

Organizational Provider Roster Addendum

Instructions: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. Roster must be completed in its entirety.
3. The Sanctions Questions below must be answered and Attestation signed and dated.
4. One addendum form must be completed for each Legal Entity/TIN.
5. If necessary, use a separate sheet of paper to provide additional information.
6. Fill in the Tax ID# at the top (right) of every page for reference purposes.
7. Supplemental Credentialing documents must be attached.

Attach the following supplemental documents to this addendum, when required:

State Operational License

General Liability Insurance (Certificate showing amounts and dates of coverage)

Other applicable State/Federal Licensures (e.g., CLIA, DEA, or Pharmacy)

Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC, ACHC, CARF, COA, or AOA)

Accreditation letter with dates of accreditation

If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency

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I. Legal Information

| | |
|-------------------|----------------|
| Entity Legal Name | Tax ID Number: |
|-------------------|----------------|

II. Sanction Questions

Note: If you answered "Yes" to any questions below, please explain on a separate attachment.

- Has your organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified, or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?
Yes No
- Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, to preclude an investigation, or while under investigation relating to personal conduct?
Yes No

II. Sanction Questions - continued

- c. Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third-Party Payer, or a Regulatory Agency (CLIA, OSHA, etc.)?
Yes No
- d. Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?
Yes No
- e. Has an officer of your organization ever been convicted of, pled guilty to, or pled "nolo contendere" to any felony, including an act of violence, child abuse, or a sexual offense?
Yes No
- f. Has the corporation, an officer, or a board member ever been convicted of a felony?
Yes No

III. PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current Centene provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Centene Credentials Committee for their review and approval, and, absent such affirmative approval, Centene members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Centene. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Centene in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Centene credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need-to-know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.

III. PROVIDER RESPONSIBILITY STATEMENT - continued

- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

IV. STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photocopy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photocopy shall have the same force and effect as the signed original.

Name of Provider:

Date:

Organization Name

Signature of Authorizing Representative

Title

NOTE: A stamp signature is not acceptable. This shall be valid for one year from the date of signature.