ALTERWOOD HEALTH
Quality Care. Better Health.

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January 2021

Dear Provider:

We are writing to invite you to participate in Alterwood Health's Medicare Advantage network. Our organization is introducing new Medicare Advantage plans in both Maryland and Delaware, and we will be working with CMS to obtain approval to begin operations as of January 2022. Based on CMS guidelines, we will first need to establish a provider network which meets access standards, and we hope you will consider working with us.

About Us

By way of background, Alterwood Health is a newly formed managed care organization. The management team consists of those individuals who formed the Medicaid MCO Riverside Health in Maryland in 2013, and we intend to introduce Medicare Advantage plans with the same core principles which guided Riverside's entry into the market, including:

- Paying providers at rates slightly above market
- Paying clean claims expeditiously
- Keeping core operations 'in house', thereby maintaining efficiency and proper oversight
- Credentialing and recredentialing providers without undue delay
- Offering superior customer service

Value Proposition

Given the low penetration rate of Medicare Advantage enrollment in both Delaware (19%) and Maryland (13%) as compared to the national average penetration rate of approximately 36%, we are eager to introduce products that will offer additional coverage options for Seniors and provide them with value added benefits not available under traditional Medicare. Such benefits will include routine vision, dental, and hearing services.

Our representatives will be providing you with a copy of our provider agreement and will be available to answer any questions you may have.

We appreciate your consideration and look forward to collaborating with you as part of our network.

Sincerely,

K. Mark Puente
President and Chief Executive Officer
Alterwood Health, Inc

Clear Form

ALTERWOOD HEALTH
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Date: _____

CREDENTIALING APPLICATION – PARTICIPATING PROVIDER/GROUP

Please complete and return this Application
and the Authorization and Release form

Alterwood Health (AH) utilizes the Council for Affordable Quality Healthcare (CAQH) Universal Credentialing DataSource as part of our credentialing process. **Please update CAQH to grant AH access to the required profile(s).**

Group Name:		Group NPI:
Address:		Phone #:
Telemedicine Offered? ☐ Yes ☐ No	EHR System in Use? ☐ Yes ☐ No	Is the office ADA Compliant? ☐ Yes ☐ No
☐ Primary Care Provider	☐ Specialist	☐ OB/Gyn
Specialty:		Age Limitations (Min-Max)
☐ **Multiple Providers – See attached List** *(All fields below are required if not checked)*		
Provider name:		Provider NPI:
Medicare #:	Medicaid #:	Provider CAQH ID:

The following elements must be current on the CAQH profile.
If not, we will not be able to process your application(s).

- CAQH Attested within the last 120 Days
- Controlled Dangerous Substance (CDS) Registration
- Drug Enforcement Administration (DEA) License
- Current State Medical License
- Board Certification or Medical Education/ Undergraduate sections completed
- 5-year work history (time gaps not to exceed 6 months without documentation)
- Hospital admitting privileges at an In-Network Hospital
- Copy of Malpractice Insurance Face Sheet for Requesting Practice. Minimum Policy Limits:
    - $1 million per occurrence/$3 million aggregate
    - Expiration date cannot be within 45 days prior to application date

ATTESTATION AND RELEASE OF INFORMATION FORM

RELEASE OF INFORMATION: As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization grant Alterwood Health permission to contact any individual, institution, facility, group, or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Alterwood Health to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization/group applicant, I, the undersigned authorized agent, acknowledge that I am required to supply Alterwood Health with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION: I hereby grant permission for Alterwood Health to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support Alterwood Health quality improvement and utilization review programs.

ATTESTATION: I certify the information on this entire application is complete, accurate and current. I acknowledge that any misstatements in or omissions from this application constitute grounds for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that a decision about participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with Alterwood Health and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by Alterwood Health.

This facility complies with all federal, state and local handicapped access requirements as well as the standards required by the 1992 federal Americans with Disabilities Act. I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service.

I certify that the appropriate state license or certification source is checked at least annually for existing and contracted serviceproviders to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contractedservice providers prior to the first provision of service.

I certify that the on-line exclusion lists for the Department of Health and Human Services Office of Inspector General and System for Award Management are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals performany function related to any state or federal healthcare program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal healthcareprogram.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Group to the truthfulness of its answers.

Authorized Signature: _____ Print Name: _____

Date: _____

Group Name: _____

Form Approved
OMB NO. 0938-0086

DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

I. Identifying Information

(a) Name of Entity	D/B/A	Provider No.	Vendor No.	Telephone No.
Street Address		City, County, State		Zip Code

II. Answer the following questions by checking "Yes" or "No." If any of the questions are answered "Yes," list names and addresses of individuals or corporations under Remarks on page 2. Identify each item number to be continued.

(a) Are there any individuals or organizations having a direct or indirect ownership or control interest of 5 percent or more in the institution, organizations, or agency that have been convicted of a criminal offense related to the involvement of such persons, or organizations in any of the programs established by titles XVIII, XIX, or XX?

☐ Yes ☐ No

(b) Are there any directors, officers, agents, or managing employees of the institution, agency or organization who have ever been convicted of a criminal offense related to their involvement in such programs established by titles XVIII, XIX, or XX?

☐ Yes ☐ No

(c) Are there any individuals currently employed by the institution, agency, or organization in a managerial, accounting, auditing, or similar capacity who were employed by the institution's, organization's, or agency's fiscal intermediary or carrier within the previous 12 months? (Title XVIII providers only)

☐ Yes ☐ No

III. (a) List names, addresses for individuals, or the EIN for organizations having direct or indirect ownership or a controlling interest in the entity. (See instructions for definition of ownership and controlling interest.) List any additional names and addresses under "Remarks" on page 2. If more than one individual is reported and any of these persons are related to each other, this must be reported under Remarks.

Name	Address	EIN

(b) Type of Entity: ☐ Sole Proprietorship ☐ Partnership ☐ Corporation
☐ Unincorporated Associations ☐ Other (Specify)

(c) If the disclosing entity is a corporation, list names, addresses of the Directors, and EINs for corporations under Remarks.

Check appropriate box for each of the following questions:

(d) Are any owners of the disclosing entity also owners of other Medicare/Medicaid facilities? (Example: sole proprietor, partnership or members of Board of Directors.) If yes, list names, addresses of individuals and provider numbers.

☐ Yes ☐ No

Name	Address	Provider Number

IV. (a) Has there been a change in ownership or control within the last year?
If yes, give date _____ ☐ Yes ☐ No

(b) Do you anticipate any change of ownership or control within the year?
If yes, when? _____ ☐ Yes ☐ No

(c) Do you anticipate filing for bankruptcy within the year?
If yes, when? _____ ☐ Yes ☐ No

V. Is this facility operated by a management company, or leased in whole or part by another organization?
If yes, give date of change in operations _____ ☐ Yes ☐ No

VI. Has there been a change in Administrator, Director of Nursing, or Medical Director within the last year?
☐ Yes ☐ No

VII. (a) Is this facility chain affiliated? (If yes, list name, address of Corporation, and EIN)
Name EIN # ☐ Yes ☐ No

Address

VII. (b) If the answer to Question VII.a. is No, was the facility ever affiliated with a chain?
(If yes, list Name, Address of Corporation, and EIN)
Name EIN # ☐ Yes ☐ No

Address

VIII. Have you increased your bed capacity by 10 percent or more or by 10 beds, whichever is greater, within the last 2 years?
☐ Yes ☐ No

If yes, give year of change _____
Current beds _____ LB16 Prior beds _____

WHOEVER KNOWINGLY AND WILLFULLY MAKES OR CAUSES TO BE MADE A FALSE STATEMENT OR REPRESENTATION OF THIS 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 ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

Name of Authorized Representative (Typed)	Title

Signature	Date

Remarks

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*