OPTIMA HEALTH

Join Our Network: Provider Contracting & Credentialing Guide

PRSS Enrollment

The federal act requires providers who serve Medicaid patients through Managed Care Organization (MCO) networks to enroll directly in the state Medicaid program. Providers who fail to enroll in the Medicaid program risk termination of their MCO contracts.

Here are the steps:

The Provider must notify Optima Health of their DMAS approval/approval date and request participation with Optima Health Medicaid by submitting a Provider Update form.

When the Provider Update form is received by Optima Health, the Provider will be updated to PAR for Optima Health Medicaid effective as the DMAS approval/Enrollment date.

Claims submitted for DOS on or after Provider's Optima Health Medicaid effective date will be processed/reimbursed as in the network.

STEP 1

Determine the type of request appropriate for you. There are two options available:

1. a contracting request
2. a credentialing request

Click the link to determine which request applies to you.

STEP 2

Once your request is submitted, a Contract Manager will contact you to discuss your contract and provide credentialing instructions. The approval and loading time can take 30 to 45 days to complete.

STEP 3

Welcome to Optima Health! Once your contract and credentialing process is approved, you will officially be an Optima Health partner.

Join Our Network

Non-contracted providers, group practices, or facilities that have not joined Optima Health will need to complete the Request for Participation form available on the Optima Health website under Join Our Network.

Credentialing

The Optima Health credentialing process allows healthcare professionals to join the Sentara Healthcare provider network. It also ensures that providers who are contracted with Optima Health meet the healthcare industry standard. To request credentialing, please submit a Provider Update form.

For more information, visit:
optimahealth.com/providers

OptimaHealth

Contracting Scenarios

LTSS/Optima Health Community Care Provider Relations

Optima Health delegates and provides oversight for credentialing and re-credentialing of OHCC LTSS Providers to HEOPS-Centipede per requirements. OHCC ensures that HEOPS-Centipede credentials and re-credentials Providers per DMAS and OHCC requirements and ensures that all Providers comply with provisions of the CMS Home and Community-Based Settings Rule.

Phone: **1-855-359-5391**

Email: joincentipede@heops.com

New Provider Joining Optima Health or an Existing Provider Joining a New Group

1. New provider and existing provider requests with new non-contracted groups are submitted through a **Request for Participation** form located on the provider portal.
2. Your request for participation form is routed to network management for review.
3. If your request is approved, a Contract Manager will contact you regarding contract and credentialing instructions.
4. You will receive an email from Optima Health confirming that the provider and contract has been set up with an effective date.

Credentialing Scenarios

1. Confirm the Optima Health contract is completed. To receive or request credentialing instructions, the Optima Health contract must be completed and approved.
2. New provider requests or existing provider requests with existing contracted groups are submitted through the **Submit a Provider Update Form**. This form will include the practitioner CAQH number. All credentialing requests for new providers who are joining existing groups must be submitted through this form.
3. The application loading process completion may take up to 30 days.
4. Once the application loading process is completed, you will receive a letter from the credentialing department confirming your provider update approval.

Facility/Ancillary Provider

1. New facility/ancillary requests are submitted through a **Request for Participation** form located on the provider portal.
2. The request for participation form is routed to network management. A network manager will send the contract and credentialing packet to the provider.
3. Please contact your assigned network educator at **1-877-865-9075**, option 2 to inquire about the contracting process.

Provider Malpractice Important Note

Virginia providers must maintain malpractice coverage in amounts not less than the medical malpractice caps currently in effect under section 8.01-581 of the **Virginia Code**.

Non-prescribing providers (including behavioral health providers) must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.

In all states except Virginia, providers must maintain the coverage amount required under the applicable state law governing minimum medical malpractice coverage. If the state does not have a requirement for minimum medical malpractice coverage, the provider must maintain coverage in an amount not less than $1 million per occurrence and $3 million in the aggregate per year.