# DOULA SERVICES PRACTITIONER CREDENTIALING APPLICATION CHECKLIST

Doula Services Practitioners should complete this application checklist and submit it along with all required documentation so that we may ensure that you meet our criteria for participation in our network(s).

For your convenience and ease-of-use, you need only complete this single, consolidated application checklist to be considered for participation in one or in both of our networks:

- Horizon NJ Health Network (to treat patients enrolled in Medicaid/NJ FamilyCare plans)
- Horizon Managed Care Network (for members enrolled in commercial plans).

Though we require that you review, complete and sign a separate agreement for each network in which you are seeking to be credentialed, we do not expect you to provide other details/information more than once.

Please note that some fields and documentation requirements outlined on the following pages apply only if you are seeking to be credentialed in our Horizon NJ Health Network (Medicaid/NJ FamilyCare). If you are not seeking to participate in this network, you need not complete those fields or include that documentation.

Email DoulaRecruitment@HorizonBlue.com if you have questions about Doula credentialing.

## CREDENTIALING PROCESS OVERVIEW

Below is an overview of what you need to do, and what you can expect from us, as you proceed through our credentialing process.

### Complete This Application

Complete the fields on this application checklist, as appropriate.

### Gather Required Documentation

Gather/prepare the documentation below, as appropriate.

- ☐ A copy of your certificate showing successful completion of doula training from an approved Doula Training Organization.
- ☐ Your Curriculum Vitae (CV) or Resume organized by month/year and outlining your work history from completion of Doula training to the present. Please explain any gaps in work history of greater than six months.
- ☐ A completed W-9 for each Tax Identification Number under which you practice.
- ☐ A copy of your professional liability (malpractice) insurance certificate face sheet from a carrier authorized to issue policies for the state in which your primary office is located. The face sheet must display your name, the policy effective date, expiration date, and coverage limits. A minimum of $1 million per occurrence and $3 million aggregate is required.
- ☐ Proof of your enrollment in FFS NJ FamilyCare.
  (Only required if you are seeking to participate in the Horizon NJ Health Network (Medicaid/NJ FamilyCare).
- ☐ A completed and signed Horizon NJ Health Network (Medicaid/NJ FamilyCare) Agreement, as appropriate. Participation in this network allows you to treat members enrolled in Medicaid/NJ FamilyCare plans. See instructions for obtaining agreements on the following page.
- ☐ A completed and signed Horizon Managed Care Network (commercial) Agreement, as appropriate. Participation in this network allows you to treat members enrolled in Individual Health Coverage (IHC) Program plans within the Horizon Managed Care Network (commercial) at an in-network level of benefits. See instructions for obtaining agreements on the following page.

**INSTRUCTIONS FOR OBTAINING AGREEMENTS**
Please email DoulaRecruitment@HorizonBlue.com to request copies of the agreements noted on the previous page.

In your email, please include:

- Your name
- Your address
- Your phone number
- The agreements you are seeking (i.e., the Horizon Managed Care Network (commercial) Agreement, the Horizon NJ Health Network (Medicaid/NJ FamilyCare) Agreement, or both agreements

## Submit Your Application

Submit this completed application checklist along with all supporting documentation to Horizon:

- Email to DoulaRecruitment@HorizonBlue.com
- Or mail to: **Horizon Credentialing & Recredentialing Department**
  **Three Penn Plaza East, PP-14C**
  **Newark, NJ 07105-2200**

## Our Response to You

We will send written notice to advise you that we have received your Application.

You have the right to review the information submitted and we will notify you if any information obtained during the credentialing process varies substantially from the information you provided.

We will withdraw Applications that do not include all required information. If your Application is withdrawn, you will be required to submit a new Application.

## Our Credentialing Process

Our process may take up to **60 days** from the date that we have all required information. We will send a written response to advise you of our credentialing determination.

Email DoulaRecruitment@HorizonBlue.com to check your Application status if 60 days have passed and you have not received our credentialing determination.

After we approve your application, we will email you a letter that includes your participation effective date, instructions to access a welcome kit of important information, and copies of your fully executed Agreements.

## CONTACT FOR CREDENTIALING/RECREDENTIALING

Please provide information about a person who can address credentialing or recredentialing questions we might have.

Contact Person Name _____

Contact Person Title _____

Contact Person Telephone Number _____

Contact Person FAX Number _____

Contact Person E-mail Address _____

## DOULA INFORMATION

Doula First Name _____

Doula Middle Initial _____

Doula Last Name _____

Doula Date of Birth _____

Doula Gender

- ☐ Female
- ☐ Male

Doula Social Security Number _____

Doula Type 1 National Provider Identifier (NPI) _____

Doula Medicaid Number
Required for Horizon NJ Health Network (Medicaid/NJ Family Care) participation _____

Languages spoken (other than English) _____

### Doula Race and Ethnicity

We display practitioner race and ethnicity in our online and printed directories so our members can consider this information as one of the factors when making decisions about in-network care. Though not required, your providing race/ethnicity information helps us address racial and ethnic health disparities in the communities we serve by allowing members to select a provider that matches their cultural needs. Choosing not to disclose this information will have no impact on your credentialing or your participation in our networks.

**DOULA RACE**

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Other Race
- ☐ Unknown
- ☐ I Prefer Not to Respond

**DOULA ETHNICITY**

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Other Ethnicity
- ☐ Unknown
- ☐ I Prefer Not to Respond

## DOULA PRACTICE INFORMATION

Please provide information pertaining to your primary practice location below. If you practice at multiple locations, please include a separate sheet to include the details requested below for each additional location.

Primary Practice Name _____

Primary Practice Address _____

County in which your practice is located _____

Is the Primary Practice Address above also your residential address? If you select "Yes," we will NOT display your residential address in our online and printed directories.

☐ Yes

☐ No

Primary Practice Telephone Number _____

Primary Practice Website Address (URL) _____

Primary Practice Email _____

Telephone Number that patients call to make appointments _____

Primary Practice Billing Address _____
Please provide a physical street address above. PO Box information is NOT acceptable.

Primary Practice Billing Address Telephone _____

Primary Practice Billing Address Email Address _____

### Group Practice Information

If you participate with a group practice, please complete the following fields. If you participate with multiple group practices, please include a separate sheet to include the details requested below for each practice. If you are a solo practitioner and not affiliated with a group practice, you may leave these fields blank.

Group Practice Name My Doula Group

Group Practice Address _____

☐ I use my Social Security Number in lieu of TIN as my group practice identification number.

Group Practice Tax Identification Number (TIN) _____

Group Practice Type 2 National Provider Identifier (NPI) _____

Group Practice Billing Address _____
Please provide a physical street address above. PO Box information is NOT acceptable.

Group Practice Billing Address Telephone _____

Group Practice Billing Address Email Address _____

## PROFESSIONAL LIABILITY INSURANCE COVERAGE

Please complete the fields below to provide information about your professional liability (malpractice) insurance coverage.

Name of Current Malpractice Insurance Carrier _____

Address of Carrier _____

Policy Number _____

Period of Coverage _____

Amount of Coverage per Occurrence _____

Amount of Coverage per Aggregate _____

In addition to the information above, please also include a copy of your current malpractice insurance certificate face sheet from a carrier authorized to issue policies for the state in which your primary office is located with this application. The face sheet must display your name, the policy effective date, expiration date, and coverage limits. A minimum of $1 million per occurrence and $3 million aggregate is required.

## DOULA TRAINING

Complete the fields below to provide information about the Doula Training you completed. In addition to the information below, please also include proof of your completion of Doula Training with this application.

Name of Doula Training Institution _____

Doula Training Start Date (MM/YY) _____

Doula Training End Date (MM/YY) _____

## SPECIAL NEEDS TRAINING/EXPERIENCE

Complete the fields below to help us understand the patient populations you treat as well as the level of training and/or experience you have treating patients with special needs.

- This section is required if you are seeking to participate with our Horizon NJ Health (Medicaid/NJ FamilyCare) network.
- You do not need to complete this section if you are not seeking to participate with our Horizon NJ Health (Medicaid/NJ FamilyCare) network.

### Patient Populations

Check the appropriate boxes below to indicate the patient population categories you currently treat and to indicate if you are accepting new patients in these categories.

☐ Do you treat children age 0 to 5?

☐ Are you accepting new patients age 0 to 5?

☐ Do you treat children age 6 to 12?

☐ Are you accepting new patients age 6 to 12?

☐ Do you treat adolescents age 13 to 17?

☐ Are you accepting new patients age 13 to 17?

☐ Do you treat adults age 18 to 64?

☐ Are you accepting new patients age 18 to 64?

☐ Do you treat adults age 65 and older?

☐ Are you accepting new patients age 65 and older?

## Special Needs Training/Experience

Do you have formal training and/or experience treating patients with special needs including persons with physical, mental, substance abuse or developmental disabilities?

☐ Yes

☐ No

If you selected "Yes" above, please check the appropriate boxes below to indicate the special needs categories for which you have formal training and/or experience treating. For each category you select, please provide details about the formal training you received and/or your experience. Include a separate sheet if more space is required for your details.

☐ Developmentally Disabled Patients

Training/Experience _____

☐ Patients who are Blind

Training/Experience _____

☐ Patients who are Deaf

Training/Experience _____

☐ Non-Ambulatory Patients

Training/Experience _____

☐ Patients who have HIV/Aids?

Training/Experience _____

## INDIVIDUAL DISCLOSURE QUESTIONS

Please answer "Yes" or "No" to each individual disclosure question below.

1. Have you been the subject of an investigation, or have proceedings ever been initiated to have your doula training/certification to practice limited, suspended, revoked, denied, sanctioned or subject to probationary conditions, or have you voluntarily or involuntarily relinquished your doula training/certification in this or any other state?

   ☐ No

   ☐ Yes

2. If applicable, have you ever received a reprimand or been fined by any state medical board?

   ☐ No

   ☐ Yes

   ☐ N/A

3. If applicable, has your medical staff membership, employment, or medical staff status at any health care institution, ever been rejected, limited, suspended, revoked, not renewed or subject to probationary conditions, or have you been the subject of an investigation, or, relinquished medical staff membership or clinical privileges while under investigation or disciplinary action, or are any such actions pending?

- ☐ No
- ☐ Yes
- ☐ N/A

4. If applicable, have you ever received sanctions, been the subject of an investigation or currently the subject of an investigation by any medical facility, training/certification authority, education or training program, Medicare or Medicaid program, or any other private, federal or state health program?

- ☐ No
- ☐ Yes
- ☐ N/A

5. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your individual liability history?

- ☐ No
- ☐ Yes

6. Have you ever had any malpractice actions (pending, settled, dropped, dismissed, arbitrated, mediated, or litigated)?

- ☐ No
- ☐ Yes

7. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any felony?

- ☐ No
- ☐ Yes

8. Have you ever been convicted of, pled guilty to, or pled nolo contendere to any misdemeanor (excluding minor traffic violations), or have you ever been found liable or responsible for or named as a defendant in any civil offense that alleged fraud, an act of violence, child abuse or a sexual offense or sexual misconduct?

- ☐ No
- ☐ Yes

9. Have you ever been indicted in any civil or criminal suit?

- ☐ No
- ☐ Yes

10. Are you able to perform the essential functions of a practitioner in your area of practice with or without reasonable accommodation?

- ☐ No
- ☐ Yes

11. Are you currently engaged in the illegal use of drugs?

- ☐ No
- ☐ Yes

12. Do you use any chemical substances that would in any way impair or limit your ability to practice medicine and perform the functions of your job with reasonable skill and safety?

- ☐ No
- ☐ Yes

## Disclosure Explanations

If you responded "Yes" to any questions above, please provide explanation(s) below. Include a separate sheet if more space is required for your response(s).

## DISCLOSURE STATEMENT: INDIVIDUAL PRACTITIONERS AND GROUPS OF PRACTITIONERS

Doulas seeking to participate with our Horizon NJ Health Network (Medicaid/NJ FamilyCare) must complete this section. If you are not seeking to participate in this network, you need not complete the fields in this section.

Federal and State law require this form to be completed by any individual practitioner or group of practitioners with a contractual arrangement with Horizon NJ Health relating to the managed Medicaid and NJ FamilyCare programs. Horizon must provide this information to DMAHS upon request.

Please direct any questions regarding this details in this section to your legal counsel and refer to the New Jersey Medicaid HMO Contract as well as 42 CFR 455.100, et seq.

### Identifying Information of the Provider

Name of Disclosing Provider and D/B/A _____

Street Address of Disclosing Provider and D/B/A _____

City of Disclosing Provider and D/B/A _____

County of Disclosing Provider and D/B/A _____

State of Disclosing Provider and D/B/A _____

Zip Code of Disclosing Provider and D/B/A _____

Telephone Number of Disclosing Provider and D/B/A _____

NJ Medicaid Provider Number of Disclosing Provider and D/B/A _____

### Disclosure by Provider: Information Related to Business Transactions

42 C.F.R. §455.105(b)(1) requires disclosure of ownership information for any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

Has this individual practitioner or group practice had business transactions with a subcontractor totaling more than $25,000 during the past 12-month period?

☐ No

☐ Yes

If you selected "Yes" above, provide the following information. Include additional pages as necessary.

Name 1 _____

Address 1 _____

Ownership 1 _____

Name 2 _____

Address 2 _____

Ownership 2 _____

42 C.F.R. §455.105(b)(2) requires disclosure of significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the past 5 years. "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 or 5 percent of a provider's total operating expenses.

Has this individual practitioner or group practice had significant business transactions with a wholly owned supplier and/or a subcontractor during the past 5 years?

☐ No

☐ Yes

If you selected "Yes" above, provide the following information. Include additional pages as necessary.

Name of Parties to Transaction 1 _____

Amount of Transaction 1 _____

Date of Transaction 1 _____

Nature of Transaction 1 _____

Name of Parties to Transaction 2 _____

Amount of Transaction 2 _____

Date of Transaction 2 _____

Nature of Transaction 2 _____

## Disclosure of Information on Persons Convicted of Crimes

42 C.F.R. §455.106(a) requires identification of any person who has ownership or control interest in the provider, or is a director, officer, agent or managing employee of the provider, and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs.

Has any person with ownership or control interest in the provider, or who is a director, officer, agent or managing employee of the provider been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, CHIP, or the Title XX services program since the inception of those programs?

☐ No

☐ Yes

If you selected "Yes" above, provide the following information. Include additional pages as necessary.

Person 1 Name _____

Person 1 Address _____

Person 1 Date of Birth _____

Person 1 Social Security Number _____

Tax Identification Number (TIN) _____

Person 2 Name _____

Person 2 Address _____

Person 2 Date of Birth _____

Person 2 Social Security Number _____

Tax Identification Number (TIN) _____

## Disclosure statement Attestation

☐ I attest that the information provided in this Disclosure Statement section is accurate and complete.

Whoever knowingly and willfully makes or causes to be made a false statement or representation on this Disclosure Statement may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate, or where the provider already participates, a termination of its agreement or contract with the Horizon NJ Health Network (Medicaid/NJ FamilyCare), as appropriate.

## DOULA APPLICATION ATTESTATION

By signing below, I attest that all answers provided and the information submitted as part of this application checklist are true and correct to the best of my knowledge and belief. I understand that any of this information that we find to be false, misleading or incomplete, could result in denial of this application or termination of my participation in the networks.

## Signature Requirement

Practitioner Name _____

Practitioner Signature _____

Date of Signature _____