Checklist

- ☐ Name
- ☐ Date of Birth
- ☐ Social Security Number
- ☐ License number
- ☐ DEA (if applicable)
- ☐ Are you participating in Medicare/Medicaid? (must be checked yes in CAQH)
- ☐ Medicaid and Medicare numbers
- ☐ NPI
- ☐ Education
- ☐ Specialty
- ☐ Board certification
- ☐ Primary address, includes tax ID of group, physical location, phone and fax numbers
- ☐ Remittance/Pay To information: includes name checks are to be made payable to, and address payments should be sent to
- ☐ Office Hours
- ☐ Services and Accessibilities section (must be completely filled out)
- ☐ Hospital Affiliation (for PCP only)
- ☐ Professional Liability Insurance (please ensure it is not expired)
- ☐ Work History (must be for last 5 years with no more than a 6 month gap. If there is a gap, there must be an explanation. We can also use education to help fill in the last 5 years)
- ☐ Disclosure questions (must be completely filled out)
- ☐ Any additional addendum pages
- ☐ Any additional locations (please ensure this is completed for any additional locations)

Attestation Date

- We must verify the attestation date on the CAQH report (page 1) is valid.
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Incomplete & Outdated CAQH

Incomplete and outdated CAQH information, and/or outdated attestations can significantly delay the credentialing and provider load process.

CAQH Contact Information

https://www.caqh.org/
Tutorials available on the website
Toll Free: **1 (888) 599-1771**

CAQH® Reminders

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- Please refresh your provider's CAQH® application on CAQH ProView® for its quarterly update. With CAQH ProView® you can update information and attach supporting documents without having to fax the information to CAQH®. By uploading the documents (attestation, medical liability insurance, DEA), the changes take place in real time.
- If you are not familiar with the new system, please take few minutes go through the guide at http://caqh.org/ProView/PR-QuickRef.pdf.
- To access CAQH ProView,® please use the following link: https://proview.caqh.org/Login/Index?ReturnUrl=%2f then type in your Username and Password.
- A link for a tutorial is also available under "Provider User Guide".
- For some users the database may ask you to enter a new Username and Password. Once you are in the system, please be sure to turn on authorized users tab and choose 742, or simply choose "All Users" for all networks.
- For questions, please contact the CAQH® Help Desk by calling: 1-888-599-1771 or via email at providerhelp@proview.caqh.org.

CAQH® Web Site

- For more information: https://www.caqh.org/
- (888)599-1771
- Web site has tutorials should assistance be needed.

Add Letter (Existing Contract)

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SAMPLE "Letter to Load"

[Practice Letterhead]

Date

Send To: **.ky_providercorrection@wellcare.com**

Re: CREDENTIALING - Adding providers

This letter authorizes WellCare Health Plan to load the list of providers below to the following:

Tax Identification #:_____

GROUP NPI #:_____

Physical Address(es):_____

_____

Pay To Name:_____

Pay To (Vendor) Address:_____

_____

Name	Licensure	NPI	PCP: YES or NO?	CAQH #	Medicaid #	Medicare #

Thank you,
Authorized Signatory
Title

Add Letter (New Contract)

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SAMPLE "Letter to Load"

[Practice Letterhead]

Date

WellCare Health Plan of Kentucky
13551 Triton Park Boulevard, Suite 1800
Louisville, KY 40223

Re: CREDENTIALING – provider list for **new contract**

This letter authorizes WellCare Health Plan to load the list of providers below to the following:

Tax Identification #:_____

GROUP NPI:_____

Physical Address(es):_____

_____

Pay To Name:_____

Pay To (Vendor) Address:_____

_____

Name	Licensure	NPI	PCP: YES or NO?	CAQH #	Medicaid #	Medicare #

Thank you,
Authorized Signatory
Title

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Thank You

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PRO_63954E State Approved 10282020