St. Clair County Community Mental Health Authority

Organizational Deemed Status Request

TO: St. Clair County Community Mental Health Authority, Contract Management Department

FROM: _____

DATE: _____

SUBJECT: Provider Enrollment: Organizational Deemed Status Request

I. CURRENT CREDENTIALING STATUS:

_____ is requesting recognition by the St. Clair County Community Mental Health Authority (SCCCMHA) as having an approved credentialing and privileging program. As such, we request that our organization which has already been determined to have the appropriate "credentials" and "credentialing program" to provide Medicaid billable services, and who is "privileged" within an approved scope of practice by our organization, shall be granted 'Deemed Status' by the SCCCMHA Privileging and Credentialing Committee and to enrolled into the SCCCMHA Provider Network based. Included is a copy of our Conflict of Interest, our approved Privileging and Credentialing application, accreditation, insurance, and licensures as applicable. It is realized and agreed to at the time of the Agency's annual contract site review that the Provider Network will verify and validate the licensing and privileges of the below applicant.

Organization: _____
NPI Number : _____
Licensing Body: _____ Expiration Date: _____
Accreditation Body: _____ Expiration Date: _____
LARA Licensure: _____ Expiration Date: _____

Key Executive Staff:

Executive Director: _____ Phone: _____
Email: _____
Medical Director: _____ Phone: _____
Email: _____
Chief Financial Officer: _____ Phone: _____
Email: _____
Chief Operating Officer: _____ Phone: _____
Email: _____
Information System Director: _____ Phone: _____

Email: _____
Customer Service Director: _____ Phone: _____
Email: _____
Recipient Rights Officer: _____ Phone: _____
Email: _____

II. PROVIDER NETWORK RESPONSE

Your request has been reviewed to allow for Deemed Status of the above named organization, allowing the organization to be enrolled and credentialed as providers for the SCCCMHA Provider Network. The review has resulted in the following:

☐ Your request has been approved for "Deemed Status" recognition and enrollment into the Provider Network as an organization for Medicaid. The Provider Network will update its database and enroll your organization as requested.

☐ Your request has been denied for the following reason(s): _____

_____

_____ _____

Credentialing Chair Date

You may appeal this denial (as applicable) using the appeal form contained in the Provider Network Credentialing Policy.

cc: Chief Executive Officer Credentialing Committee Contracts