MSO-CRE-PPT-107-120921-S

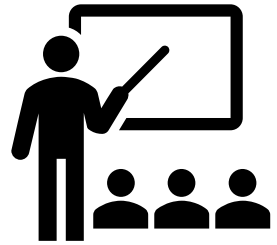
MSO | HOLDINGS

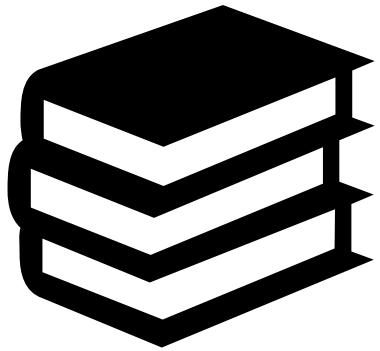
Working Instructions:
Aplicación de Ancilares

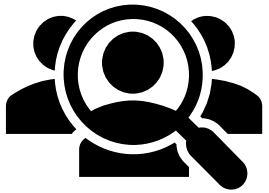
CREDENTIALING TEAM

Tabla de contenido

- Puntos importantes
- ¿Cómo se realiza el proceso?

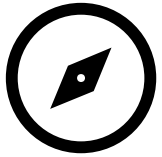






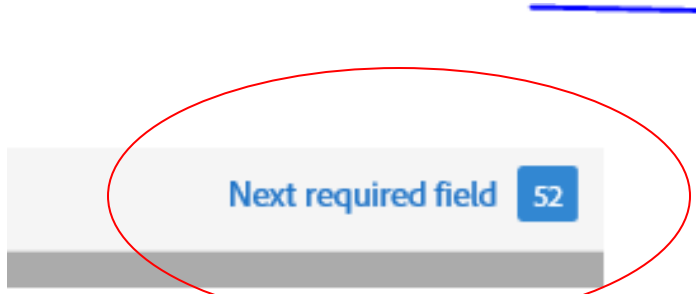
Puntos importantes

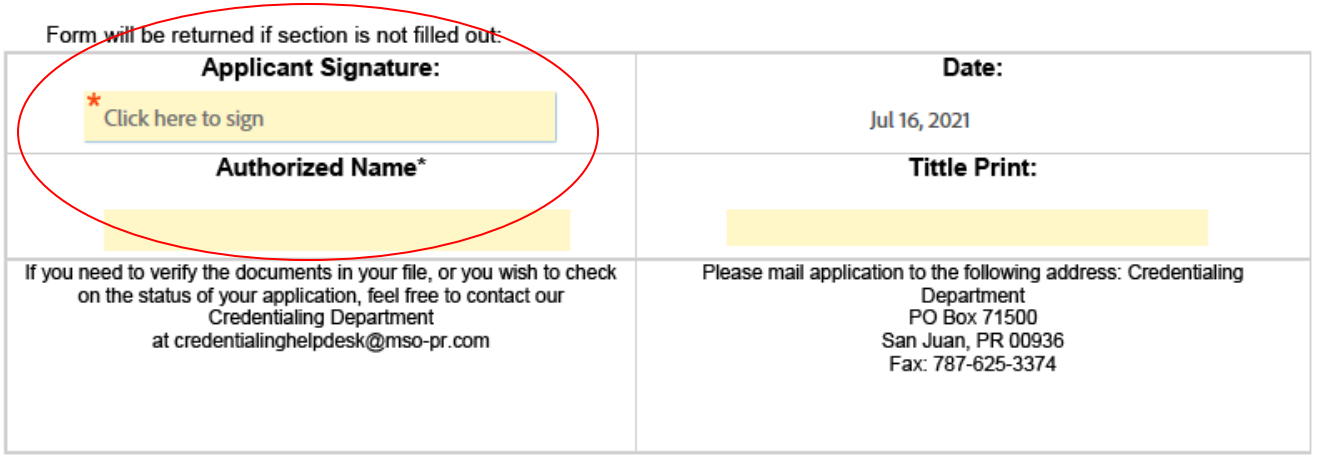
- Si la aplicación se cierra antes de enviar la información, esta no se guardará. Algunas razones probables:
  - El *time-out system* cierra la aplicación tras 15 minutos de inactividad.
  - Conexión inestable de internet
- Asegúrese de buscar los requisitos (bajo la opción de **aplicaciones**) para saber cuáles documentos necesita antes de comenzar el proceso.
- Tener todas las credenciales disponibles antes de comenzar el mismo.
- Antes de comenzar, confirme que llenó la aplicación de facilidad y **no** la de proveedor.
- La aplicación irá llenando los encasillados según usted vaya completando el documento.



Puntos importantes

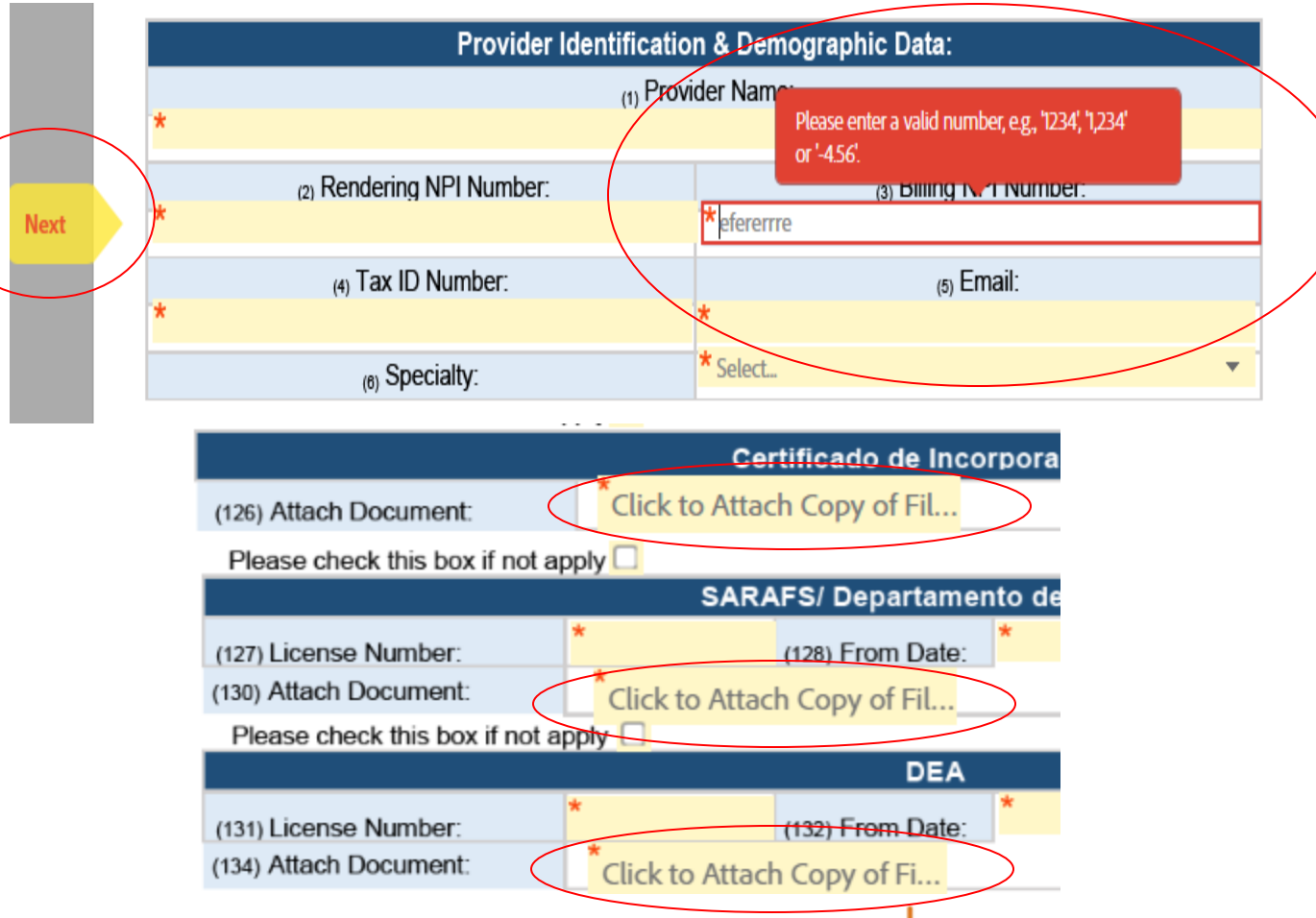
- Si no aparece la opción de *Click to sign* al llegar al final de la aplicación, significa que no se ha llenado en su totalidad.
  - En la parte superior derecha, aparece un botón que le indicará los errores en la aplicación para solucionarlos de manera rápida.
- Al pulsar *click to sign,* la aplicación **no** se enviará; primero tiene que verificar un correo electrónico que Adobe le enviará para completar el proceso.
- La aplicación debe firmarse a nombre del dueño o administrador (pagina 8).
- El proceso de completar la aplicación toma de 20 a 30 minutos.





Puntos importantes

- La aplicación cuenta con un marcador que le indica cuál es el siguiente paso al llenar la aplicación.
- Cualquier información ingresada incorrectamente será resaltada e incluirá una nota que explica el error.
- Para anejar un documento, presione *Click to Attach* y seleccione el documento requerido. Este se anejará a la aplicación.

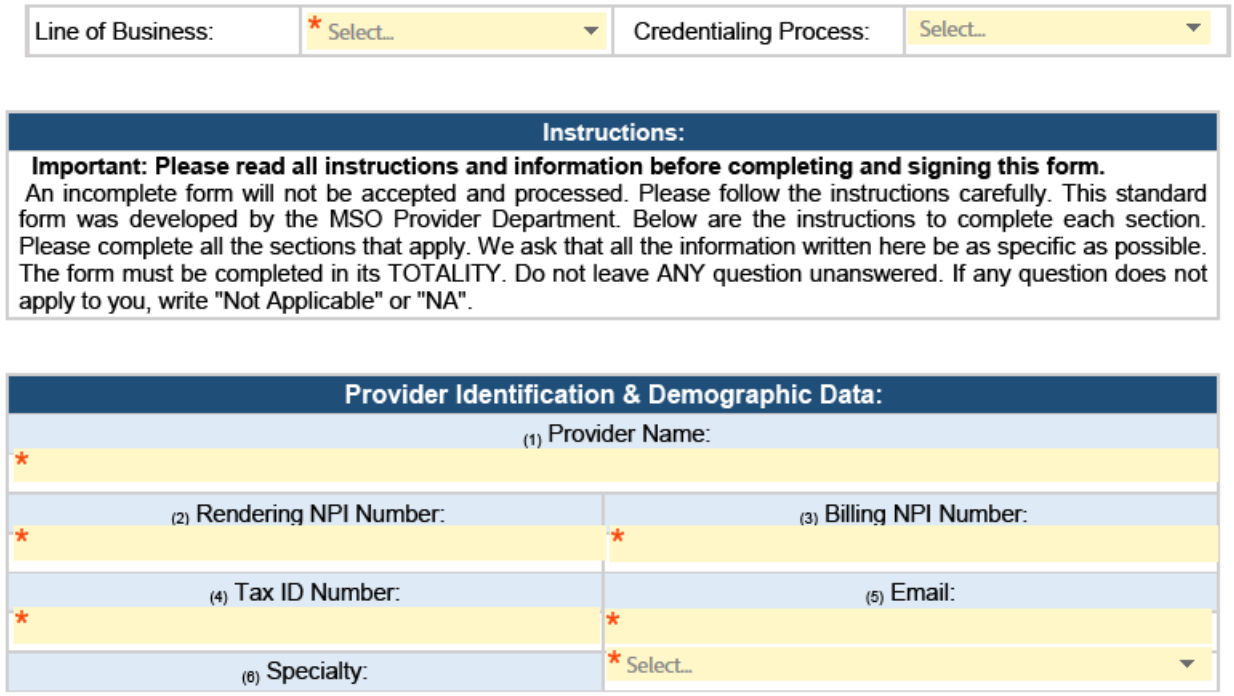


¿Cómo se realiza el proceso?

- ✓ Visite este enlace: https://www.mso-pr.com/solicitudes/#
- ✓ Abajo, busque la opción de **Ver Requisitos** y escoja la opción que le corresponda.
- ✓ Se abrirá una ventana nueva con los requisitos de su campo. Asegúrese de leer y tener los documentos requeridos antes de comenzar el proceso.
- ✓ Para comenzar, tendrá que volver a la ventana previa y desplazarse hacia arriba hasta llegar a la opción de **Solicite como Facilidad.**

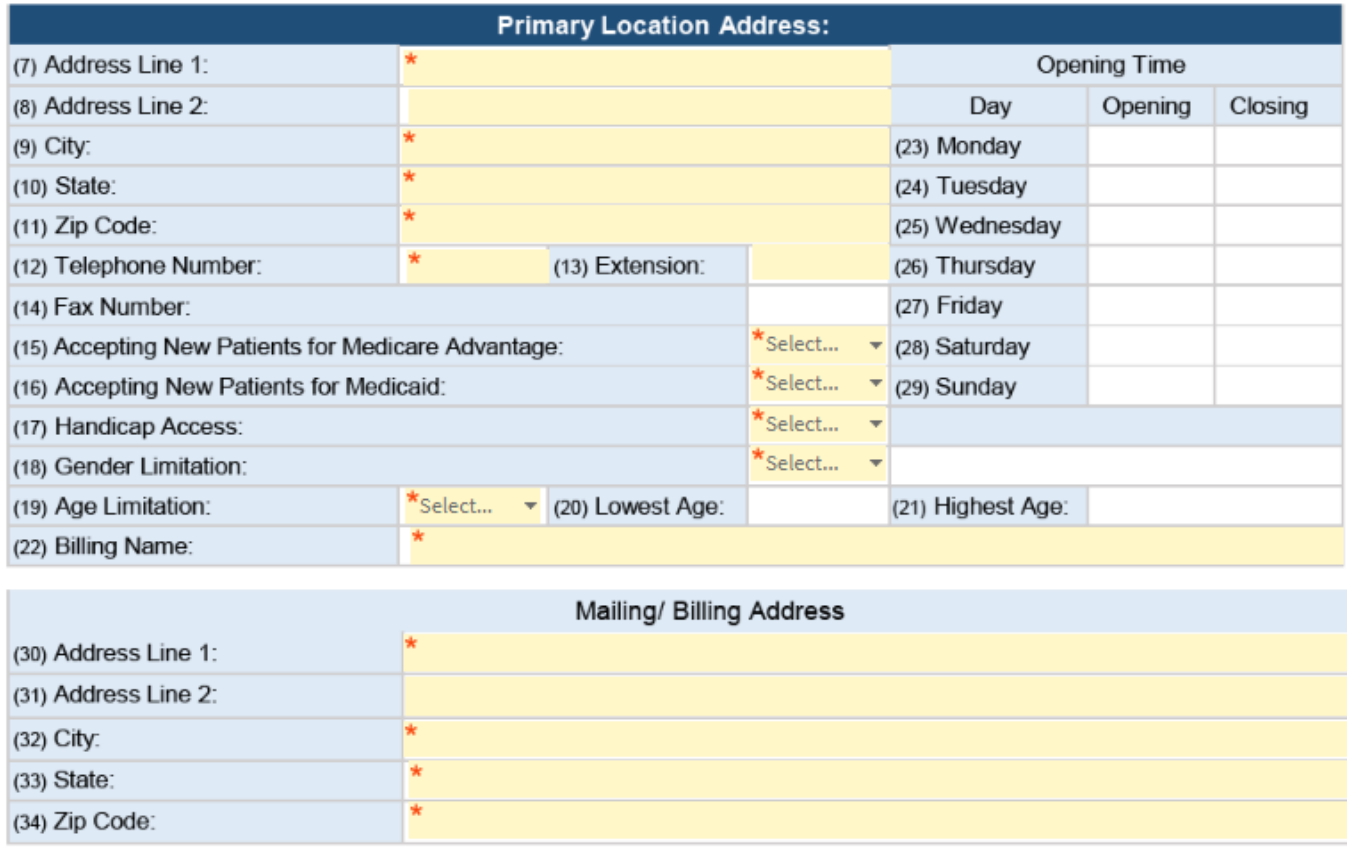
¿Cómo se realiza el proceso? (Continuación)

- ✓ Comience la aplicación eligiendo:
  - ✓ *Line of Business*
    - ✓ Medicare Advantage (MMM)
    - ✓ MMM Multi health (Vital)
    - ✓ Medicare Advantage and Vital
  - ✓ *Credentialing Process*
    - ✓ Initial
    - ✓ Recredentialing
    - ✓ Change
- ✓ Luego, leer instrucciones cuidadosamente y seguirlas
- ✓ En *Provider Identification & Demographic Data*, incluya:
  - ✓ *Provider Name*
  - ✓ *Rendering NPI number and Billing NPI Number*
  - ✓ *Tax ID Number and Email*
  - ✓ *Select your Speciality*



¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Primary Location Address*, incluya:
  - ✓ *Primary Location Address – Address Line #1 (Address Line #2 is optional), City, State, Zip Code*
  - ✓ *Telephone, Extension, Fax, Office Hours, Accessibility Questions* y *Billing Name*.
- ✓ Luego, continúe en *Mailing Billing Address*, incluyendo:
  - ✓ *Location Address- Address line #1 (Address Line #2 is optional), City, State, Zip Code.*

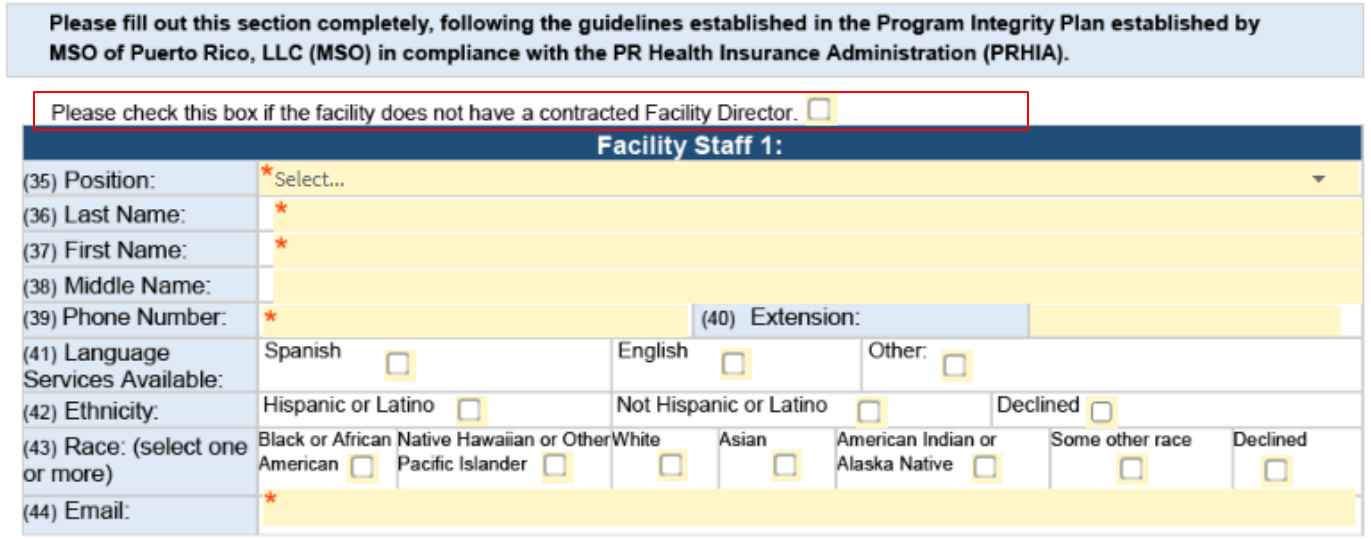


Primary Location Address:						
(7) Address Line 1:	*			Opening Time		
(8) Address Line 2:				Day	Opening	Closing
(9) City:	*			(23) Monday		
(10) State:	*			(24) Tuesday		
(11) Zip Code:	*			(25) Wednesday		
(12) Telephone Number:	*	(13) Extension:		(26) Thursday		
(14) Fax Number:				(27) Friday		
(15) Accepting New Patients for Medicare Advantage:			*Select...	(28) Saturday		
(16) Accepting New Patients for Medicaid:			*Select...	(29) Sunday		
(17) Handicap Access:			*Select...			
(18) Gender Limitation:			*Select...			
(19) Age Limitation:	*Select...	(20) Lowest Age:		(21) Highest Age:		
(22) Billing Name:	*					

Mailing/ Billing Address	
(30) Address Line 1:	*
(31) Address Line 2:	
(32) City:	*
(33) State:	*
(34) Zip Code:	*

¿Cómo se realiza el proceso? (Continuación)

- ✓ Llene la siguiente sección utilizando las guías establecidas por el *Program Integrity Plan* establecido por MSO de Puerto Rico, LLC (MSO)
- ✓ Marque el encasillado *Please check this box if the facility does no have a contracted Facility Director* si no le aplica.
- ✓ En los encasillados de *Facility Staff #1, #2, #3, #4,* incluya:
  - ✓ Posición
    - ✓ *Administrator*
    - ✓ *Biller*
    - ✓ *Secretary*
    - ✓ *Other Office Staff*
  - ✓ Apellido
  - ✓ Primer nombre
  - ✓ Segundo nombre
  - ✓ Teléfono y extensión
  - ✓ Idiomas
  - ✓ Etnicidad
  - ✓ Raza
  - ✓ Email



Please fill out this section completely, following the guidelines established in the Program Integrity Plan established by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA).

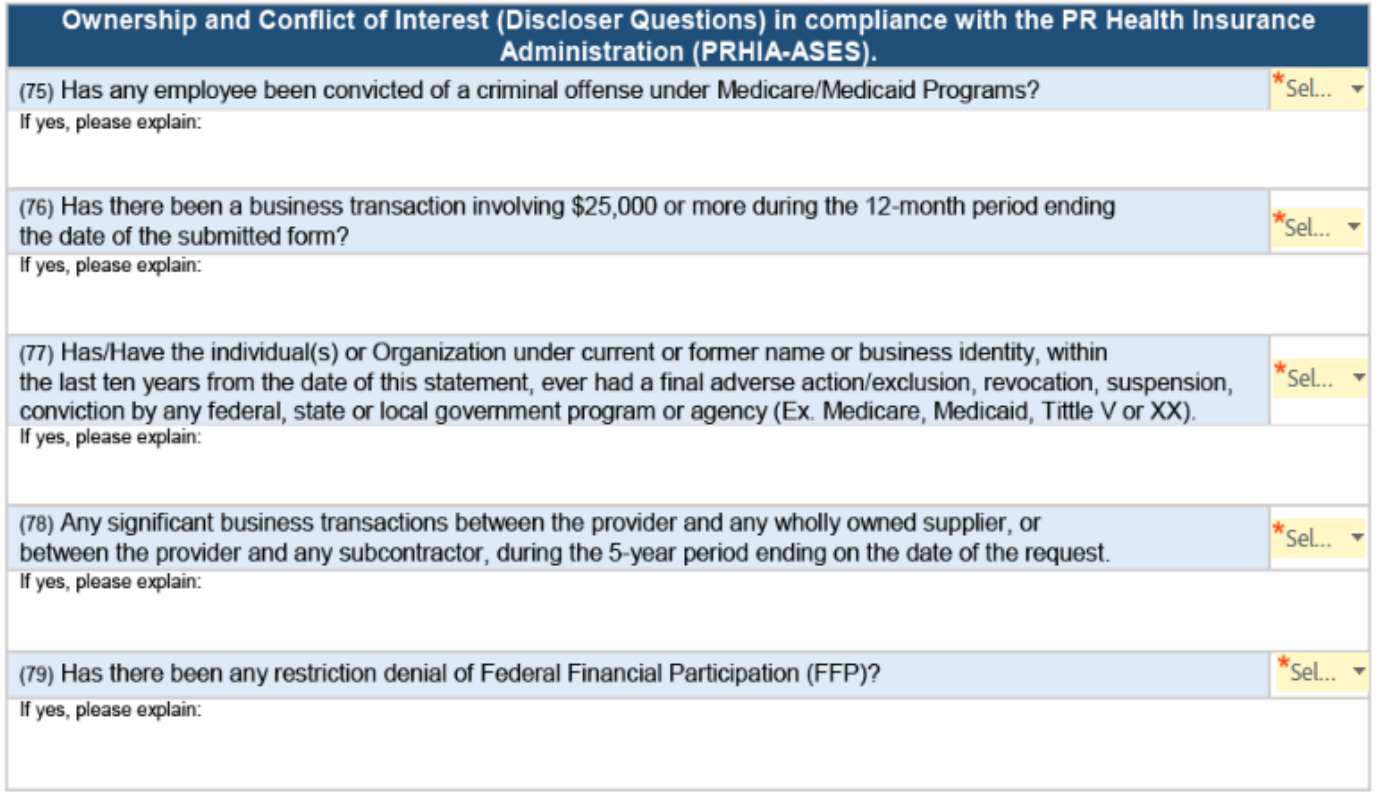
Please check this box if the facility does not have a contracted Facility Director. ☐

Facility Staff 1:

(35) Position:	*Select...						
(36) Last Name:	*						
(37) First Name:	*						
(38) Middle Name:							
(39) Phone Number:	*	(40) Extension:					
(41) Language Services Available:	Spanish ☐	English ☐	Other: ☐				
(42) Ethnicity:	Hispanic or Latino ☐	Not Hispanic or Latino ☐	Declined ☐				
(43) Race: (select one or more)	Black or African American ☐	Native Hawaiian or Other Pacific Islander ☐	White ☐	Asian ☐	American Indian or Alaska Native ☐	Some other race ☐	Declined ☐
(44) Email:	*						

¿Cómo se realiza el proceso? (Continuación)

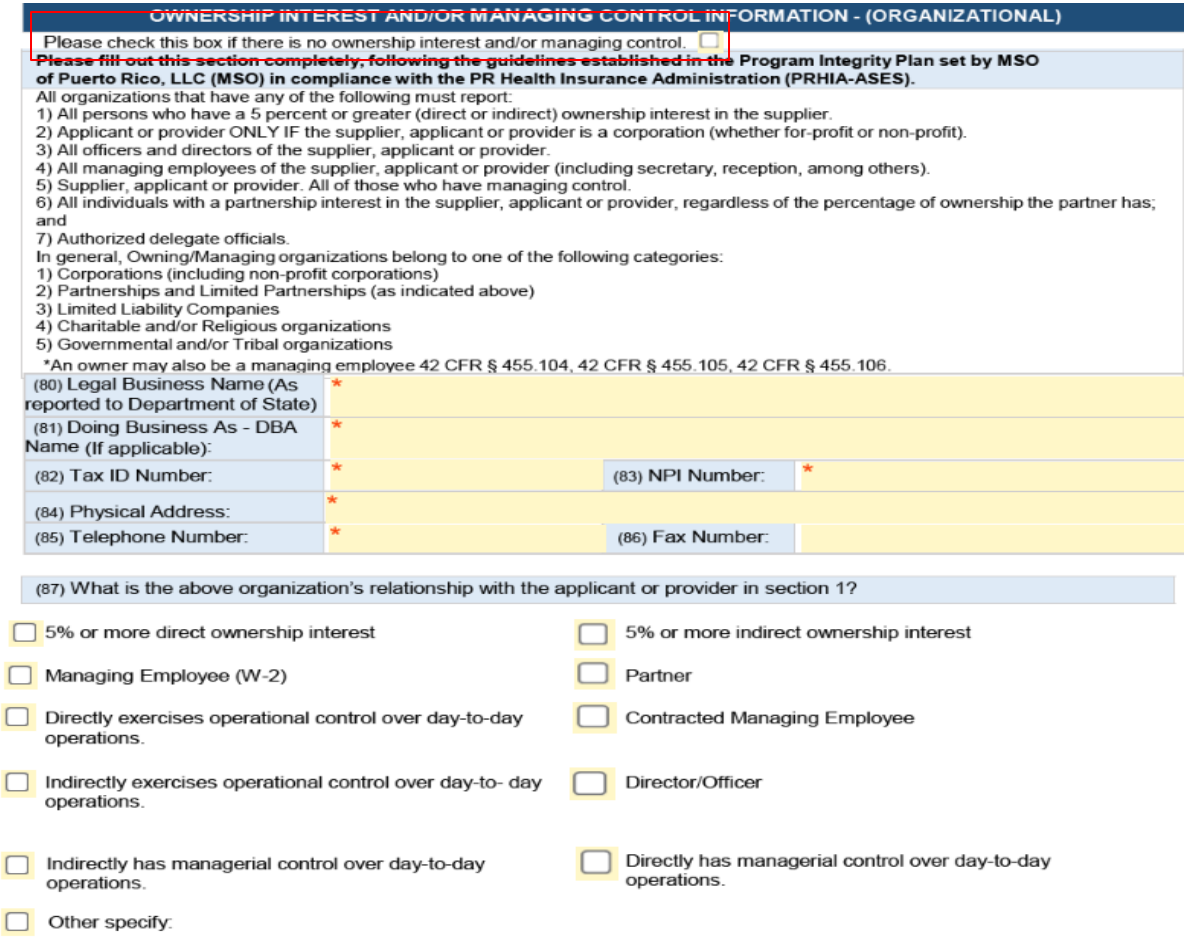
- ✓ En *Ownership and Conflict of Interest Disclosure Questions in compliance with the PR Health Insurance Administration,* haga lo siguiente:
  - ✓ Conteste preguntas con las opciones **Sí** o **No**, a la derecha de la pregunta.
    - ✓ Si la respuesta es **Sí,** ofrezca una explicación en el encasillado bajo la pregunta.



Ownership and Conflict of Interest (Discloser Questions) in compliance with the PR Health Insurance Administration (PRHIA-ASES).	
(75) Has any employee been convicted of a criminal offense under Medicare/Medicaid Programs?	*Sel...
If yes, please explain:	
(76) Has there been a business transaction involving $25,000 or more during the 12-month period ending the date of the submitted form?	*Sel...
If yes, please explain:	
(77) Has/Have the individual(s) or Organization under current or former name or business identity, within the last ten years from the date of this statement, ever had a final adverse action/exclusion, revocation, suspension, conviction by any federal, state or local government program or agency (Ex. Medicare, Medicaid, Tittle V or XX).	*Sel...
If yes, please explain:	
(78) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.	*Sel...
If yes, please explain:	
(79) Has there been any restriction denial of Federal Financial Participation (FFP)?	*Sel...
If yes, please explain:	

¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Ownership Interest and/or Managing Control Information – (Organizational):*
  - ✓ Marque *Please check this box if there is no ownership interest and/or managing control* si no le aplica.
  - ✓ Leer las guías antes de comenzar a llenar la sección.
  - ✓ Incluya:
    - ✓ *Legal Business Name, Doing Business As – DBA Name, Tax ID Number, NPI Number, Physical Address, Telephone Number and Fax Number.*
  - ✓ Contestar la pregunta *What is the above organizations´ relationship with the applicant or Provider in section 1?* marcando todas las opciones que aplican. También hay opción de añadir un *other*.



OWNERSHIP INTEREST AND/OR MANAGING CONTROL INFORMATION - (ORGANIZATIONAL)

Please check this box if there is no ownership interest and/or managing control. ☐

Please fill out this section completely, following the guidelines established in the Program Integrity Plan set by MSO of Puerto Rico, LLC (MSO) in compliance with the PR Health Insurance Administration (PRHIA-ASES).

All organizations that have any of the following must report:
1) All persons who have a 5 percent or greater (direct or indirect) ownership interest in the supplier.
2) Applicant or provider ONLY IF the supplier, applicant or provider is a corporation (whether for-profit or non-profit).
3) All officers and directors of the supplier, applicant or provider.
4) All managing employees of the supplier, applicant or provider (including secretary, reception, among others).
5) Supplier, applicant or provider. All of those who have managing control.
6) All individuals with a partnership interest in the supplier, applicant or provider, regardless of the percentage of ownership the partner has; and
7) Authorized delegate officials.

In general, Owning/Managing organizations belong to one of the following categories:
1) Corporations (including non-profit corporations)
2) Partnerships and Limited Partnerships (as indicated above)
3) Limited Liability Companies
4) Charitable and/or Religious organizations
5) Governmental and/or Tribal organizations

*An owner may also be a managing employee 42 CFR § 455.104, 42 CFR § 455.105, 42 CFR § 455.106.

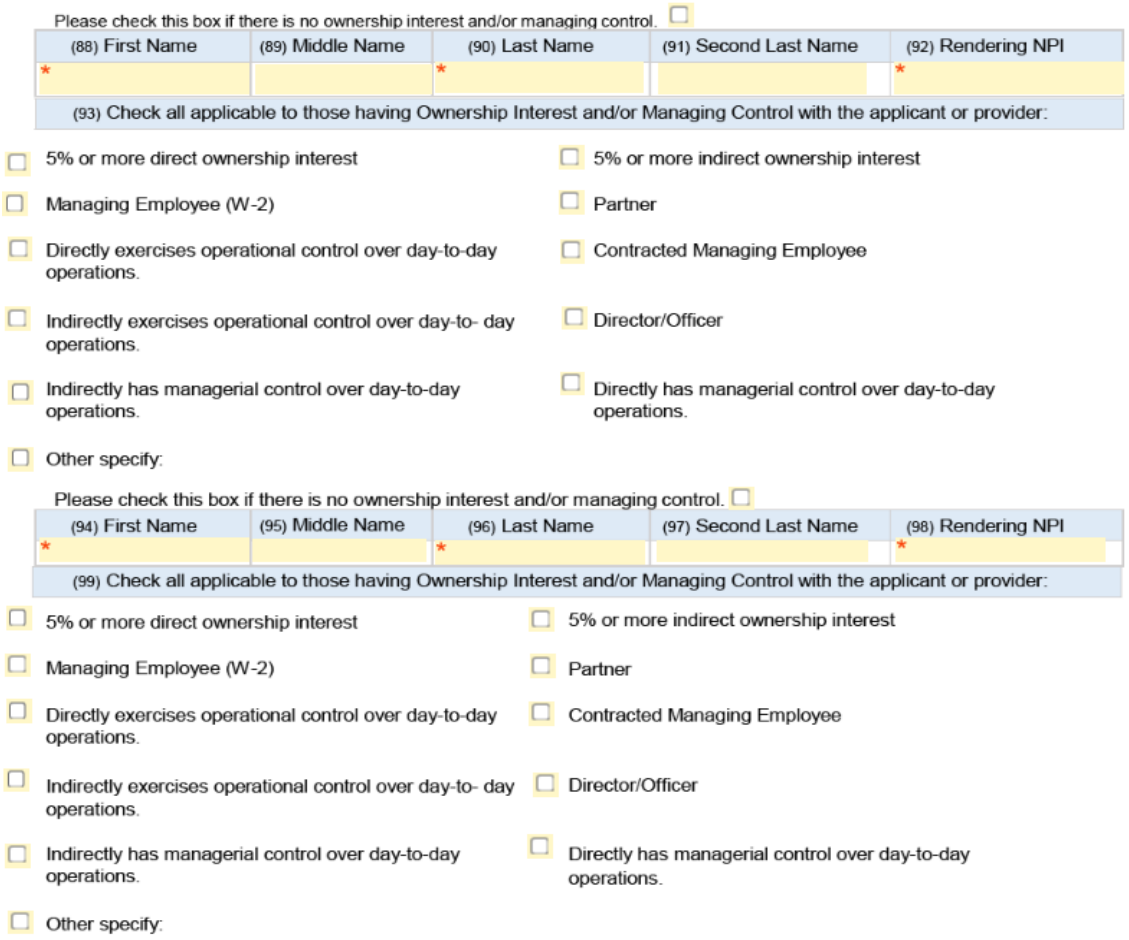
(80) Legal Business Name (As reported to Department of State)	*		
(81) Doing Business As - DBA Name (If applicable):	*		
(82) Tax ID Number:	*	(83) NPI Number:	*
(84) Physical Address:	*		
(85) Telephone Number:	*	(86) Fax Number:	

(87) What is the above organization's relationship with the applicant or provider in section 1?

- ☐ 5% or more direct ownership interest
- ☐ 5% or more indirect ownership interest
- ☐ Managing Employee (W-2)
- ☐ Partner
- ☐ Directly exercises operational control over day-to-day operations.
- ☐ Contracted Managing Employee
- ☐ Indirectly exercises operational control over day-to- day operations.
- ☐ Director/Officer
- ☐ Indirectly has managerial control over day-to-day operations.
- ☐ Directly has managerial control over day-to-day operations.
- ☐ Other specify:

¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Ownership Interest and/or Managing Control Information - (Individuals):*
  - ✓ Si no le aplica, marque *Please check this box if there is no ownership interest and/or managing control.*
  - ✓ Leer las instrucciones antes de continuar.
  - ✓ Este paso le aparecerá tres (3) veces. Incluya:
    - ✓ Nombre, segundo nombre, primer apellido, segundo apellido y *rendering NPI*.
    - ✓ Luego, marcar todas las opciones que apliquen en la pregunta *Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider.*



Please check this box if there is no ownership interest and/or managing control. ☐

(88) First Name	(89) Middle Name	(90) Last Name	(91) Second Last Name	(92) Rendering NPI
*		*		*

(93) Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ 5% or more indirect ownership interest
- ☐ Managing Employee (W-2)
- ☐ Partner
- ☐ Directly exercises operational control over day-to-day operations.
- ☐ Contracted Managing Employee
- ☐ Indirectly exercises operational control over day-to- day operations.
- ☐ Director/Officer
- ☐ Indirectly has managerial control over day-to-day operations.
- ☐ Directly has managerial control over day-to-day operations.
- ☐ Other specify:

Please check this box if there is no ownership interest and/or managing control. ☐

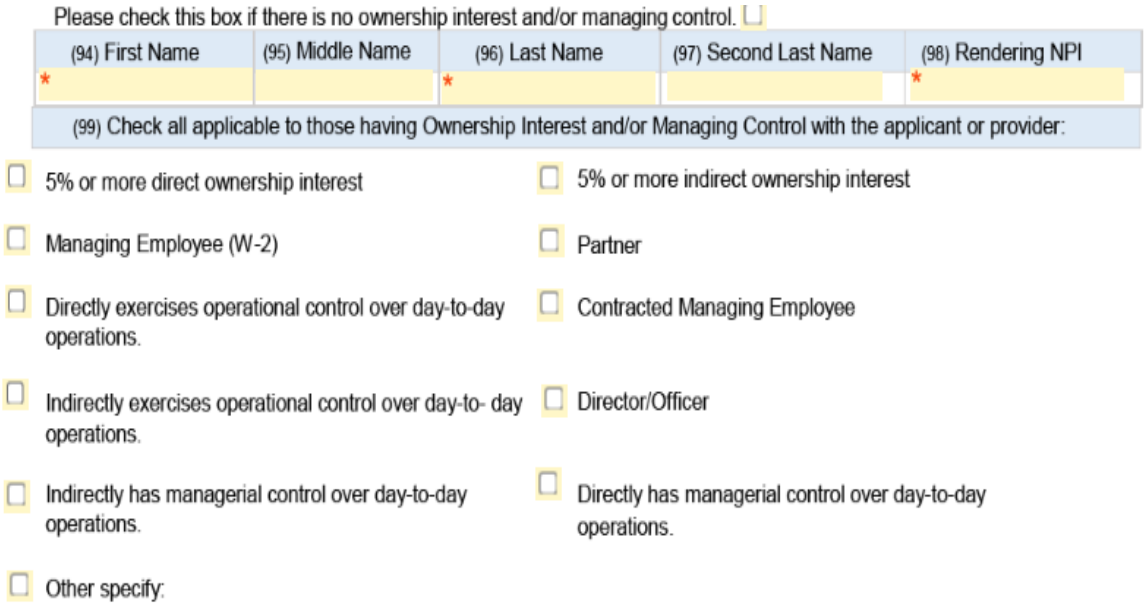
(94) First Name	(95) Middle Name	(96) Last Name	(97) Second Last Name	(98) Rendering NPI
*		*		*

(99) Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- ☐ 5% or more direct ownership interest
- ☐ 5% or more indirect ownership interest
- ☐ Managing Employee (W-2)
- ☐ Partner
- ☐ Directly exercises operational control over day-to-day operations.
- ☐ Contracted Managing Employee
- ☐ Indirectly exercises operational control over day-to- day operations.
- ☐ Director/Officer
- ☐ Indirectly has managerial control over day-to-day operations.
- ☐ Directly has managerial control over day-to-day operations.
- ☐ Other specify:

¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Ownership Interest and/or Managing Control Information- (Individuals)*
  - ✓ Si no le aplica, marque *Please check this box if there is no ownership interest and/or managing control*.
  - ✓ Luego, marque todas las opciones que apliquen en *Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider.*
  - ✓ Si no le aplica, marque *Please check this box if there is no ownership interest and/or managing control*.
  - ✓ Luego, marque todas las opciones que apliquen en *Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider.*
  - ✓ Si no le aplica, marque *Please check this box if there is no ownership interest and/or managing control*.
  - ✓ Luego, marque todas las opciones que apliquen en *Check all applicable to those having Ownership interest and/or Managing Control with the applicant or provider.*


Please check this box if there is no ownership interest and/or managing control.

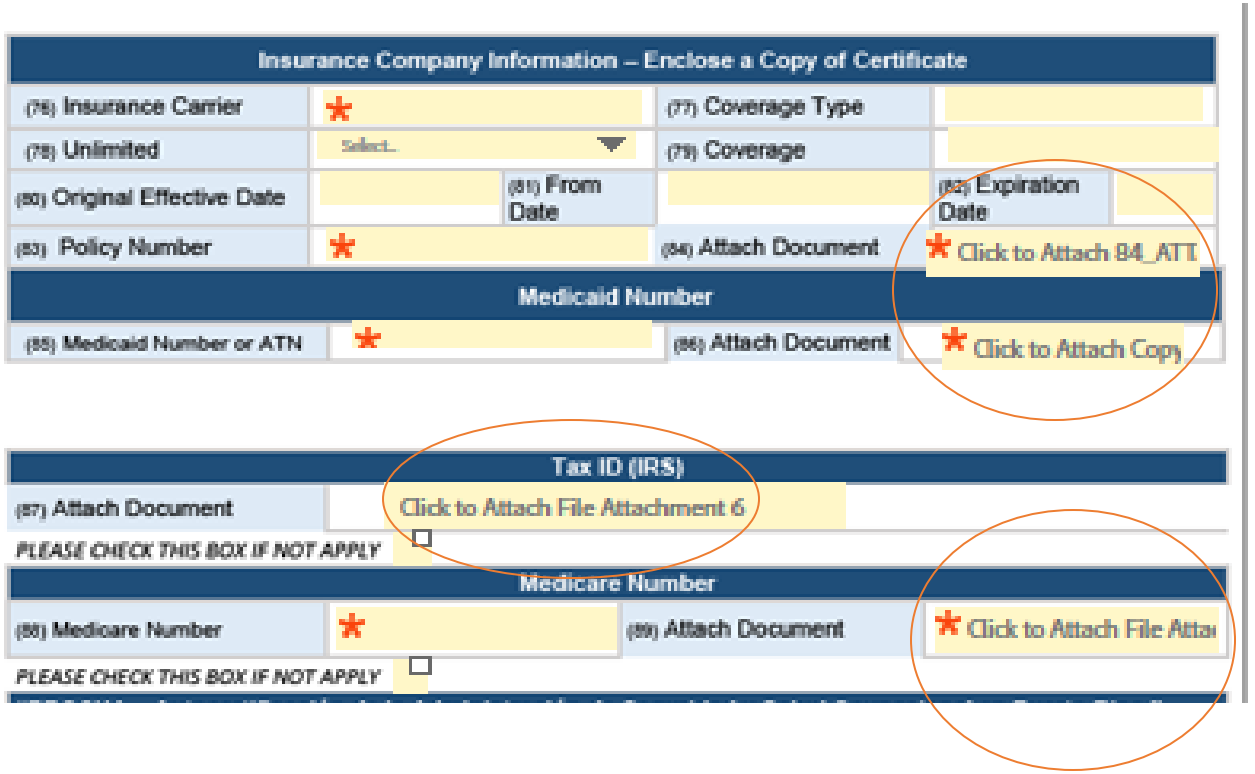
(94) First Name	(95) Middle Name	(96) Last Name	(97) Second Last Name	(98) Rendering NPI
*		*		*

(99) Check all applicable to those having Ownership Interest and/or Managing Control with the applicant or provider:

- 5% or more direct ownership interest
- 5% or more indirect ownership interest
- Managing Employee (W-2)
- Partner
- Directly exercises operational control over day-to-day operations.
- Contracted Managing Employee
- Indirectly exercises operational control over day-to- day operations.
- Director/Officer
- Indirectly has managerial control over day-to-day operations.
- Directly has managerial control over day-to-day operations.
- Other specify:

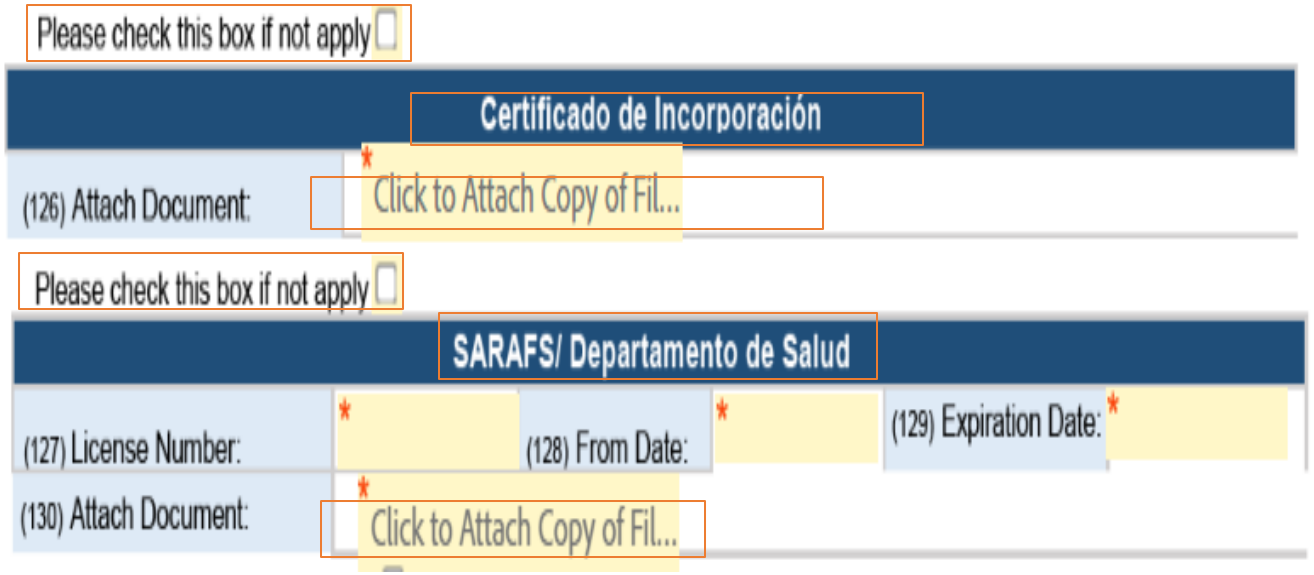
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Insurance Company Information – Enclose a Copy of Certificate*, incluya:
  - ✓ *Insurance carrier, coverage type, unlimited (yes or no), coverage, original effective date, from date, expiration date, policy number, and attach document*.
- ✓ En *Medicaid Number*, incluya:
  - ✓ *Medicaid Number or ATN and attach a copy*.
- ✓ En *Tax ID (IRS),* incluya:
  - ✓ *Attach Document*
- ✓ En *Medicaid Number*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ *Medicare number and attached document.*



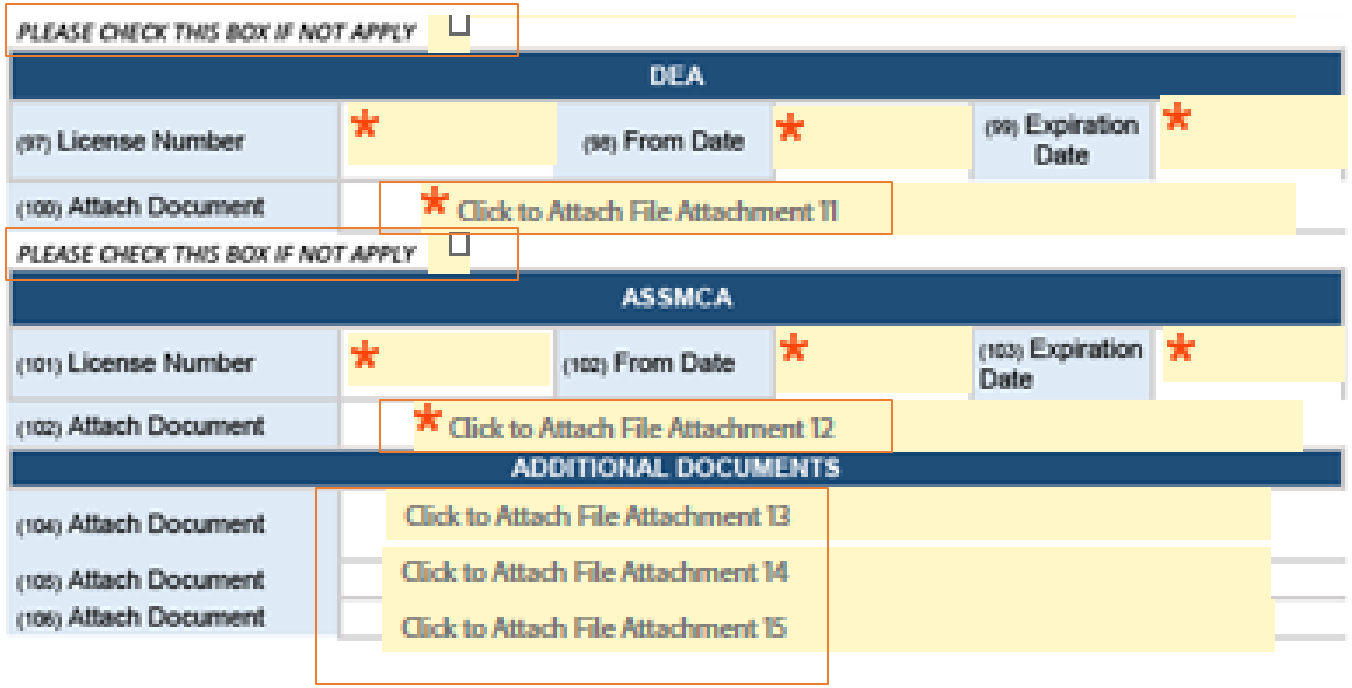
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Certificado de Incorporación*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ *Attach Document*
- ✓ En *SARAFS/Departmento de Salud*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ *License Number, from date and Expiration date.*
    - ✓ *Attach Document*



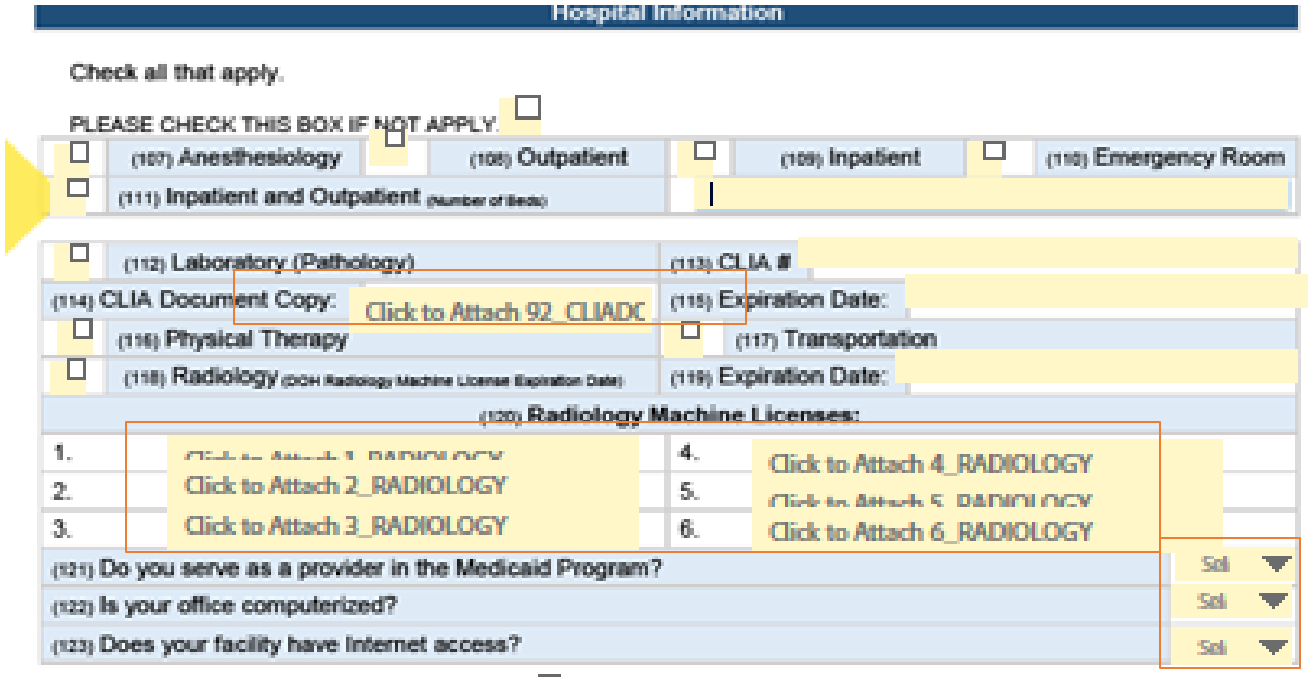
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *DEA*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ *License Number, from date and Expiration date.*
    - ✓ *Attach Document*
- ✓ En *ASSMCA*
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ *License Number, from date and Expiration date.*
    - ✓ *Attach Document*
- ✓ Hay un encasillado adicional para añadir más documentos, si fuera necesario.



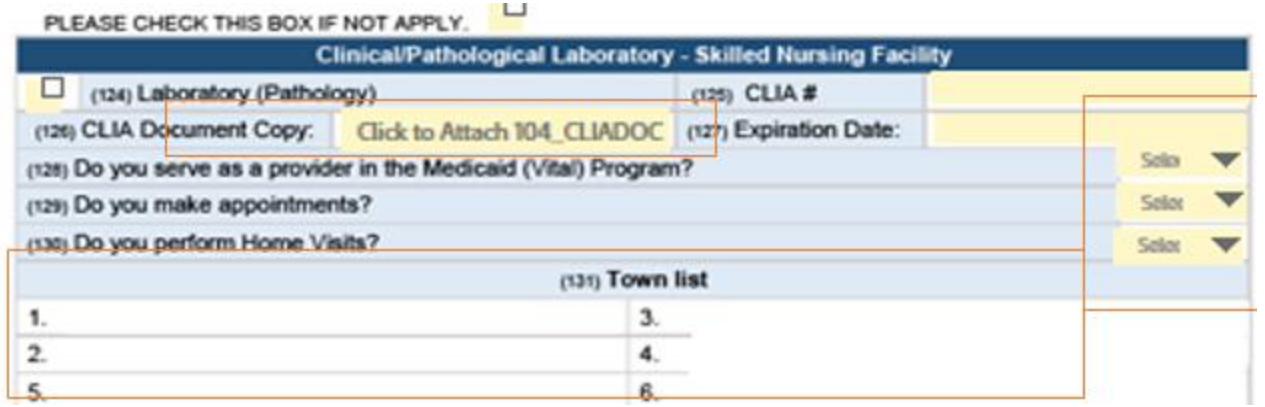
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Hospital Information*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Luego, seleccione todas las opciones que le apliquen, enlace documentos y licencias necesarias, y responda las preguntas con **Sí** o **No**, a la derecha.
- ✓ En *Clinical Pathological Laboratory- Skilled Nursing Facility*:
  - ✓ Si no le aplica, *marque Please check this box if not apply.*
  - ✓ Luego, llene los encasillados y responda las preguntas con **Sí** o **No,** a la derecha.
    - ✓ Si la respuesta a la tercera pregunta es **sí**, incluya los lugares en los encasillados bajo esta.



¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Clinical Pathological Laboratory- Skilled Nursing Facility*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Llene los encasillados e incluya copia de documento de CLIA.
  - ✓ Conteste preguntas #128-#130 con **Sí** o **No**. Estas opciones están a la derecha de la pregunta.
  - ✓ Si la respuesta a la pregunta #130 es **Sí**, enliste los lugares en los encasillados que dicen *Town List*.



¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Radiology Machine License*, incluya:
  - ✓ Llene los encasillados de DOH Radiology Machine License y la fecha de expiración.
  - ✓ Incluya enlace a las licencias.

- En *Radiology Services*:

  - ✓ Marque los servicios y acreditaciones que tenga la facilidad emitidos por la American College of Radiology (ACR).
  - ✓ Incluya las licencias.

Please check this box if not apply ☐

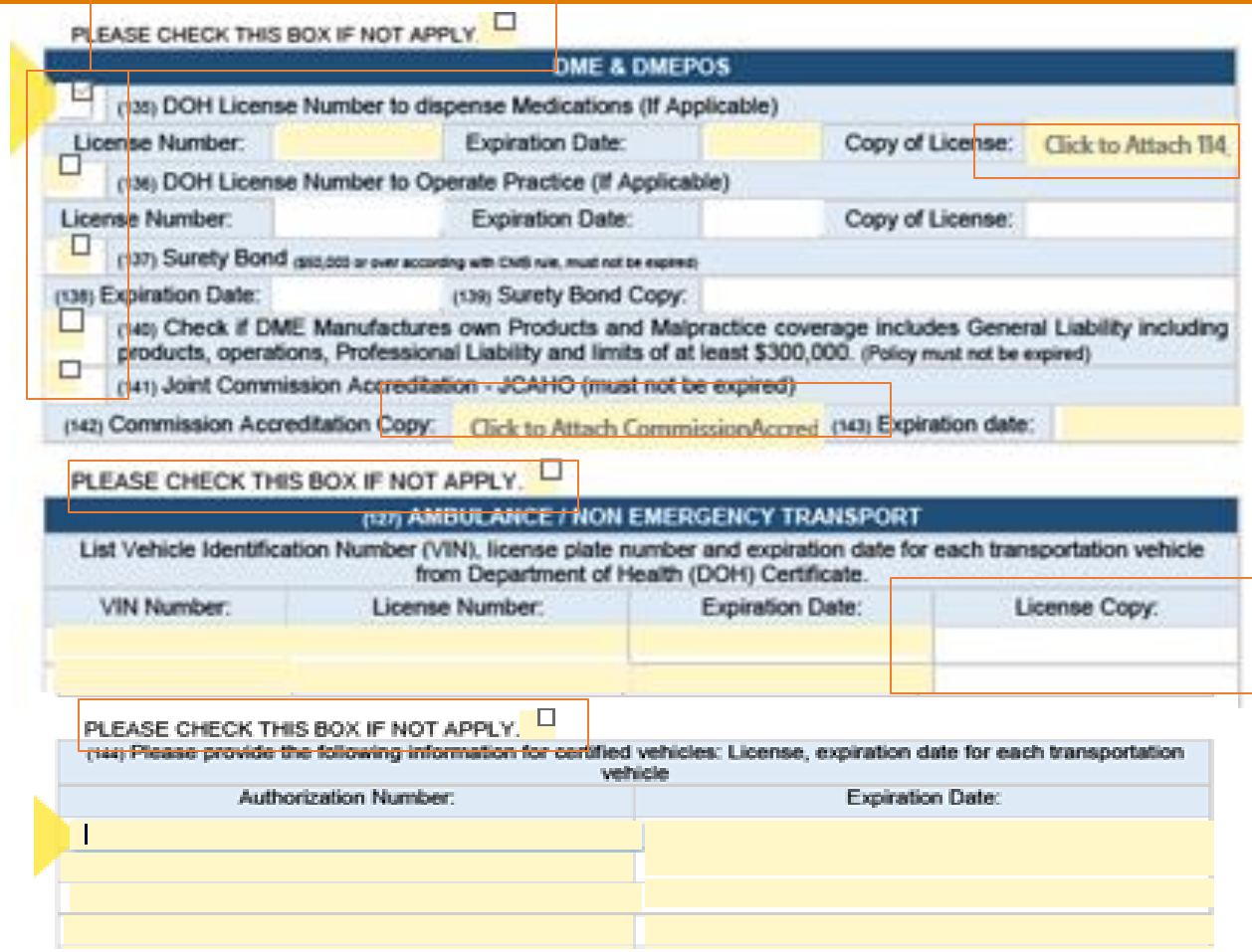
Radiology Facility with Mammogram			
☐	(167) DOH Radiology Machine License:	(168) Expiration Date:	
(169) Radiology Machine License			
1.		4.	
2.		5.	
3.		6.	

Please check this box if not apply ☐

Radiology Services	
Services	Certification (ACR) (Please Upload Document)
☐ Conventional Radiology	
☐ Breast Ultrasound	
☐ CT	
☐ Mammography	
☐ MRI	
☐ Nuclear Medicine & PET	
☐ Radiation Oncology Practice	
☐ Stereotactic Breast Biopsy	
☐ Ultrasound	

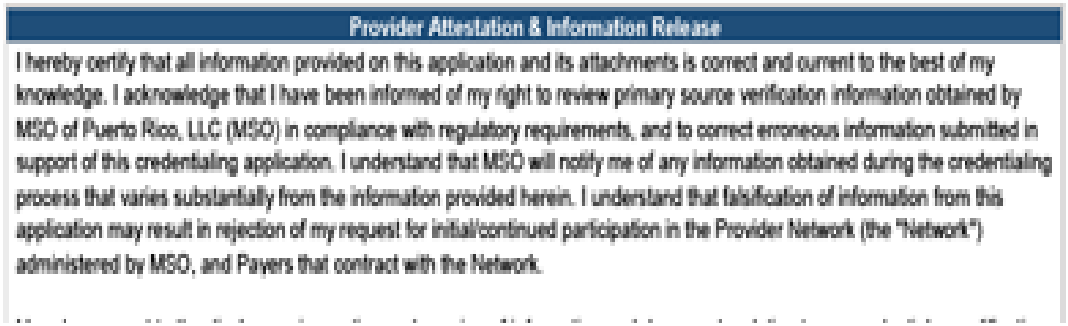
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *DME & DMEPOS*:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Luego, llene los encasillados e incluya copia de licencia y *commission accreditation copy*.
- ✓ En la sección de *Ambulance/Non Emergency Transport:*
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ *VIN number, license number*, *expiration date* y el *license copy* de cada vehículo de transportación.
- ✓ En la siguiente sección:
  - ✓ Si no le aplica, marque *Please check this box if not apply.*
  - ✓ Incluya:
    - ✓ Licencias y fechas de expiración para cada vehículo de transportación.



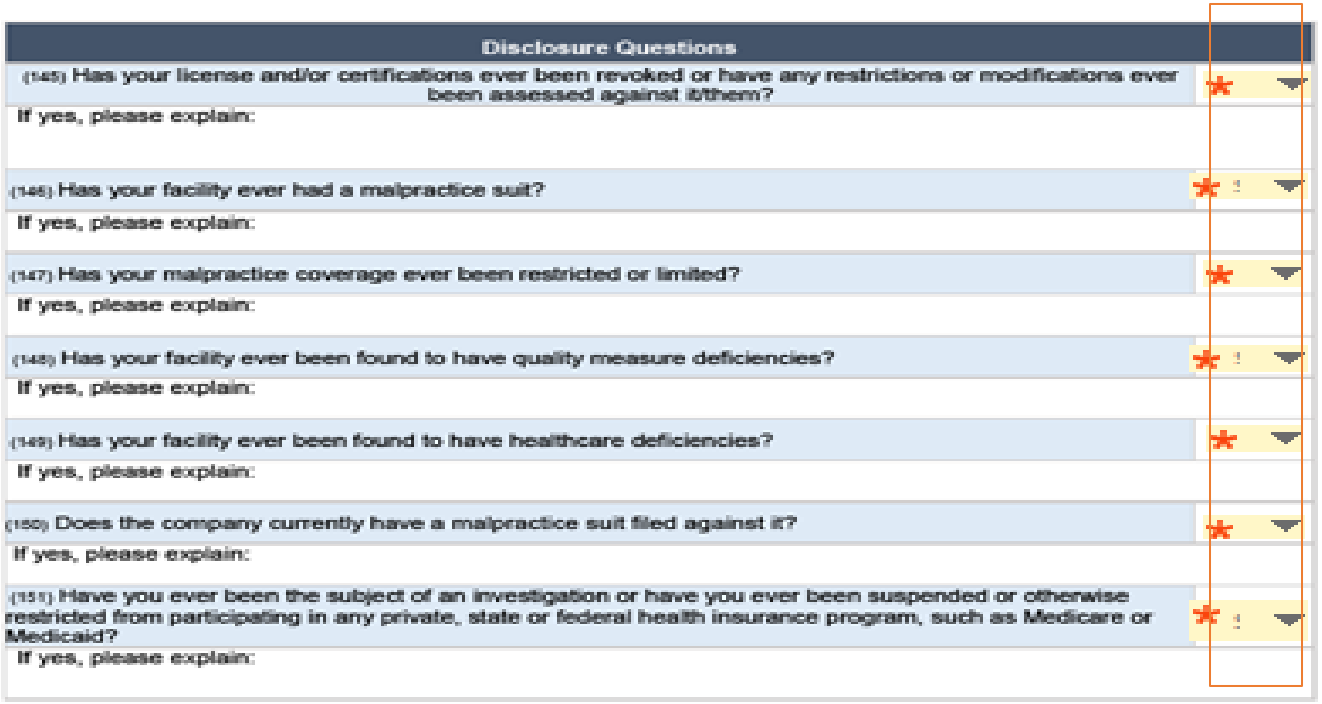
¿Cómo se realiza el proceso? (Continuación)

- ✓ En *Disclosure questions,* conteste las preguntas con **Sí** o **No**.
  - ✓ Si la respuesta es **Sí**, explique en el encasillado bajo la pregunta.
- ✓ Leer completamente el *Provider Attestation & Information Release* antes de continuar con la siguiente sección.



Provider Attestation & Information Release

I hereby certify that all information provided on this application and its attachments is correct and current to the best of my knowledge. I acknowledge that I have been informed of my right to review primary source verification information obtained by MSO of Puerto Rico, LLC (MSO) in compliance with regulatory requirements, and to correct erroneous information submitted in support of this credentialing application. I understand that MSO will notify me of any information obtained during the credentialing process that varies substantially from the information provided herein. I understand that falsification of information from this application may result in rejection of my request for initial/continued participation in the Provider Network (the "Network") administered by MSO, and Payers that contract with the Network.



Disclosure Questions

(145) Has your license and/or certifications ever been revoked or have any restrictions or modifications ever been assessed against it/them? *

If yes, please explain:

(146) Has your facility ever had a malpractice suit? *

If yes, please explain:

(147) Has your malpractice coverage ever been restricted or limited? *

If yes, please explain:

(148) Has your facility ever been found to have quality measure deficiencies? *

If yes, please explain:

(149) Has your facility ever been found to have healthcare deficiencies? *

If yes, please explain:

(150) Does the company currently have a malpractice suit filed against it? *

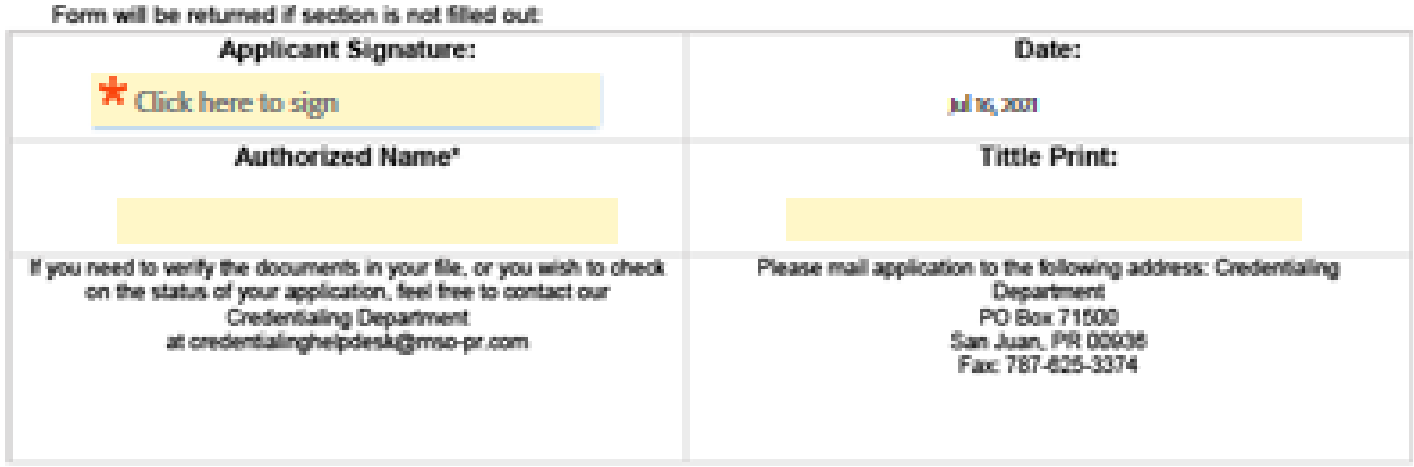
If yes, please explain:

(151) Have you ever been the subject of an investigation or have you ever been suspended or otherwise restricted from participating in any private, state or federal health insurance program, such as Medicare or Medicaid? *

If yes, please explain:

¿Cómo se realiza el proceso? (Continuación)

- ✓ Escribir su nombre en *Applicant Signature.*
- ✓ Recuerde que, al pulsar *click to sign*, recibirá un correo electrónico de Adobe para confirmar y enviar la aplicación completada.



Form will be returned if section is not filled out:

Applicant Signature:	Date:
* Click here to sign	jul 16, 2021
Authorized Name*	**Tittle Print:**
If you need to verify the documents in your file, or you wish to check on the status of your application, feel free to contact our Credentialing Department at credentialinghelpdesk@mso-pr.com	Please mail application to the following address: Credentialing Department PO Box 71500 San Juan, PR 00936 Fax: 787-625-3374

Credentialing Staff

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¿Aún tiene dudas sobre el proceso?

- Si necesita actualizar alguna credencial vencida para mantener su expediente al día, envíe la información a: **CredentialingUpdates@mso-pr.com**.
- Puede comunicarse a través del app InnovaMD Chat al seleccionar la opción **Credenciales**.
- De necesitar información adicional, llame a Servicios al Proveedor al:
  - **787-993-2317 (Área Metro)**
  - **1-866-676-6060 (Libre de cargos)**

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