McLaren
HEALTH PLAN

October 16, 2020

McLaren Health Plan (MHP) is dedicated to meeting the health care needs of every member. Our mission is to partner with providers who offer high-quality, accessible, and cost-efficient care throughout our service area. As a result of your reputation for delivering high quality care, McLaren Health Plan is pleased to invite you to become a participating partner.

MHP products include Medicaid, Medicare, and Commercial membership, and all of our products are growing rapidly in your community. To better acquaint you with MHP, we have included a fact sheet titled, "About McLaren Health Plan." Also attached is our Provider Application Package, which will need to be completed in order to begin your credentialing process.

We take great pride in partnering with providers who are as dedicated as we are to service excellence and improving the health of its members. We appreciate your consideration and look forward to your participation.

If you have any questions, call our Network Development Department at (888) 327-0671 to speak to your local Network Development Coordinator.

Sincerely,

McLaren Health Plan
Network Development

Enclosures

MHP41061074
April 2019

G-3245 Beecher Road • Flint, Michigan • 48532
tel (888) 327 0671 • fax (833) 540 8648
MclarenHealthPlan.org

McLaren HEALTH PLAN

McLaren Health Plan Provider Application Packet

In this provider packet you will find:

1. All Product Provider Agreement for McLaren Health Plan Commercial and Medicaid, McLaren Health Advantage, McLaren Health Plan Insurance Company and Medicare Advantage
2. Provider Information form
3. Practitioners' rights during the credentialing process
4. Provider Disclosure Information Form
5. W-9 form

After reviewing the enclosed provider agreement, please follow the steps below:

1. Complete and sign signature page of the provider agreement
2. Complete the Provider Information Form
3. Complete and sign the Provider Disclosure Information Form
4. Complete and sign the W-9 Form
5. Return the **full** agreement and **all** documentation to:

McLaren Health Plan Provider
Contracts
G-3245 Beecher Road Flint, MI
48532

Upon completion of the credentialing requirements, notification of your effective date and a counter-signed copy of the agreement will be mailed to you along with relevant information to get you started.

For more information about MHP, feel free to visit our website, MclarenHealthPlan.org, or contact us at (888) 327-0671.

MHPC20190411
April 2019

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Practitioners' Rights during Credentialing Process

These rights pertain to practitioners applying for participation with McLaren Health Plan (MHP) and its subsidiaries.

The following are your rights as they pertain to the credentialing process. Consistent with the requirements of MCL 500.3528 of the Michigan Insurance Code and accreditation standards, MHP will have the following information available for all applicants:

- Applicants may review all information obtained by MHP during the credentialing process, including the source of that information, unless it is prohibited or protected by law.
- MHP will notify an applicant of any information obtained during the credentialing verification process that does not meet the MHP credentialing verifications standards or that varies substantially from the information provided to MHP by the applicant.
- Applicants may correct any erroneous information. Practitioners need to submit corrections to the MHP Credentialing Department in writing. Corrected information will be shared with the MHP Quality Improvement Committee for consideration. Supplemental information is subject to verifications by MHP.
- Applicants may be informed of the status of the application upon written request.
- Applicants will be informed of the credentialing decision within sixty (60) days of the decision date.
- Copies of all application and credentialing verification policies and procedures are available upon written request.

All information obtained during the credentialing verification process is kept confidential, except as otherwise provided by law.

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PROVIDER DISCLOSURE INFORMATION FORM

In Compliance with Federal Law, McLaren Health Plan requires the following information be provided:

PROVIDER NAME:_____ **TIN:**_____

ADDRESS: _____

CITY, STATE, ZIP: _____

1. **Does any person who has ownership or control interest in the provider, or is an agent or managing employee of the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of these programs? If so, please list.**
   a. _____
   b. _____
   c._____

2. **Please provide the Name and Social Security number of each person who is a managing employee *(Managing employee means a general manager, business manager, administrator, director or other individual who directly or indirectly conducts the day-to-day operation of the above provider).* Make additional copies of this form, if needed.**

Full Name:_____ **Social Security Number:** _____

Full Name: _____ **Social Security Number:** _____

Full Name: _____ **Social Security Number:** _____

3. **Please provide a list of all persons with 5% or more ownership or control interest.**
   (Ownership interest is defined as ownership of 5% or more controlling interest which is either direct or indirect).

Full Name: _____

Address: _____

Full Name: _____

Address: _____

I attest that the information provided is true and accurate to the best of my knowledge.

_____

Authorizing Provider or Agent (Please Print Name) **Date**

_____

Authorizing Provider or Agent Signature **Date**

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

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

Print or type
See Specific Instructions on page 2.

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; 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. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member 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.)

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 Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 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 on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

General Instructions

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

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

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?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

PROVIDER INFORMATION FORM

Please complete this form to ensure accurate provider directory and payment information.
If needed, copy this form for additional sites.

Group Name (or Name of Practice): _____ **Fed Tax:** _____

Hospital Affiliation(s): _____

Contact Name: _____

Email Address: _____ **How many physicians within practice?** _____

Service Location(s):

PRIMARY ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

SECONDARY ADDRESS (if applicable)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

Please list additional service locations submitted on a separate sheet.

Billing Location:

ADDRESS (NO PO BOX)	SUITE	CITY	STATE	ZIP- 9 DIGIT	PHONE	FAX	Hours
				-	( )	( )	

Is Payment Location the same as Billing____Yes___No If No, Please list Payment Address:

ADDRESS	SUITE	CITY	STATE	ZIP- 9 DIGIT
				-

E-Prescribing: ___Yes ___No
Patient Portal: ___Yes___No
Certified Patient Centered Medical Home (PCMH): ___Yes ___No

Please return with provider contract and mail to McLaren Health Plan, Provider Contracts, G-3245 Beecher Road, Flint, MI 48532 If you have any question please contact us at: (888) 327-0671

PLEASE RETURN ALL OF THE FOLLOWING DOCUMENTS: THE PROVIDER DISCLOSURE INFORMATION FORM, PROVIDER INFORMATION FORM, COPY OF YOUR W-9 AND THE SIGNED CONTRACT

MHPC20150711
7/1/2015

McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

Please complete one form for each provider within the practice. INDIVIDUAL AND GROUP NPI IS REQUIRED FOR ALL PROVIDERS. IF THE PROVIDER DOES NOT USE A GROUP NPI, PLEASE SIGNIFY WITH N/A.

Provider Information:

Last Name	
First Name	

Title		**Type - Circle One**	Primary Care Specialist
CAQH #		**Specialty**	
Individual NPI #		**Group NPI #**	
Alt. Language(s)		**State License #**	

American Sign Language	☐ Yes	☐ No	
Race - Circle One	American Indian or Alaskan Native Black or African American	Asian Native Hawaiian or other Pacific Islander	White Other _____
Ethnicity - Circle One	Hispanic or Latino Not Hispanic or Latino	**Champs Enrolled?**	☐ **Yes** ☐ **No**

Meaningful Use Participation **Please check the appropriate box if you have received incentive payments from Medicare or Medicaid.**

Medicare	Stage 1 _____	Stage 2 _____	Stage 3 _____
Medicaid	Stage 1 _____	Stage 2 _____	Stage 3 _____

Completed Cultural Competency? (CLAS) Attestation Required	☐ Yes	☐ No
Children's Special Health Provider? Attestation Required	☐ Yes	☐ No
Does Provider practice at each location?		

PRIMARY CARE PROVIDER READINESS SURVEY
CHILDREN'S SPECIAL HEALTH CARE SERVICES

Physician Information (Please provide the following information for all PCPs in your practice)			
Primary Care Physician Name:			
Practice Address:	Street:		
	City:	State:	Zip:
NPI(s):			

CSHCS Primary Care Requirements	**Yes**	**No**	**Comments** (if applicable)
Do you currently take care of children or youth with complex chronic health conditions?			
Does your practice have a method to identify children/youth with chronic health conditions? Please explain:			
Does your practice offer expanded appointments when the child/youth has complex needs and requires more time?			
Does your practice have experience coordinating care for children/youth that see multiple professionals (i.e. pediatric subspecialists, physical therapists, mental health professionals?			
Does your practice have a dedicated professional responsible for care coordination for children/youth that see multiple professionals?			
Is your practice willing to accept new patients (children/youth) with complex chronic health conditions?			
As a Primary Care Physician, do you treat youth who are transitioning to adulthood?			

Responses can be faxed to Network Development at (810) 600 7979. Thank you for your participation!

G-3245 Beecher Rd Flint, Michigan 48532
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