

Welcome to Kettering Health Medical Group

To ensure a smooth integration, we need to begin the credentialing process with all our payors. If you will be joining the KHMG team, please see the following documents needed for credentialing. Please provide all the information and documentation requested on as follows.

Copy of OHIO DEA Certificate (Please change to your new Practice address)

Website is: <http://www.dea diversion.usdoj.gov/drugreg/index.html>

Copy of ALL Board Certifications

Copy of Medical School, Internship, Residency and Fellowship certificates including the ECFMG (if applicable)

Copy of Current Driver's Licenses

Copy of CV accounting for all time since completion of Medical School (or Masters) (Month & Year must be included for work history and training)

Explanation for any gaps in work history; greater than 30 days

Explanation Documentation of any Malpractice Claims

PA-C: Copy of Supervision Agreement

CNP or NS: copy of Standard Care Agreement

- If you need staff privileges at one of the Kettering Health hospitals, please complete the initial application for your privileges. Be sure to complete the Delineation of Privileges (DOP), read the bylaws, etc.
- **No Electronic Signatures are allowed, wet signatures only. Please DO NOT DATE your signatures.**
- Dates will be added to your Signature by a credentialing specialist once your application has been verified and approved.
- Please send these forms to the the following address:

Kettering Health Medical Group
Central Credentialing Office
1 Prestige Place, Suite 550
Miamisburg, OH 45342-6115

- Or email directly to: CCO@ketteringhealth.org
- Please don't hesitate to contact us if there is anything we can do to assist with this process.

Sincerely,

Kettering Health Medical Group Payor Enrollment Team

O (937) 762-1300

F (937) 522-9990



**Kettering Health Medical Group
Central Credentialing Office**
1 Prestige Place
Miamisburg, OH
O (937) 762-1300
F (937)522-9990
ketteringhealth.org

Surrogacy Request for CMS

Welcome to Kettering Health Medical Group also known as KHMG. We hope this is a smooth transition for you.

We just wanted to inform you, that during the On Boarding process, the Central Credentialing Office, will be requesting a Surrogacy through CMS for PECOS, NPPES and the EHR Incentive Program.

This must be completed so that we are able to start the payor credentialing process.

What to expect:

Once a credentialing specialist has been assigned to you, we will send you an email from the Central Credentialing Office that will have all the details regarding the Surrogacy. Please keep in mind that when we request the surrogacy, it is ONLY for us here at KPN/KHMG.

If you are affiliated with any other group or Tax ID #, it will NOT interfere with them at all.

In the email that we provide, it will give a detailed explanation for the Surrogacy request. Around the same time that you receive our email, you will receive an email from CMS. If you don't see this email in your inbox, you might want to look in your spam folder. This email will provide the link to click on to get to the login screen.

At any time during this process, feel free to reach out to us with any questions that might come up.

We look forward to working with you to make this process as seamless as possible.

Sincerely,

Kettering Health Medical Group Payor Enrollment Team



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F (937)522-9990
ketteringhealth.org

Kettering Health Medical Group Applicant:

Please follow the instructions below to complete these necessary forms:

- W9
- CMS-855I
- CMS-855R
- CAQH Number
- CAQH Form for Standard Authorization, Attestation and Release
- MEDCO-13
- **Please DO NOT DATE these forms. No Electronic Signatures are allowed, only Wet Signatures.**
- **Dates will be added to the Signatures by a credentialing specialist once your application has been verified and approved.**
- Please send these forms to the the following address:
 - Kettering Health Medical Group
Central Credentialing Office
1 Prestige Place, Suite 550
Miamisburg, OH 45342-6115**
- Or email directly to: CCO@ketteringhealth.org
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Sincerely,

Kettering Health Medical Group Payor Enrollment Team

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SECTION 15: CERTIFICATION STATEMENT AND SIGNATURE

As an individual practitioner, you are the only person who can sign this application. The authority to sign the application on your behalf may not be delegated to any other person.

The Certification Statement contains certain standards that must be met for initial and continuous enrollment in the Medicare program. Review these requirements carefully.

By signing this Certification Statement, you agree to adhere to all of the requirements listed therein and acknowledge that you may be denied entry into or have your billing privileges revoked from the Medicare program if any requirements are not met.

A. CERTIFICATION STATEMENT

You **MUST SIGN AND DATE** the certification statement below in order to be enrolled in the Medicare program. In doing so, you are attesting to meeting and maintaining the Medicare requirements stated below.

Under the penalty of perjury, I, the undersigned, certify to the following:

1. I have read the contents of this application, and the information contained herein is true, correct, and complete. If I become aware that any information in this application is not true, correct or complete, I agree to notify my designated Medicare Administrative Contractor of this fact in accordance with the time frames established in 42 C.F.R. section 424.516.
2. I authorize the Medicare Administrative Contractor to verify the information contained herein. I agree to notify the Medicare Administrative Contractor of any change in practice location, final adverse legal action, or any other changes to the information in this form in accordance with the timeframes established in 42 C.F.R. section 424.516. I understand that any change to my status as an individual practitioner may require the submission of a new application. I understand that any change in the business structure of my private practice may require the submission of a new application.
3. I have read and understand the Penalties for Falsifying Information, as printed in this application. I understand that any deliberate omission, misrepresentation, or falsification of any information contained in this application or contained in any communication supplying information to Medicare, or any deliberate alteration of any text on this application, may be punishable by criminal, civil, or administrative penalties including, but not limited to, the denial or revocation of Medicare billing privileges, and/or the imposition of fines, civil damages, and/or imprisonment.
4. I agree to abide by the Medicare laws, regulations and program instructions that apply to me or to the organization listed in section 4A of this application. The Medicare laws, regulations, and program instructions are available through the Medicare Administrative Contractor. I understand that payment of a claim by Medicare is conditioned upon the claim and the underlying transaction complying with such laws, regulations and program instructions (including, but not limited to, the Federal Anti-Kickback Statute, 42 U.S.C. section 1320a-7b(b) (section 1128B(b) of the Social Security Act) and the Physician Self-Referral Law (Stark Law), 42 U.S.C. section 1395nn (section 1877 of the Social Security Act)).
5. Neither I, nor any managing employee reported in this application, is currently sanctioned, suspended, debarred or excluded by Medicare or a State Health Care Program (e.g., Medicaid program), or any other Federal program, or is otherwise prohibited from providing services to Medicare or other federal program beneficiaries.
6. I agree that any existing or future overpayment made to me, or to my business as reported in section 4A, by the Medicare program, may be recouped by Medicare through the withholding of future payments.
7. I understand that the Medicare identification number (PTAN) issued to me can only be used by me or by a Medicare enrolled provider or supplier to whom I have reassigned my benefits under current Medicare regulations when billing for services rendered by me.
8. I will not knowingly present or cause to be presented a false or fraudulent claim for payment by Medicare and will not submit claims with deliberate ignorance or reckless disregard of their truth or falsity.
9. I further certify that I am the individual practitioner who is applying for Medicare billing privileges and the signature below is my signature.

B. SIGNATURE AND DATE

First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Practitioner Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., etc.</i>)			Date Signed (<i>mm/dd/yyyy</i>)

In order to process this application it MUST be signed and dated.

SECTION 6: CERTIFICATION STATEMENTS AND SIGNATURES

Title XVIII of the Social Security Act prohibits payment for services provided by an individual practitioner to be paid to another individual or organization/group unless the individual practitioner who provided the services specifically authorizes another individual or organization/group to receive said payments in accordance with 42 C.F.R. section 424.73 and 42 C.F.R. section 424.80. All individual practitioners who allow another individual or organization/ group to receive payment for their services must sign the Reassignment of Medicare Benefits Statement below. By signing this Reassignment of Medicare Benefits Statement, you are authorizing the organization/group or individual identified in Section 2 to receive Medicare payments on your behalf. The signature(s) below authorize the reassignment of benefits, or the termination of a reassignment of benefits, between the individual practitioner shown in Section 3 and the organization/group or individual shown in Section 2. The employment of, or contract between, the individual practitioner and organization/group or individual must be in compliance with CMS regulations and applicable Medicare program safeguard standards described in 42 C.F.R. section 424.80. These signatures also serve as an attestation and acknowledgment to the compliance with all laws and regulations pertaining to the reassignment of Medicare benefits.

A. Individual Practitioner Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Individual Practitioner Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., etc.</i>)			Date Signed (<i>mm/dd/yyyy</i>)

In order to process this application it MUST be signed and dated.

B. Delegated or Authorized Official of Organization/Group Certification Statement and Signature

Under penalty of perjury, I, the undersigned, certify that the above information is true, accurate and complete. I understand that any misrepresentation or concealment of any information requested in this application may subject me and/or the organization/group to liability under civil and criminal laws.

Delegated or Authorized Official's First Name (Print)	Middle Initial	Last Name (Print)	Jr., Sr., M.D., etc.
Delegated or Authorized Official's Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., etc.</i>)			Date Signed (<i>mm/dd/yyyy</i>)

In order to process this application it MUST be signed and dated.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1179 (Expires: 01/2023). The time required to complete this information collection is estimated to average 15 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please visit <http://www.cms.gov/MedicareProviderSupEnroll>.



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1 Prestige Place
Miamisburg, OH 45342
O (937) 762-1300
F (937) 522-9990
ketteringhealth.org

Name of Practitioner: _____

CAQH number, user ID and Password

Number: _____

Username: _____

Password: _____

If you do not know this information, please contact the CAQH Help Desk @ 888-599-1771.

The Help desk will be able to give the provider only this information.

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)*

M M D D Y Y Y Y

DATE SIGNED*

CAQH ID: _____

3094 DOB: _____ ST License: _____

4. Provider application/agreement

By signing this application/agreement, the provider agrees to, and may be decertified pursuant to Ohio Administrative Code (OAC) 4123-6-02.5 and OAC 4123-6-17 for failure to adhere to conditions below.

Provider agrees to abide by the Ohio Revised Code (ORC) and rules promulgated thereunder by BWC and the Ohio Industrial Commission. In addition, provider agrees to accept and abide by all billing and/or other policies, procedures and criteria as set forth and amended from time to time in BWC's *Provider Billing and Reimbursement Manual*, which is incorporated by reference into this application/agreement, and all other terms of this application/agreement.

Provider agrees to notify BWC within 30 days of any change in the provider's business address/location, business name, NPI number, Social Security number (if applicable), employer ID number, tax identification number and/or ownership, or any change in the provider's status regarding any of the credentialing criteria of paragraphs (B) or (C) of OAC 4123-6-02.2.

Provider agrees to provide health services that are applicable to a work-related injury and not to substantially engage in the practice of experimental modalities of treatment; provide adequate on-call coverage for patients; use BWC-certified providers when making referrals to other providers; and timely schedule and treat injured workers to facilitate a safe and prompt return to work.

Provider agrees to practice in a managed care environment and to adhere to MCO and BWC procedures and requirements concerning provider compliance, outcome measurement data, peer review, quality assurance, utilization review, bill submission, dispute resolution, and reporting of injuries and occupational diseases of employees. Provider agrees to acknowledge and treat injured workers in accordance with BWC recognized treatment guidelines and the vocational rehabilitation hierarchy, adhere to BWC's confidentiality and sensitive data requirements, and to use information obtained from BWC by means of electronic account access for the sole purpose of facilitating treatment and no other purpose, including but not limited to engaging in advertising or solicitation directed to injured workers.

Provider agrees to maintain workers' compensation coverage to the extent required under Ohio law or the equivalent law of another state, as applicable. Provider attests that it presently has and agrees to maintain professional malpractice and liability insurance (commercial liability insurance if applicable) at all times during the course of this contract. Provider agrees to provide proof of such coverage to BWC upon request.

Provider agrees to bill BWC, self-insuring employer, appropriate certified MCO and/or qualified health plan (QHP) in accordance with the statute of limitations only for services and supplies that the provider has delivered, rendered or directly supervised and that are medically necessary, cost-effective, and reasonably related to the claimed or allowed condition related to the industrial injury or occupational disease. Provider understands BWC, self-insuring employer, appropriate certified MCO and/or QHP does not reimburse for failed or missed appointments (no-shows).

Provider agrees to charge BWC, self-insuring employer, appropriate certified MCO and/or QHP no more than the usual fee billed non-industrial patients for the same service. Provider further agrees not to seek additional payment from the injured worker or employer for the difference between the amount allowed and the provider's billed charge when a provider's fee bill for services or supplies has been approved for payment by BWC, self-insuring employer, appropriate certified MCO, and/or QHP.

Provider agrees to assume responsibility for the accuracy of all bills submitted for payment to BWC, self-insuring employer, appropriate certified MCO, and/or QHP by provider, or any employee or agent of provider.

Provider agrees to create, maintain and retain sufficient records, papers, books, and documents in such form to fully substantiate the delivery, value, necessity and appropriateness of goods and services provided to injured workers under the Health Partnership Plan (HPP) or of significant business transactions, as provided by OAC 4123-6-45.1. Provider further agrees to make such records available for review by BWC, self-insuring employer, appropriate certified MCO and/or QHP within 30 days or such time as agreed to by the parties, in accordance with OAC 4123-6-45.

Provider agrees to keep injured worker patient records (including but not limited to those records set forth under OAC 4123-6-45.1) confidential, and to maintain the confidentiality of injured worker patient records in accordance with all applicable state and federal statutes and rules, and prevent such information from further disclosure or use by unauthorized persons.

Pursuant to Ohio Revised Code (ORC) 9.76(B) Provider warrants that Provider is not boycotting any jurisdiction with whom the State of Ohio can enjoy open trade, including Israel, and will not do so during the contract period.

Conflict of interest and ethics law compliance certification

Provider affirms he or she presently has no interest and shall not acquire any interest, direct or indirect, which would conflict, in any manner or degree, with the performance of services that are required to be performed under this contract. In addition, provider affirms a person who is or may become an agent of provider not having such interest upon execution of this contract shall likewise advise BWC in the event it acquires such interest during the course of this contract.

Provider agrees to adhere to all ethics laws contained in chapters 102 and 2921 of the ORC governing ethical behavior, understands such provisions apply to persons doing or seeking to do business with BWC and agrees to act in accordance with the requirements of such provisions; and warrants that it has not paid and will not pay, has not given and will not give, any remuneration or thing of value directly or indirectly to BWC or any of its board members, officers, employees, or agents, or any third party in any of the engagements of this contract or otherwise, including, but not limited to a finder's fee, cash solicitation fee, or a fee for consulting, lobbying or otherwise.

Certification statements

I certify the information submitted by me in this application is true, accurate and complete to the best of my knowledge and belief, and that the application is without misrepresentation, misstatement or omission of a relevant fact, or other acts involving dishonesty, fraud, or deceit.

I hereby authorize BWC to consult with persons, companies, governmental authorities, organizations and others who may have any information or documents regarding my character, background qualifications, professional competence and credentials. I hereby consent to the release of any such information or documents to BWC for purposes of its evaluation of me in connection with the HPP.

I hereby release from liability any such person, company, government authority, organization, and others that provide information as part of this credentialing process.

Any person who knowingly makes a false statement, misrepresentation, concealment of fact, or any other act of fraud to obtain payment as provided by BWC, or who knowingly accepts payment to which that person is not entitled is subject to a felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Applicant signature (required)

Date

Please print or type name