



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
Passport Health Plan by Molina Healthcare	Provider Relation Support 1-877-902-1207
WellCare	Provider Relation Support 1-877-389-9457

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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Molina <input type="checkbox"/> Yes <input type="checkbox"/> No	Wellcare <input type="checkbox"/> Yes <input type="checkbox"/> No
Practice website*:				<input type="checkbox"/> No website	
Practice email*:				<input type="checkbox"/> No email	
Does this practitioner provider face-to-face direct care services to members in an office setting? <input type="checkbox"/> Yes <input type="checkbox"/> 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 - <input type="checkbox"/> pending
Primary Specialty		Secondary Specialty		Languages Spoken <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other _____	
Primary Taxonomy	Secondary Taxonomy		CDS Issue State	CDS License Number	
States License No. KY _____ OH _____ IL _____ TN _____ IN _____ WV _____ VA _____ MO _____ Other _____			DEA Number - <input type="checkbox"/> pending KY _____ OH _____ IL _____ TN _____ IN _____ WV _____ VA _____ MO _____ Other _____		
Supervising Physician <input type="checkbox"/> NA Name: _____	Primary Hospital Affiliation - <input type="checkbox"/> No hospital privileges		City, State	Affiliation Start Date	
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 <input type="checkbox"/> Primary Office <input type="checkbox"/> Covering Only		Tax ID#	Group Name (include DBA)	
Scope of Practice for this site <input type="checkbox"/> Primary Care <input type="checkbox"/> FQHC <input type="checkbox"/> DME <input type="checkbox"/> Specialty Care <input type="checkbox"/> RHC <input type="checkbox"/> Inpatient Care <input type="checkbox"/> ASC <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Emergency Care <input type="checkbox"/> Urgent Care <input type="checkbox"/> Home Health <input type="checkbox"/> Other			Address 1	Address 2 (suite)
If specialty care, please designate practice specialty			City, State, Zip <input type="checkbox"/> Dir Opt-OUT for this location	

CLIA Number	CLIA Expiration	Group NPI	Phone #	Fax #
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Location-Specific Information	Y	N		Y	N
Does practice offer lab services at this site? (CLIA Required)	<input type="checkbox"/>	<input type="checkbox"/>	Is address handicap accessible?	<input type="checkbox"/>	<input type="checkbox"/>
Is provider at this site at least 16 hours per week?	<input type="checkbox"/>	<input type="checkbox"/>	Is address TDD hearing equipped?	<input type="checkbox"/>	<input type="checkbox"/>
Can patients call this site to make appointment with provider?	<input type="checkbox"/>	<input type="checkbox"/>	Is address accessible by bus route?	<input type="checkbox"/>	<input type="checkbox"/>
Is provider accepting new patients at this site?	<input type="checkbox"/>	<input type="checkbox"/>	Does practice provide American Sign Language services at this site?	<input type="checkbox"/>	<input type="checkbox"/>
Is provider a PCP at this site?	<input type="checkbox"/>	<input type="checkbox"/>	Does provider provide telemedicine services at this site?	<input type="checkbox"/>	<input type="checkbox"/>
Does provider provide EPSDT services at this site?	<input type="checkbox"/>	<input type="checkbox"/>	Does this site participate in KHIE?	<input type="checkbox"/>	<input type="checkbox"/>
If PCP, is provider's panel open at this site for Medicaid?	<input type="checkbox"/>	<input type="checkbox"/>	Is provider a locum tenens provider?	<input type="checkbox"/>	<input type="checkbox"/>
What is the maximum panel capacity for Medicaid at this site?			Has provider completed cultural competence training?	<input type="checkbox"/>	<input type="checkbox"/>
What are the age limitations for patients seen by provider?			Is provider certified in trauma-informed care (TIC)?	<input type="checkbox"/>	<input type="checkbox"/>
Should this provider be printed in the directory?	<input type="checkbox"/>	<input type="checkbox"/>	Has provider been trained in evidence-based practice?	<input type="checkbox"/>	<input type="checkbox"/>

Is there a gender restriction at this site? (If yes, please specify)							
Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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

Notes:

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 <input type="checkbox"/> Primary Office <input type="checkbox"/> Covering Only		Tax ID#		Group Name (include DBA)			
Scope of Practice for this site <input type="checkbox"/> Primary Care <input type="checkbox"/> FQHC <input type="checkbox"/> DME <input type="checkbox"/> Specialty Care <input type="checkbox"/> RHC <input type="checkbox"/> Inpatient Care <input type="checkbox"/> ASC <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Emergency Care <input type="checkbox"/> Urgent Care <input type="checkbox"/> Home Health <input type="checkbox"/> Other				Address 1		Address 2 (suite)	
				City, State, Zip		<input type="checkbox"/> Dir Opt-OUT for this location	
If specialty care, please designate practice specialty							
CLIA Number		CLIA Expiration		Group NPI		Phone #	
Location-Specific Information				Y	N		
Does practice offer lab services at this site? (CLIA Required)				<input type="checkbox"/>	<input type="checkbox"/>	Is address handicap accessible? <input type="checkbox"/>	
Is provider at this site at least 16 hours per week?				<input type="checkbox"/>	<input type="checkbox"/>	Is address TDD hearing equipped? <input type="checkbox"/>	
Can patients call this site to make appointment with provider?				<input type="checkbox"/>	<input type="checkbox"/>	Is address accessible by bus route? <input type="checkbox"/>	
Is provider accepting new patients at this site?				<input type="checkbox"/>	<input type="checkbox"/>	Does practice provide American Sign Language services at this site? <input type="checkbox"/>	
Is provider a PCP at this site?				<input type="checkbox"/>	<input type="checkbox"/>	Does provider provide telemedicine services at this site? <input type="checkbox"/>	
Does provider provide EPSDT services at this site?				<input type="checkbox"/>	<input type="checkbox"/>	Does this site participate in KHIE? <input type="checkbox"/>	
If PCP, is provider’s panel open at this site for Medicaid?				<input type="checkbox"/>	<input type="checkbox"/>	Is provider a locum tenens provider? <input type="checkbox"/>	
What is the maximum panel capacity for Medicaid at this site?						Has provider completed cultural competence training? <input type="checkbox"/>	
What are the age limitations for patients seen by provider?						Is provider certified in trauma-informed care (TIC)? <input type="checkbox"/>	
Should this provider be printed in the directory?				<input type="checkbox"/>	<input type="checkbox"/>	Has provider been trained in evidence-based practice? <input type="checkbox"/>	
Is there a gender restriction at this site? (If yes, please specify)							
Office Hours	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Billing/ Vendor Information <i>a sample claim must be submitted with this application <u>unless</u> contracted as full cap vendor</i>			
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	<input type="checkbox"/>	<input type="checkbox"/>
Assessing and Managing Suicide Risk (AMSR)	<input type="checkbox"/>	<input type="checkbox"/>
Cognitive Behavioral Therapy (CBT)	<input type="checkbox"/>	<input type="checkbox"/>
Consumer Operated Programs	<input type="checkbox"/>	<input type="checkbox"/>
Coordinated Care Model for Early Interventions for First Episode Psychosis	<input type="checkbox"/>	<input type="checkbox"/>
Dialectical Behavior Therapy (DBT)	<input type="checkbox"/>	<input type="checkbox"/>
Dual Diagnosis Capability in Addiction Treatment (DDCAT)	<input type="checkbox"/>	<input type="checkbox"/>
Eye Movement Desensitization and Reprocessing (EMDR)	<input type="checkbox"/>	<input type="checkbox"/>
Family Psychoeducational	<input type="checkbox"/>	<input type="checkbox"/>
First Episode Psychosis	<input type="checkbox"/>	<input type="checkbox"/>
Functional Family Therapy (FFT)	<input type="checkbox"/>	<input type="checkbox"/>
Individual Placement and Support (IPS) Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>
Integrated Treatment for Co-occurring Disorders (MH and SUD)	<input type="checkbox"/>	<input type="checkbox"/>
Medication Assisted Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Motivational Interviewing	<input type="checkbox"/>	<input type="checkbox"/>
Multi-Systemic Therapy	<input type="checkbox"/>	<input type="checkbox"/>
NIATx model for addiction treatment	<input type="checkbox"/>	<input type="checkbox"/>
Parent Child Interaction Therapy (PCIT)	<input type="checkbox"/>	<input type="checkbox"/>
Peer Support	<input type="checkbox"/>	<input type="checkbox"/>
Screening, Brief Intervention and Referral to Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Seeking Safety	<input type="checkbox"/>	<input type="checkbox"/>
Supported Employment	<input type="checkbox"/>	<input type="checkbox"/>
Supportive Housing	<input type="checkbox"/>	<input type="checkbox"/>
Trauma Focused Cognitive Behavior Therapy (TF-CBT)	<input type="checkbox"/>	<input type="checkbox"/>
Trauma Informed Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Trauma Recovery and Empowerment Model (TREM)	<input type="checkbox"/>	<input type="checkbox"/>
Treatment for Depression in Older Adults	<input type="checkbox"/>	<input type="checkbox"/>
Wraparound	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>

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)							
<input type="checkbox"/> Primary Office <input type="checkbox"/> Covering Only											
Scope of Practice for this site				Address 1			Address 2 (suite)				
<input type="checkbox"/> Primary Care <input type="checkbox"/> FQHC <input type="checkbox"/> DME <input type="checkbox"/> Specialty Care <input type="checkbox"/> RHC <input type="checkbox"/> Inpatient Care <input type="checkbox"/> ASC <input type="checkbox"/> Behavioral Health <input type="checkbox"/> Emergency Care <input type="checkbox"/> Urgent Care <input type="checkbox"/> Home Health <input type="checkbox"/> Other				City, State, Zip			<input type="checkbox"/> Dir Opt-OUT for this location				
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)				<input type="checkbox"/>	<input type="checkbox"/>	Is address handicap accessible?				<input type="checkbox"/>	<input type="checkbox"/>
Is provider at this site at least 16 hours per week?				<input type="checkbox"/>	<input type="checkbox"/>	Is address TDD hearing equipped?				<input type="checkbox"/>	<input type="checkbox"/>
Can patients call this site to make appointment with provider?				<input type="checkbox"/>	<input type="checkbox"/>	Is address accessible by bus route?				<input type="checkbox"/>	<input type="checkbox"/>
Is provider accepting new patients at this site?				<input type="checkbox"/>	<input type="checkbox"/>	Does practice provide American Sign Language services at this site?				<input type="checkbox"/>	<input type="checkbox"/>
Is provider a PCP at this site?				<input type="checkbox"/>	<input type="checkbox"/>	Does provider provide telemedicine services at this site?				<input type="checkbox"/>	<input type="checkbox"/>
Does provider provide EPSDT services at this site?				<input type="checkbox"/>	<input type="checkbox"/>	Does this site participate in KHIE?				<input type="checkbox"/>	<input type="checkbox"/>
If PCP, is provider's panel open at this site for Medicaid?				<input type="checkbox"/>	<input type="checkbox"/>	Is provider a locum tenens provider?				<input type="checkbox"/>	<input type="checkbox"/>
What is the maximum panel capacity for Medicaid at this site?						Has provider completed cultural competence training?				<input type="checkbox"/>	<input type="checkbox"/>
What are the age limitations for patients seen by provider?						Is provider certified in trauma-informed care (TIC)?				<input type="checkbox"/>	<input type="checkbox"/>
Is there a gender restriction at this site? (If yes, please specify)						Has provider been trained in evidence-based practice?				<input type="checkbox"/>	<input type="checkbox"/>
Should this provider be printed in the directory?											
Office Hours	Sunday	Monday	Tuesday	Wednesday		Thursday	Friday	Saturday			