SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Addendum
to
CAQH/North Carolina Uniform Credentialing/Re-Credentialing Application to Participate as a Health Care Practitioner

For IPRS (State Funding) and Medicaid

Please email application to:

Credentialing@sandhillscenter.org
OR
Recredentialing@sandhillscenter.org

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph & Richmond Counties

Instructions	
A Licensed Independent Practitioner/Licensed Practitioner must apply for and be credentialed/re-credentialed as a practitioner with Sandhills Center to qualify for reimbursement of services provided to Sandhills Center members. Additionally, Licensed Independent Practitioners must have a signed contract with Sandhills Center or be employed by an Organization or Group Practice that has a signed contract with Sandhills Center to qualify for reimbursement of services provided to Sandhills Center Members.	
*******Please Identify Areas of Clinical Expertise and Treatment by completing and signing the Practice Preference Data on the attached Cultural, Racial, Ethnic, Gender, and Linguistic Data Form.*******	
******LIP/LPs are required to submit two (2) ea. references – see "Provider Evaluation Form"******	
The Credentialing/Re-Credentialing process includes the following steps:	
1.	**Provider completes and signs the Licensed Independent Practitioner Credentialing/Re-Credentialing Application Addendum for Medicaid and IPRS to Participate as a Health Care Practitioner, in addition to the CAQH LIP application and returns it to:**
Sandhills Center for MH/I/DD/SAS Network Operations Department credentilaing@sandhillscenter.org OR Recredentilaing@sandhillscenter.org	
	Retain a copy of your completed Credentialing/Re-Credentialing Application and all documentation submitted with the Credentialing/Re-Credentialing Application for your records. Providers will be notified via email from Sandhills Center upon receipt of their application. Please do not submit claims for dates of services prior to the effective date.
	Billing information and clinical coverage policies are available on Sandhills Center website at: http://www/sandhillscenter.org.
	Providers are requested to include on their application the name, e-mail address, and fax number of the individual contact person at their site who is responsible for receiving Sandhills Center Health Plan Information.
	We want to thank you in advance for your efforts in completing your Credentialing/Re-Credentialing application process in the manner stated above. Submitting an organized application will expedite the review process and increase efficiency and accuracy. Please ensure that all applicable information requested is submitted to avoid delays with processing.
2.	**A Credentialing/Re-Credentialing Application Addendum to Participate as a Health Care Practitioner is considered to be invalid if:**
	The version date on any of the documents that comprise the provider Credentialing/Re-Credentialing packet is prior to March 2020. Older versions are not accepted.
	All spaces in the application **have not been completed**. ***(Please indicate "N/A" or "None", if the question is not applicable)***
	The Signatures, where required, are not original/scanned and dated.
	The Signatures are not by the individual applicant.
	The text has been altered, highlighted, struck through, or obstructed through the use of correction fluids.
	The responses are illegible.
	Any of the documents or pages that comprise the Credentialing/Re-Credentialing Application to participate as a Heath Care Practitioner are missing.
	Any of the requested information in any of the documents that comprise the Credentialing/Re-Credentialing Application Addendum to participate as a Health Care Practitioner is missing.

3.	**Before submitting the Credentialing/Re-Credentialing Application, make sure you have completed the following:**
☐	Include an answer in all spaces. Indicate "N/A" or "None", if the question is not applicable.
☐	Copy of National Provider Identifier (NPI) Certification Letter for Agency and Clinician(s).
☐	Copy of current Federal DEA certificate (for MDs. Physician Assistants and Psychiatric Nurse Practitioner(s). The Certificate must have a valid date and refer to current address.
☐	Copy of South Carolina Controlled Drug Substance Certificate and DEA information, if applicable.
☐	Copy of the provider's original state(s) license(s) and current registration.
☐	Copy supervision contract and completed clinical supervisor information, if provisionally licensed.
☐	Copy of certificate from the Specialty Board, if applicable.
☐	Physicians who are not "Board Certified" must provide an official certified copy of educational transcripts from highest level of education.
☐	Hospital Admitting Privileges (if applicable).
☐	Professional Information questions answered and signed and Supplemental Form completed.
☐	Signed and dated Attestation Statement.
☐	Sandhills Center Provider Evaluation Forms (2 Minimum).
☐	Completed Cultural, Racial, Ethnic, Gender, and Linguistic Data Form. Cultural Competency Training is required.
☐	Certificate/documentation for specialized training indicated under Treatment Specialties (if applicable).
☐	• Copy of Certificate of Insurance for your current professional liability, with coverage amounts of $1,000,000 / $3,000,000 aggregate, effective date, expiration date and policy. • Completed Insurance Attestations form regarding all liability insurance coverages. Licensed Practitioners who certify in writing that they do not transport clients shall not be required to obtain Automobile Liability Insurance. • Licensed Practitioners who do not employ any staff shall not be required to obtain Worker's Compensation or Employer's Liability Insurance.
☐	Each provider facility must be accommodating for members with physical disabilities. If facility is not accommodating, please provide an explanation of how those members with physical disabilities would be accommodated.
☐	Current Valid NC Tracks enrollment, active status in Medicaid Health Plan, and appropriate affiliation to employment agencies.
☐	Completed Acknowledgement and Authorization for Social Security Number Check form.
4.	**For Solo Licensed Independent Practitioners only.**
☐	Original signed and dated W9 Tax Payer Request for Tax ID#.
☐	Original signed and dated SBI Authority for Release of Information form.
☐	Original signed and dated Trading Partner Agreement.
	Sandhills Center will schedule a Health & Safety Review, if applicable.

Credentialing & Re-Credentialing Data Form

Date of Application: **Solo LIP?** ◯ **LP w/agency?** ◯

***Please note* Solo LIPs are required to submit a completed original W9 Tax Payer Request for Tax ID # form for initial credentialing & recredentialing**

Name of Practitioner:

Name of Practice:

Licensure:

Primary Practice Address:

Additional Practice Address(es):
(attach additional pages if applicable)

Mailing Address:

Email Address (for correspondence):

Phone:

Are you registered with CAQH? Yes ◯ No ◯ | CAQH #:

Required Information Below

Date of Birth: | Social Security Number:

NPI #:

Taxonomy number(s): List all applicable to you.

NC Tracks Requirements:

a. Are you enrolled in NC Tracks? Yes ◯ No ◯

If "No", provide Enrollment Registration # and submission date and/or provide the Managed Change Request (MCR) # and submission date below.

NC Tracks Registration/MCR#:
Submission Date:

b. Do you have an active status in the Medicaid Health Plan? Yes ◯ No ◯

c. Are all applicable service locations active in NC Tracks? Yes ◯ No ◯

d. Do you have a valid taxonomy for each service location? Yes ◯ No ◯

e. Have you affiliated yourself with your employment agency in NC Tracks? Yes ◯ No ◯

List all hospitals where you currently have privileges and indicate the type and status of those privileges:

Hospital # 1: | Estimated % of Admissions:

Privilege and Status of Privilege:

Type: ☐ Active ☐ Admitting ☐ Associate ☐ Consulting ☐ Courtesy
Status: ◯ Pending ◯ Provisional ◯ Suspended ◯ Temporary ◯ Visiting

Hospital # 2: (if applicable) | Estimated % of Admissions:

Type: ☐ Active ☐ Admitting ☐ Associate ☐ Consulting ☐ Courtesy
Status: ◯ Pending ◯ Provisional ◯ Suspended ◯ Temporary ◯ Visiting

If you do not have admitting privileges, who admits for you: *(Please attach a copy of your Admitting Plan)*

Name of Admitting Individual:

Address: _____
Street *City* *State* *Zip+4 (Required)*

Phone #: | Email:

Is each facility/site equipped to accommodate members with physical disabilities? ◯ Yes ◯ No
If no, please explain the plan to accommodate members with physical disabilities below or submit plan with the application.

Section 3: Professional Information

Please check (√) **yes** or **no** for the following questions. Please complete the attached Supplemental Form for any questions to which you answer **"yes"**. Also, **please sign and date this application**. If this application does not have the provider's signature, **it cannot be accepted**.

1. Has your license to practice in any jurisdiction ever been limited, restricted, reduced, suspended, voluntarily surrendered, revoked, denied or not renewed; have you ever been reprimanded by a state licensing agency; or are any of these actions pending with respect to your license; are you under investigation by any licensing or regulatory agency? *(If yes, please complete Supplemental Question #1.)*	◯ Yes	◯ No
2. Has your professional employment or membership in a professional organization ever been subject to disciplinary proceedings, denied, limited, restricted, reduced, suspended, revoked, not renewed, or voluntarily relinquished during or under threat of termination for any reason? *(If yes, please complete Supplemental Question #2.)*	◯ Yes	◯ No
3. Has your Drug Enforcement Agency registration or other controlled substance authorization ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your registration during or under the threat of an investigation or any such actions pending? *(If yes, please complete Supplemental Question #3.)*	◯ Yes	◯ No
4. Have you ever been sanctioned or suspended by Medicare or Medicaid? *(If yes, please complete Supplemental Question #4.)*	◯ Yes	◯ No
5. To your knowledge, have you ever been reported to the National Practitioner Data Bank or the North/South Carolina Board of Medical Examiners? (If yes, please complete Supplemental Question #5.)	◯ Yes	◯ No
6. Have you ever been convicted of a felony or misdemeanor, or are you under investigation with respect to such conduct? *(If yes, please complete Supplemental Question #6.)*	◯ Yes	◯ No
7. Has a professional liability claim been assessed against you in the past five years, or are there any professional liability cases pending against you? *(If yes, please complete Supplemental Question #7.)*	◯ Yes	◯ No
8. Has any liability insurance carrier cancelled, refused coverage, or rated up because of unusual risk or have any procedures been excluded from your coverage? *(If yes, please complete Supplemental Question #8.)*	◯ Yes	◯ No
9. Have you ever practiced without liability coverage? *(If yes, please complete Supplemental Question #9.)*	◯ Yes	◯ No
10. Do you currently have any medical, chemical dependency or psychiatric conditions that might adversely affect your ability to practice medicine or surgery or to perform the essential functions of your position without reasonable accommodation? *(If yes, please complete Supplemental Question #10.)*	◯ Yes	◯ No
11. Have your Hospital and/or Clinic privileges ever been limited, restricted, reduced, suspended, revoked, denied, not renewed, or have you voluntarily surrendered or limited your privileges during or under the threat of an investigation or are any such actions pending? *(If yes, please complete Supplemental Question #11.)*	◯ Yes	◯ No

Signature ***Date***

******Please provide additional detailed information on the following Supplemental Form.***

Supplemental Form

All spaces in the application must be completed. *(Please indicate "N/A" or "None", if the question is not applicable)*		
Applicant Name:		**SHC Provider ID #:** *(if applicable)*
1. License Limited, Reprimanded, etc.:		
List State(s) where action took place:		
Date(s) license revoked, suspended, etc.:	From	To
Please explain:		
2. Employment/Membership Suspended, Limited, etc.:		
List State(s) where action took place:		
Date(s) license revoked, suspended, etc.:	From	To
Please explain:		
3. Drug Enforcement Agency (DEA) Explanation		
List State(s) where action took place:		
Date(s) license revoked, suspended, etc.:	From	To
Please explain:		
4. Medicare/Medicaid Sanction Disciplinary Action(s)		
Disciplined Action(s):		
List State(s) where action took place:		
Date(s) of Action:	From	To
Please explain:		
5. National Practitioner Data Bank Report(s)		
Please explain the NPDB report: *(if you have a copy please attach)*		
6. Felony or Misdemeanor		
Did you serve a sentence: ◯ Yes ◯ No		
If Yes, please check (√) how many years ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ Other:		
Please explain charge and verdict:		
List State(s):		
7. Named in Professional Liability Judgment, Settlement, etc.		
Please explain, include dates & amounts:		
8. Cancelled Refused Coverage, etc.		
Please list Insurance Carrier(s):		
Please explain:		
9. Practiced Without Liability Coverage		
Please explain:		
10. Medical, Chemical Dependency, or Psychiatric Conditions		
Please explain:		
11. Hospital or Clinic Privileges Revoked, Restricted, etc.		
List Hospital(s):		
Date privileges revoked, suspended, etc.:	From	To
Please explain:		

Section 4: Ownership Information

Completion of this section is required for all providers, shareholders, partners (including self) who have 5% or more direct or indirect ownership (or whose parent, child or sibling has such an interest), and for all individuals officers, directors, managing employees, agents, subcontractors or wholly owned suppliers (as the terms are defined in CFR 42 § 455.101), and Electronic Funds Transfer (EFT) authorized individuals.

1. Do you have ownership or control interest of 5% or more in this organization? If yes, please complete Item # 2 below.	◯ Yes	◯ No

2. List all partners, managing employees and Electronic Funds Transfer (EFT) authorized individuals associated with your practice, and provide the information requested on each.

Name:		**Address:**		
Title:	**SSN:**		**License #:**	
Date of birth:		**% Owner:**		
Check business relationship that applies:				
◯ Owner	◯ Shareholder	◯ Partner	◯ Manager	◯ EFT Auth. Staff
Check relationship to enrolling provider. *(if applicable)*				
◯ Spouse	◯ Parent	◯ Child	◯ Sibling	
Name:		**Address:**		
Title:	**SSN:**		**License #:**	
Date of birth:		**% Owner:**		
Check business relationship that applies:				
◯ Owner	◯ Shareholder	◯ Partner	◯ Manager	◯ EFT Auth. Staff
Check relationship to enrolling provider. *(if applicable)*				
◯ Spouse	◯ Parent	◯ Child	◯ Sibling	
Name:		**Address:**		
Title:	**SSN:**		**License #:**	
Date of birth:		**% Owner:**		
Check business relationship that applies:				
◯ Owner	◯ Shareholder	◯ Partner	◯ Manager	◯ EFT Auth. Staff
Check relationship to enrolling provider. *(if applicable)*				
◯ Spouse	◯ Parent	◯ Child	◯ Sibling	

3. Do you have ownership or control interest of 5% or more in other organizations that bills Medicaid for services?	◯ Yes	◯ No
If yes, please fill in the following for each organization:		
Organization Legal Business Name:		
Employer ID #:		
National Provider Identifier (NPI) #:		
Organization Legal Business Name:		
Employer ID #:		
National Provider Identifier (NPI) #:		
Organization Legal Business Name:		
Employer ID #:		
National Provider Identifier (NPI) #:		

Sandhills Center
Network Operations
Credentialing Specialist
P.O. Box 9, West End, NC 27376
Fax: (910) 673-7013

Provider Evaluation Form

◯ Peer *(Licensed Practitioner, not partner)* ◯ Referring Physician or Practitioner ◯ Supervisor ◯ Chief of Department/Staff where practitioner has admitting privileges *(Not partner)*	
Name of the Applicant:	**Group Name:**
The above provider is a Sandhills Center network applicant. Please provide us with information concerning his/her professional qualifications. All information submitted will be held in strict confidence.	
1. What is your specialty/credentials:	
2. What is your relationship to the applicant:	
3. How long have you known the applicant:	
4. How would you rate the applicant's professional abilities: ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor **5. How would you rate the applicant's ability to work and communicate with physician and non physician staff:** ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor **6. How would you rate the applicant's rapport with members:** ◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor **7. What do you believe to be the applicant's strenghts and weaknesses:** *(if any)*	
a). Strengths:	
b). Weaknesses:	
8. To your knowledge, has the applicant had any of the following:	
Malpractice claim(s):	Yes ◯ No ◯
Problems with medical licensure, certification or licensing boards:	Yes ◯ No ◯
Revocation, denial or change in hospital privileges:	Yes ◯ No ◯
History of/or current impairment due to drugs and/or alcohol:	Yes ◯ No ◯
******If your answer is yes to any of the above questions, please provide details.******	
9. Would you recommend this person as a provider for the Sandhills Center network: ◯ Without reservation ◯ With reservation ◯ Would not recommend **10. Please provide any other information that would be helpful to us in evaluating this applicant:**	
Evaluator's Signature	***Evaluator's Printed Name*** ***Date***
Group Name:	
Address: ***Street***	***City*** ***State*** ***Zip***
Phone #:	**Email:**

Sandhills Center
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P.O. Box 9, West End, NC 27376
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Provider Evaluation Form

◯ Peer *(Licensed Practitioner, not partner)* ◯ Referring Physician or Practitioner ◯ Supervisor ◯ Chief of Department/Staff where practitioner has admitting privileges *(Not partner)*	
Name of the Applicant:	**Group Name:**

The above provider is a Sandhills Center network applicant. Please provide us with information concerning his/her professional qualifications. All information submitted will be held in strict confidence.

1. What is your specialty/credentials:

2. What is your relationship to the applicant:

3. How long have you known the applicant:

4. How would you rate the applicant's professional abilities:

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

5. How would you rate the applicant's ability to work and communicate with physician and non physician staff:

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

6. How would you rate the applicant's rapport with members:

◯ Excellent ◯ Very Good ◯ Good ◯ Fair ◯ Poor

7. What do you believe to be the applicant's strenghts and weaknesses: *(if any)*

a). Strengths:

b). Weaknesses:

8. To your knowledge, has the applicant had any of the following:

Malpractice claim(s):	Yes ◯	No ◯
Problems with medical licensure, certification or licensing boards:	Yes ◯	No ◯
Revocation, denial or change in hospital privileges:	Yes ◯	No ◯
History of/or current impairment due to drugs and/or alcohol:	Yes ◯	No ◯

******If your answer is yes to any of the above questions, please provide details.******

9. Would you recommend this person as a provider for the Sandhills Center network:

◯ Without reservation ◯ With reservation ◯ Would not recommend

10. Please provide any other information that would be helpful to us in evaluating this applicant:

Evaluator's Signature ***Evaluator's Printed Name*** ***Date***

Group Name:

Address: ***Street*** ***City*** ***State*** ***Zip***

Phone #:	**Email:**

SANDHILLS CENTER

Licensed Independent Practitioners/Licenses Practitioners

Cultural, Racial, Ethnic, Gender, and Linguistic Data Form

By providing the information below, you will be assisting Sandhills Center with member/provider matching as well as providing information necessary for analyzing our Network and its ability to meet our Members cultural, racial, ethnic and linguistic needs.

(This information will reside within Sandhills Center's Provider Directory and the online Provider Search. This section is self-reported information and requires no backup documentation.

Name of Practitioner:					
Name of Practice:					
Email Address:					
Where do you provide services?					
Office: ◯ Yes ◯ No			Community: ◯ Yes ◯ No		
Counties Served: ☐ Anson ☐ Guilford ☐ Harnett ☐ Hoke ☐ Lee ☐ Montgomery ☐ Moore ☐ Randolph ☐ Richmond ☐ Other:					
Provider Type:					
☐ APPCNS *(Advanced Practice Psychiatric Clinical Nurse Specialist)*					
☐ DO	☐ LCAS	☐ LCSW	☐ LMFT	☐ LPA	
☐ LCMHC	☐ PA	☐ PhD	☐ PsyD	☐ MD/NP Psychiatric	
☐ Provisional License:			Other *(please specify)*:		
Your Gender: ◯ Female ◯ Male					
Your Race and/or Ethnicity *(please check (√) appropriate categories)*:					
☐ White	☐ Black or African American		☐ American Indian and Alaska Native		
☐ Asian, Pacific Islander	☐ Hispanic or Latino		☐ Other:		
Populations(s) that you serve *(please check (√) ONLY those that apply)*:					
☐ All Populations			☐ Gay & Lesbian		
☐ Gender Identity Issues			☐ Geriatric		
☐ Hearing Impaired			☐ HIV/Aids		
☐ Men			☐ Sexually Reactive/Aggressive Youth		
☐ Visually Impaired			☐ Women		
	MH		SA		IDD
Adult	☐ 18-21 ☐ 22-54 ☐ 55 & Up		☐ 18-21 ☐ 22-54 ☐ 55 & Up		☐ 18-21 ☐ 22-54 ☐ 55 & Up
Child	☐ 3-11 ☐ 12-17		☐ 12-17 ☐ 18-21		☐ 3-11 ☐ 12-17
Culturally diverse populations that you feel competent to treat *(please check (√) ONLY those that apply)*:					
☐ All Races/Ethnicities			☐ American Indian & Alaska Native		
☐ Asian, Pacific Islander			☐ Black or African American		
☐ Hispanic or Latino			☐ White		
☐ Other:					
Completed Cultural Competency Training? ◯ Yes ◯ No					
Language(s) you are able to communicate in fluently *(please check (√) ONLY those that apply)*:					
☐ American Sign Language	☐ Chinese/Korean		☐ English		
☐ French	☐ German		☐ Hmong		
☐ Portuguese	☐ Spanish		☐ Telugu		
☐ Other:		Translator On Site? Yes ◯ No ◯			

Focus of Treatment: *(please check (✓) ONLY those that apply)*:	
☐ Anger Management	☐ Factitious Disorders
☐ Anxiety/Phobias	☐ Faith Based Counseling
☐ Assessment Evaluation	☐ General Psychiatry
☐ Attention Deficit Hyperactivity Disorder	☐ General Psychology
☐ Autism	☐ Grief and Loss Therapy
☐ Bipolar Disorder	☐ Impulse Control
☐ Career/Vocational Counseling	☐ Intellectual/Developmental Disabilities
☐ Chemical Dependency/Substance Abuse	☐ Obsessive-Compulsive Disorder
☐ Chronic Medical Conditions	☐ Personality Disorders
☐ Conduct Disorder	☐ Post-Traumatic Stress Disorder
☐ Co-Occurring/Dual DX-Mental Illness	☐ Schizophrenia and other Psychotic Disorders
☐ Crisis/Solution Focused Brief Therapy	☐ Sexual & Gender Identity Disorders Illness, Mental Health/Substance Abuse
☐ Dementia Disorder	☐ Sleep Disorders
☐ Depression	☐ Somatoform Disorders
☐ Eating Disorders	

(The section below must have backup documentation to be listed with Sandhills Center)

Clinician Expertise/Certified Specialties that require verification*(please check (✓) ONLY those that apply)*:

Psychological Testing	**Therapy/Service Type**	**Trauma Focused**
☐ Cognitive/IQ	☐ Dialectical Behavior Therapy	☐ EMDR
☐ Developmental limited/extended	☐ Gero Psychiatry	☐ TF-CBT
☐ Forensic Screening/Evaluation	☐ Child Psychiatry	**Other**
☐ Neuro Psychological	☐ Parent-Child Interactive Therapy	☐ ABA
	☐ Play Therapy	☐ IDD OPT
	☐ Sex Offender Treatment w/o SOSE	☐ Opioid Treatment Prescriber
	☐ SOSE with Treatment	

Thank you for taking the time to submit this form. If this form is not completed and returned, your provider information will not appear within the Sandhills Center online Provider Search or the Provider Directory.

To the best of my knowledge, I am able to meet all requirements necessary to apply for Sandhills Center Credentialing for Licensed Independent Practitioners/Licensed Practitioners. I am submitting the attached Sandhills Center Licensed Independent Practitioner/Licensed Practitioner Credentialing Application, which, to my knowledge, is a true and complete representation of the required materials.

Signature of Licensed Independent Practitioner/Licensed Practitioner ***Date***

Printed Name

Outpatient Behavioral Health Service Codes for IPRS & Medicaid

Sandhills Center is a closed Network. The Network Credentialing Department will receive approved service codes through the email address below.

ProviderJoin@SandhillsCenter.org

SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Trading Partner Agreement

TRADING PARTNER AGREEMENT– Electronic Data Interchange (EDI)

This document constitutes an agreement to the following provisions for exchanging Electronic Data Interchange (EDI) between the Trading Partner and Sandhills Center (SHC).

The Trading Partner agrees:

1. To conform to the requirements for *Administrative Simplifications* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects SHC's HIPAA compliance.

2. That it will promptly notify SHC of any and all unlawful or unauthorized disclosures of confidential information or protected health information (PHI) that comes to its attention and will cooperate with SHC in the event any litigation arises concerning the unauthorized use, transfer, or disclosure of either confidential or protected health information.

3. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.

4. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, in effect on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

5. That it will establish and maintain procedures and controls so that information concerning SHC health plan participants or any information obtained from SHC, shall not be used by agents, officers, or employees of the trading partner other than for its sole intended purpose.

6. That the information stated in any EDI Trading Partner Profile(s) submitted with this Agreement, or subsequently is correct and complete.

7. That it will allow SHC 30 days after receipt of written notice from the Trading Partner if there is any change in the trading partner representative or location where electronic transactions are sent.

8. That it is bound by this written agreement to comply with state and federal law, if the trading partner is an intermediary for the billing provider.

SHC agrees:

1. To conform to the requirements for *Administrative Simplifications* as defined in the provisions of the *Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-91),* and regulations promulgated there under and to take no action which adversely affects the trading partner's HIPAA compliance.

2. That it will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all participant-specific data from improper access.

3. That it will ensure that all files transmitted comply with the appropriate national *Electronic Data Interchange (EDI) Transaction Set Implementation Guide, in effect on the date of transmission, as provided by the Health Insurance Portability and Accountability Act (HIPAA) of 1996.*

Both parties agree:

1. That documents will not be considered as received and no responsibility assigned until accessible at the receiving party's computer.

2. That upon receiving any documents, to prepare and transmit a timely response or an acknowledgement of transaction receipt. If acceptance of a document is required, a document is not considered received until an acceptance acknowledgement is returned.

3. To notify the other party within a reasonable time frame if any transmitted data are received in an unintelligible or garbled form.

4. That each party will provide and maintain the equipment, software, services, and testing necessary to transmit and receive documents.

5. To conduct business and perform as required by this agreement and any applicable rules or regulations.

6. That this agreement will remain in effect until terminated by either party with at least 30 days prior written notice. The notice will specify the effective date of termination, but will not affect the obligations or rights of either party prior to the effective date of termination. This agreement is automatically terminated in the event the trading partner is disqualified through a federal administrative action or state action. That any document transmitted according to this agreement will be considered an original and signed when received.

Effect of Termination

1. Except as provided in paragraph (2) of this section or in the contract or by other applicable law or agreements, upon termination of this agreement and services provided by the Trading Partner, for any reason, the Trading Partner shall return or destroy all Protected Health Information received from SHC, or created or received by Trading Partner on behalf of SHC. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of the Trading Partner. Trading Partner shall retain no copies of the Protected Health Information.

2. In the event that Trading Partner determines that returning or destroying the electronic protected health information is not feasible, Trading Partner shall provide to SHC notification of the conditions that make return or destruction not feasible. Trading Partner shall extend the protections of this agreement to such Protected Health Information and limit further uses and disclosures of such Protected Health Information to those purposes that make the return or destruction infeasible, for so long as Trading Partner maintains such Protected Health Information.

_____

Trading Partner Name

_____

Street Address Line 1 (Site/Physical Address, not a P.O. Box)

_____

Street Address Line 2

_____

City, State, Zip Code

Contact Information (Phone Number, email address)

Signature of Applicant or Authorized Individual Date

Printed Name and Title

For Sandhills Center for MH, DD & SAS use only

Trading Partner's EDI Submitter ID: _____

Sandhills Center for MH, DD & SAS Receiver ID: SHC303

Please return completed form to:
Sandhills Center for MH, DD & SAS
P.O. Box 9
West End, NC 27376
Attn: EDI Coordinator, Information Technology Department

SANDHILLS CENTER

Managing Mental Health, Intellectual/Developmental Disabilities and Substance Abuse Services
910-673-9111 (FAX) 910-673-6202 www.sandhillscenter.org Victoria Whitt, CEO

Attestation Statement

Important: Submit Original only
No Stamps or Copies Please

This Application is to be signed by the individual provider/clinician applying for Credentialing/Re-Credentialing.

All information submitted by me in this application, as well as any attachments or supplemental information, is true, current, and complete to my best knowledge and belief as of the date of signature below. I fully understand that any significant misstatement in this application may constitute cause for denial of my application or termination of a resulting participation agreement.

By application for membership in the Sandhills Center Network, I signify my willingness to appear for interview in regard to my application. I authorize Sandhills Center to consult with administrators and members of the medical staffs of hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on the questions in this application. Upon request, I will obtain and provide to Sandhills Center materials pertaining to my qualifications and competence, including, materials relating to complaints filed, any disciplinary action, suspension, or action to curtail my medical-surgical privileges. I further consent to the inspection by representatives of Sandhills Center of all documents that may be material to an evaluation of my professional qualifications and competence.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics, and other qualifications and for resolving any doubt about such qualifications. I release from liability all representatives of Sandhills Center for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I release from any liability, all individuals and organizations that provide information to Sandhills Center in good faith and without malice concerning this application and I hereby consent to the release and verification of information relating to any disciplinary action, suspension, or curtailment of medical-surgical privileges to Sandhills Center.

I understand that if my application is rejected for reasons relating to my professional conduct or competence, Sandhills Center, may report the rejection to the appropriate state licensing board and/or National Practitioner Data Bank.

In the event I am accepted for participation in Sandhills Center, I hereby consent to Sandhills Center for inspection of my patient records relating to Sandhills Center members as necessary for its peer and utilization review purposed as permitted by state or federal law and regulation I further agree to notify Sandhills Center in a timely manner **(not to exceed 30 days)** of any changes to the information requested on the initial application.

Signature of Applicant	***Date***
Printed Name of Applicant	***Title***

If this application does not have the provider's signature, it cannot be accepted.
(Please sign and date this Attestation Statement).

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Provider Insurance Coverage – Attestations

Directions: These attestations are required as proof that the **signatory agency/practice (CONTRACTOR)** (1) does not transport Sandhills Center's members and therefore does not maintain Automobile Liability Insurance; and/or (2) is not required by law to acquire and maintain Workers' Compensation/Employer Liability Insurance; and (3) holds coverage under its Comprehensive General Liability, Professional Liability and Automobile insurance, if applicable, for the CONTRACTOR's employees and agents. The third and fourth attestation, regarding the scope of the CONTRACTOR's insurance coverage, and notice of changes to CONTRACTOR's insurance coverages, are required by the State of North Carolina and cannot be waived.

Provider (CONTRACTOR) Name:

Attestation No. 1 -- Automobile Liability Insurance
Select one (1) of the following in this section:

○	(Initials)	CONTRACTOR uses and maintains insurance coverage for all vehicles owned, non-owned, and hired that are used by CONTRACTOR "for the provision of services under the Contract." If not already submitted, CONTRACTOR will provide Sandhills Center with a Certificate of Insurance reflecting the requirements of the contract.
○	(Initials)	CONTRACTOR attests that it does not use any automobile or other vehicle for the provision of services under its Contract with Sandhills Center.

Attestation No. 2 – Workers' Compensation and Employer Liability Insurance
Select one (1) of the following in this section:

○	(Initials)	CONTRACTOR maintains Worker's Compensation and Employer Liability Insurance to the extent required by North Carolina Law." If not already submitted, CONTRACTOR will provide Sandhills Center with a Certificate of Insurance reflecting the requirements of the contract.
○	(Initials)	CONTRACTOR attests that it is not required under North Carolina law to secure and maintain Workers' Compensation and Employer Liability Insurance.

Attestation No. 3 – Scope of CGL and PL coverage, and Automobile coverage (if applicable)

☐	(Initials)	The scope of the CONTRACTOR's CGL and PL insurance, as well as its Automobile insurance (if applicable), must cover all of the CONTRACTOR's employees and agents.

Attestation No. 4 – Notice of Change in Insurance Policy Status

☐	(Initials)	CONTRACTOR attests that CONTRACTOR's insurance coverages cannot be suspended, voided, canceled or reduced unless the agency/practice gives thirty (30) calendar days prior written notice to Sandhills Center.

By signature and date below, CONTRACTOR attests that each of the initialed statements accurately reflect the agency/practice's insurance coverages and requirements as set out by the contract with Sandhills Center.

Printed Name	Signature
Printed Title	Date

Indemnification Agreement: By signing this waiver, I hereby agree to indemnify and hold harmless Sandhills Center from all losses, costs, damages, claims, liabilities and expenses (including attorneys' fees and court costs) whatsoever, which may arise or be claimed against Sandhills Center, for any loss, injuries or damages, consequent upon or arising from any acts, omissions, neglect or fault in connection with Sandhills Center's reliance upon this waiver.

P.O. Box 9, West End, NC 27376
24-Hour Access to Care Line: 800-256-2452
TTY: 1-866-518-6778 or 711
Serving Anson, Guilford, Harnett, Hoke, Lee, Montgomery, Moore, Randolph, & Richmond Counties

AUTHORITY FOR RELEASE OF INFORMATION
State Access Only
Name Check Access

I authorize the North Carolina Department of Justice through the State Bureau of Investigation to perform a North Carolina name-based criminal history record information check in connection with my application for employment, my employment or volunteer services with SANDHILLS CENTER FOR MENTAL HEALTH pursuant to DHHS-LONG TERM – STATE AND FED – NCGS 122C-80B/131 D-40A A1/131D-40A A1.

(type or print clearly)

Last Name	First	Middle	Maiden
Social Security #	Date of Birth	Sex	Race

I understand that the North Carolina State Bureau of Investigation, officials and employees shall not be held legally accountable in any way for providing this information to the above named agency, and I hereby release said agency and persons from any and all liability which may be incurred as a result of furnishing such information. I further understand that the above named agency cannot provide a HARD COPY of the results of this criminal history record check to me.

*Disclosure of social security number is entirely voluntary and not required. If disclosed, the social security number will be utilized to assist with accurate identification/exclusion of possible criminal history records.

Applicant's/Employee's/Volunteer's Signature

_____

Date

_____

This form must be maintained on file with the above named agency for one year. UPON COMPLETION OF THIS FORM, MAIL A PHOTOCOPY TO THE ADDRESS INDICATED BELOW:

State Bureau of Investigation
Criminal Information and Identification Section Attn: Applicant Unit
Post Office Box 29500
Raleigh, North Carolina 27626-0500
ORI # HCP000008 – SANDHILLS CENTER FOR MENTAL HEALTH

HCP000008

ACKNOWLEDGEMENT AND AUTHORIZATION FOR SOCIAL SECURITY NUMBER CHECK

I,_____, hereby authorize Sandhills Center to verify my
(Print Name)

Social Security Number through a third party consumer reporting agency for credentialing/re-credentialing purposes. This verification will be conducted by American DataBank, 110 Sixteenth St., 8th Fl., Denver, CO 80202, 1-800-200-0853, www.americandatabank.com. I agree that a facsimile ("fax"), electronic or photographic copy of this Authorization shall be as valid as the original.

All of the information requested below is mandatory and must be provided. Please type or print clearly.

Last Name:	First Name:	Middle:
Social Security Number*:	Date of Birth*:	
Present Address:		
City/State/Zip:		
Email Address:		

Signature:_____Date:_____

*This information is limited to verification of the individual's Social Security Number and will not be used for employment/hiring purposes. American DataBank's privacy policy can be found at http://www.americandatabank.com/consumer-information/privacy-policy/.