



## Doula Application Checklist

New Jersey | Medicaid

Wellpoint accepts the application from the Council for Affordable Quality Healthcare (CAQH). Provide a CAQH ID number below. If you are unable to use CAQH, you may submit our *Individual or Agency Doula Application*.

### CAQH information

**ID Number:**

**Contact name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Contact email:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

### Required documentation for individual doulas or doula agencies

This information is necessary even if a CAQH ID number is available. Doulas operating under doula agencies will require credentialing.

#### Provide the following documentation:

- Certificate of Professional Liability Insurance* that includes carrier name, policy number, minimum coverage limits of \$1 million/\$3 million, and policy period. The insured's name and address must match the CAQH application. The policy must not expire within 60 days.
- Doula Certificate or Doula Agency License*

#### Complete the following documentation:

- Group Application* (for doula agencies or doula groups operating under a registered doula company name)
- Individual or Agency Doula Application* (for individual doulas or doula agencies that do not have a CAQH ID number)
- Disclosure of Ownership and Control Interest Statement*
- Americans With Disabilities Act Survey* — required if you operate out of a home or office location.  
(Select Works out of home, if applicable.)
- Criminal Background Check Attestation Form*
- Division of Developmental Disabilities and Aged, Blind, and Disabled Form*

We look forward to working together to achieve improved outcomes.



## Individual or Agency Doula Application

New Jersey | Medicaid

### Instructions

Please complete this form and submit it to [Availity.com](#). Select Payor Spaces > Wellpoint logo > Begin New Application. Email questions to [rhonnda.talton@wellpoint.com](mailto:rhonnda.talton@wellpoint.com).

#### New Jersey provider identification

Last name:

First name:

MI:

DOB:

SSN:

M  F

Medicaid No.:

National Provider Identifier:

Email address:

In order to meet Wellpoint's diversity goals, select your race/ethnic group. This step is voluntary.

Asian or Pacific Islander  Black  Hispanic  Native American  White  Confidential —  
Do not ask

What non-English languages are fluently spoken by you and your staff?

English only

Provider age range of patients:

All ages  Not younger than \_\_\_\_ years of age and/or not older than \_\_\_\_ years of age.

#### Primary office location or residential address

P.O. box is not acceptable. Residential addresses will not be displayed in the Wellpoint directory. Only the doula's name, city, state, and telephone number will be displayed in the directory. Doula agency locations will be displayed in the directory.

Practice location name:

Street, Suite:

City:

State:

ZIP:

County:

Phone:

Fax:

Primary credential contact/phone:

Does provider bill from this address?  Y  N

*Individual or Agency Doula Application*

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**Billing information (P.O. box is acceptable)**

**Billing location name:**

**Street, Suite:**

**City:**

**State:**

**ZIP:**

**Phone:**

**Tax ID:\***

\* If you do not have a tax ID (TIN), provide SSN.

**Does provider bill from this address?  Y  N**

**Appointment hours**

**Monday:**

**Tuesday:**

**Wednesday:**

**Thursday:**

**Friday:**

**Saturday:**

**Sunday:**

**Insurance**

Attach a copy of liability insurance face sheet indicating professional coverage.

**Current carrier name:**

**Policy No:**

**Coverage type:**

**Effective date:**

**Expiration date:**

**Per incident \$:**

**Aggregate \$:**

**National provider identifier**

**Name:**

**NPI:**

**Taxonomy code(s):** 374J00000X

**Credential questions**

1. Do you have reasons for any inability to perform the essential function of the position, with or without accommodation?

Y  N

### Credential questions

- |   |   |
|---|---|
| 2. Do you have any history or current problems with chemical dependency or substance use disorder, including alcohol?   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 3. Do you have a history of license revocation, suspension, voluntary relinquishment, probationary status, or other licensure condition or limitation?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 4. Do you have a history of conviction of a criminal offense other than minor traffic violations?   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 5. Do you have a history of loss or limitation or privileges or disciplinary activity, to include denial, suspension, termination or nonrenewal of professional privileges?   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 6. Do you have a history of complaints or adverse action reports filed with a local, state, or national professional society or licensing board?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 7. Do you have a history of refusal or cancellation of professional liability insurance?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 8. Do you have a history of suspension or revocation of a <i>DEA Certificate</i> ?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 9. Do you have a history of any Medicare/Medicaid sanctions?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 10. Do you have any physical or mental health problems that may affect your ability to provide healthcare?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 11. Do you have any professional liability actions of \$250,000 or more (pending, settled, arbitrated, mediated, or litigated) within the past five years?  | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 12. Have you ever been convicted of or pleaded no contest to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?   | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 13. Do you, your business entity, or any family member have an ownership greater than 5% in any medical enterprise or business? If yes, please complete attached <i>Disclosure of Ownership and Control Interest Statement</i> in accordance with Federal Regulations 42C.F.R.§455.104. | <input type="checkbox"/> Y <input type="checkbox"/> N |
| 14. Do you have experience serving children with special healthcare needs (including developmental disabilities)?   | <input type="checkbox"/> Y <input type="checkbox"/> N |

Include an explanation for any question(s) answered **yes**.

### Attestation and information release authorization

All information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Wellpoint of any changes thereto. I understand that this application does not entitle me to participation in Wellpoint. By applying for enrollment as

a Wellpoint participating provider, I authorize the plan, its medical director, and appropriate representatives to consult with administrators and members of medical staffs of hospitals or other institutions where I currently have or have had admitting privileges and others with which I have been associated, including past and present malpractice carriers who may have information bearing on my professional competence, character, and ethical qualifications. I hereby further consent to the inspection by Wellpoint, its medical director, and appropriate representatives of all records and documents, excluding medical records of nonmembers of Wellpoint's plans at other hospitals, that may be material to an evaluation of any professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for participating provider status with Wellpoint. I hereby release Wellpoint and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials, and qualifications. I hereby release any individuals and organizations from any liability who provide information to Wellpoint or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information. By executing this application, I confirm that I am bound by the terms of the *Participating Physician or Group Agreement* between me or my group and Wellpoint, as such terms may be applicable to me.

I understand that as an applicant for participation in Wellpoint, I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Wellpoint, I have the right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or by appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

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Signature

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Date

Submit this form per the instructions on the first page.

## Americans with Disabilities Act (ADA) Provider Survey

PROVIDER NAME: \_\_\_\_\_

GROUP NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OFFICE PHONE: \_\_\_\_\_

\_\_\_\_\_

OFFICE FAX: \_\_\_\_\_

\*Complete a separate survey form for each office location or attach a copy on group letterhead stating each physician's name and practice addresses.

\*If you have already completed an ADA Provider Survey Form previously for another healthcare company, please send a copy of this already completed survey.

### **Part I.**

1. Number of staff members (include all medical professionals, members or partners of the professional association, technicians and support staff) employed at this office: \_\_\_\_\_
2. Year when the building in which provider's office is located was constructed: \_\_\_\_\_
3. Floor(s) of building on which provider's office is located: \_\_\_\_\_

Please answer the following questions regarding architectural accessibility to the provider's office:

4. Is handicap parking available?       YES       NO
5. Is the path of travel from the parking lot to the entrance of the building in which the provider's office is located barrier-free?       YES       NO
6. Is there street-level access or an accessible ramp into the building in which the provider's office is located?       YES       NO
7. If the provider's office is not on the first floor, is the office served by a working elevator which is accessible by wheelchair and motorized scooter?       YES       NO

8. Are the provider's office and other patient areas accessible by wheelchair and motorized scooter?       YES       NO
  
9. Are the examination rooms accessible by wheelchair and motorized scooter?       YES       NO
  
10. Are the office's restrooms accessible by wheelchair and motorized scooter?       YES       NO

\*\*If you answered "yes" to every question 4 through 10 above, please skip the remaining questions and sign the attached certification.

If you answered "no" to any questions 4 through 10, and:

1. The building in which the provider's office is located was built **before January 1992 and structural alterations were made to the building after January 1992**, please answer the questions in Part II and sign the attached certification:
  
2. The building in which the provider's office is located was built **before January 1992, no alterations were made after that date and 15 or more staff are employed** at the provider's office, please answer questions in Part III and sign the attached certification, or
  
3. The building in which the provider's office is located was **built before January 1992, no alterations were made to it after that date and fewer than 15 staff are employed** at the provider's office, please answer the questions in **Part IV** and sign the attached certification.

**Part II. Building constructed before January 1992 with structural alterations made to building after that date:**

1. What alterations were made to the building?

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2. If the altered portions of the building affected the usability of the facility, are the altered portions of the office readily accessible to and usable by mobility-impaired and disabled individuals?       YES       NO

3. If the answer to question 2 is "no", explain:

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**Part III. Building constructed before January 1992 with no alterations made to the building after that date – provider has 15 or more staff employed at that location:**

1. Does the provider or group have an alternate accessible location where services can be provided to mobility impaired or disabled individuals?  YES  NO
2. If the answer to question 1 is "yes", please describe the facility, including its location and distance from the provider's office:

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3. If the answer to question 1 is "no", will the provider accommodate mobility impaired and disabled individuals through home visits?  YES  NO

**Part IV. Building constructed before January 1992 with no alterations made to the building after that date – provider has 15 or more staff employed at that location:**

If you determine after conferring with a mobility-impaired or disabled individual, that you are unable to see the individual in your office without making significant architectural alterations to the building or office, are you, the provider, willing to see the patient at a mutually acceptable and appropriate accessible location?  YES  NO

THE INDIVIDUAL COMPLETING THIS FORM MUST SIGN THE ATTACHED CERTIFICATION

CERTIFICATION OF ADA COMPLIANCE

I hereby certify that I have reviewed the Americans with Disabilities Act (ADA), requirements which are set out on the attached sheet, that I have answered the above questions truthfully and to the best of my knowledge and that this (office/group practice) as well as the building in which it is located, meets the requirements of the ADA.

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Provider Name

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Provider Group Name

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Signature of Provider or Authorized Practice Designee

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Date

## Disclosure Form for Provider Entities

**Please answer all questions.** If you need additional space to respond to a question, add a separate sheet that includes your entity name and the question and header. Dates of birth and Social Security numbers (SSNs) must be provided for validation purposes, as required by 42 CFR 455.104 (b)(1)(ii).

### I. Identifying information

(This information must match form W9 – Request for Taxpayer Identification Number and Certification.)

Entity/organization name	Business name (if different from name)	Empl Ident Num (EIN)	
Entity/organization NPI numbers*	Medicaid ID number	Telephone number	
Mailing address	City	State	ZIP

\*Use individual NPI if no organization NPI.

### II. Ownership and control information

- A. Master List of all controllers, owners, agents and managing employees (use additional pages if needed):

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address	City	State	ZIP	

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address	City	State	ZIP	

<b>Full name</b>	DOB	SSN	Title (see instructions)	Ownership %
<b>Address</b>	City	State	ZIP	

## B. Specific questions

1. Is any person listed in the Master List related to another person on the Master List as a spouse, parent, child or sibling?

Yes  No  **If Yes, please provide the following information about the related persons:**

Full name of first-related person	Full name of second-related person	Type of relation
Full name of first-related person	Full name of second-related person	Type of relation

2. Does any person or entity listed in the Master List have an ownership or control interest in any other provider entity?

Yes  No  **If Yes, please provide the following information about the other provider entity:**

<b>Name of other provider entity</b>	EIN		
Mailing address (number, street, and apt. or suite no.)	City	State	ZIP
<b>Name of other provider entity</b>	EIN		
Mailing address (number, street, and apt. or suite no.)	City	State	ZIP

3. Has any person or entity listed in the Master List been convicted of a criminal offense related to that person's or entity's involvement in any program under Medicare, Medicaid, TRICARE or the CHIP services program since the inception of those programs?

Yes  No  **If Yes, please provide the following information:**

Name on court records	Date of conviction	Exclusion period
Matter of the offense		

\*Exclusion period of the offense, if excluded by the federal Office of the Inspector General (OIG)

4. Has any person or entity listed in the Master List ever been **debarred** from participation in federal government contracts? Debarred means an individual is prohibited from participation in contracts paid for by the federal government, whether or not those contracts are in the health care area.

Yes  No  **If Yes, please provide the following information:**

Full name of individual or entity	Date of debarment	Length of debarment
Reason for debarment		

5. Has any person or entity listed in the Master List ever been **excluded or terminated from participation in federal health care programs** (Medicare, Medicaid, CHIP or TRICARE) in the past? Excluded means a provider or entity has been notified by the Department of Health and Human Services, Office of the Inspector General (HHS OIG) that they are prohibited from participating as a provider in any federally funded health care program.

Yes  No  **If Yes, please provide the following information:**

Full name of individual or entity	Beginning date	End date
Reason for exclusion or termination		

6. Has any person or entity listed in the Master List ever been **terminated from a state's Medicaid or CHIP program** for reasons having to do with program integrity (fraud or abuse)? Terminated means the provider lost the right to bill a state's Medicaid and/or CHIP programs for a cause related to fraud or abuse?

Yes  No  **If Yes, please provide the following information.**

Full name of individual or entity	State of termination	Date of termination
Reason for termination		

7. Has any person or entity listed in the Master List ever had civil monetary penalties (CMP) assessed against them? A CMP is a type of fine assessed against a provider by a governmental agency that manages a federal health care program.

Yes  No  **If Yes, please provide the following information.**

Full name of individual or entity	State of CMP	Date of CMP	Amount of CMP
Reason for CMP			

8. Has any person or entity listed in the Master List obtained an ownership interest in a provider entity:
- As a result of a transfer of ownership from someone who was about to be excluded or terminated from participation in a federal health care program, or was in fact excluded or terminated from participation in a federal health care program?
  - Where the original owner is or was a member of the current owner's immediate family or member of the current owner's household at the time of the transfer of ownership? (Immediate family is defined as a person's husband or wife; natural or adoptive parent; child or sibling; stepparent, stepchild, stepbrother or stepsister; father-, mother-, daughter-, son-, brother- or sister-in-law; grandparent or grandchild; or spouse of a grandparent or grandchild. Member of household means, with respect to a person, any individual with whom they are sharing a common abode as part of a single-family unit, including domestic employees and others who live together as a family unit. A renter or boarder is not considered a member of the household.)

Yes  No  **If Yes, please provide the following information.**

*Disclosure Form for Provider Entities*

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Full name of original owner	SSN or TAX ID of original owner	Place of transfer	Date of transfer
Reason for CMP			

9. Does any person or entity listed in the Master List have a direct or indirect ownership interest of at least 5% in a subcontractor of the provider entity? A subcontractor is a person or company that the provider entity has contracted with to provide some of the provider entity's management functions (for example, billing agent or provide medical services — such as a medical lab).

Yes  No  **If Yes, please list each Subcontractor and answer questions 9a and 9b. If No, skip to Section III.**

Full name of subcontractor	EIN		
Mailing address	City	State	ZIP
Full name of subcontractor	EIN		
Mailing address	City	State	ZIP

- a. For each subcontractor listed in item 9 above, please provide the following information about all individuals with an ownership or control interest in the subcontractor:

Full name	DOB	SSN	Title (see instructions)	Ownership %
Address	City		State	ZIP
Full name	DOB	SSN	Title (see instructions)	Ownership %

Address	City	State	ZIP	

- b. Is anyone listed in 9a related to any person in the Master List?  
 Yes  No  **If Yes, please provide the following information about the related persons.**

Full name of first-related person	Type of relation
Full name of second-related person	Type of relation

### III. Business transactions

Does the provider entity wholly own a supplier? Supplier means an individual, agency or organization from which the provider entity purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds or a pharmacy).

Yes  No  **If Yes, please provide the following information.**

Name (as shown on your income tax return)	Entity NPI number(s)	EIN	
Mailing address (number, street, and apt. or suite no.)	City	State	ZIP

**Instructions for title:** Controllers, owners, agents and managing employees are defined as follows:

- **Controller:** All directors, trustees and officers of a corporation or partners in a partnership. If the entity is a non-profit or not-for-profit, list all controllers and N/A in the percentage of ownership column.
- **Owner:** Any person or business entity that owns 5% or more of the assets, stock or profits of the provider entity either directly or indirectly.
- **Agent:** Any person or entity that has the authority to obligate the provider to a contract, mortgage or loan that may or may not be secured by the entity's assets.
- **Managing employee:** Any person that has the authority to make material business decisions on behalf of the provider entity.

**IV. Signature**

The state or federal Medicaid agency may refuse to enter into, renew or terminate an agreement with a provider if it is determined that a provider did not fully, accurately and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. The signature below **must** be the written signature of an individual who can legally bind this provider.

In compliance with *42 CFR 455.104(c)*, provider shall complete this disclosure of ownership upon application for network participation and/or prior to execution of a provider agreement, at the time of recredentialing/re-enrollment, and within 35 days after any change in ownership by the provider. In compliance with *42 CFR 455.105(b)*, provider certifies that it will submit within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete subcontractor information as outlined in section III, Business Transactions, above.

Controller/owner/agent/managing employee (please print)	Signature	Title
Person completing form (please print)	Phone number	Date

## Division of Developmental Disabilities and Aged, Blind and Disabled Form

The State of New Jersey will begin to transition Medicaid enrollees with developmental disabilities and certain mental health problems into the Medicaid managed care program. Wellpoint is working to determine if the health care needs of these populations can be met by our current provider network. We ask you to please respond to the following questions.

Please include any experience with your aged, blind or deaf disabled patients. Qualifications can include years of providing care for these patients even if no formal training was undertaken in the past.

1. Do you feel qualified to handle patients (either children or adults) with developmental disabilities? (Circle) YES or NO
2. Do you feel qualified to handle patients with mental health/behavioral or substance abuse problems? (Circle) YES or NO
3. Do you feel qualified to handle patients with HIV and/or AIDS? (Circle) YES or NO
4. Do you feel qualified to handle the geriatric population (aged)? (Circle) YES or NO

If yes to the above questions, PLEASE BRIEFLY OUTLINE your qualifications including specialized training/certifications and experience.

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Signature of Practitioner or  
Authorized Designee

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Date

## Criminal Background Check Attestation

Practitioner name:	
Associated TINs:	
SSN:	
DOB:	

Under penalty of perjury, I hereby swear or affirm that I meet the requirements for qualifying for employment in regards to the background screening standards set forth in N.J.S.A. 45:1-30 et seq. requiring a criminal history background check as a health care professional. In addition, I agree to immediately inform Wellpoint if arrested or convicted of any of the disqualifying offenses during the application process and after being accepted to the provider network as a participating provider.

**Signature is required to affirm you meet state requirements:**

Practitioner signature:	
Date:	

**Practice or entity:**

Name:	
TIN:	
NPI:	

By signing below, I hereby swear or affirm that my organization is compliant with the state-required criminal history background screening requirements. A criminal history check or background investigation has been completed for prospective employees or providers, employees or volunteers. Any subcontractor, employee or volunteer having direct physical access to members and a disqualifying offense are prohibited from providing services as set forth by N.J.S.A. section 3 of P.L.2002, c.104 (C.45:1-30) or section 7 P.L.1997, c.100 (C.45:11-24.3). Upon request, verification of compliance will be shared with an Wellpoint representative during the monitoring visit.

**Signature is required to affirm you meet state requirements:**

Owner/registered/authorized agent name:	
Owner/registered/authorized agent signature:	
Date:	