DEPARTMENT OF HEALTH AND SENIOR SERVICES
Provider Agreement Certification Checklist

Carrier Name:	
NAIC #:	Contract Form Number:

	NA	Contract	Provider Manual	Section/Page	Issue/Provision
1					Standards for the minimum number of regularly scheduled office hours per week per office (for health care providers with multiple office locations) the provider must be available to treat members.
2					Standards for scheduling of routine appointments (no more than 2 weeks), physical examinations (no more than 4 months), and urgent care appointments (within 24 hours of contact).
3					Standards for the provision of 24-hour, 7-day per week emergency and urgent care to members.
4					Standards for admitting privileges.
5					Standards regarding anti-discrimination in treatment of members.
6					Standards regarding licensing, certification and malpractice coverage.
7					The compensation methodology (which cannot include financial incentives for the withholding of medically necessary health care services).
8					If the compensation methodology includes the tying of some portion of the compensation to the occurrence or non-occurrence of a pre-determined event, specification of the event.
9					If the compensation methodology includes the tying of some portion of the compensation to the occurrence or non-occurrence of a pre-determined event, the process for obtaining/performing a periodic accounting (at least annually) of the funds being held or withheld.
10					If the compensation methodology includes the tying of some portion of the compensation to the occurrence or non-occurrence of a pre-determined event, the process for providers to appeal a decision denying the provider additional compensation.
11					Explanation of the claims handling process, including timeframes for handling of claims that are "clean" and those that are not, which shall be consistent with law, including the rules set forth at N.J.A.C. 11:22-1 (e.g., 30 days for payment of claims submitted electronically, or 40 days otherwise), the payment of interest for late processing of claims, and whether there are any requirements or conditions for submission of claims timely.
12					Explanation of the internal appeals mechanism relating to payment of claims in accordance with N.J.A.C. 11:22-1.8(a)
13					Explanation of the external Alternate Dispute Resolution (ADR) that is offered to participating providers to review adverse decisions of the internal appeals process, pursuant to N.J.A.C. 11:22-1.8(b)
14					Explanation that providers may communicate openly with patients about all appropriate diagnostic testing and treatment options, and that providers may advocate for a patient in seeking appropriate, medically necessary health care services without being penalized or terminated by the carrier.
15					Explanation regarding the prohibition against providers billing members for the costs of covered services or supplies, except with respect to the collection of deductibles, copayments and/or coinsurance.
16					Standards for confidentiality regarding health care information, and exchange of information between the provider and the carrier, including mutual right to member medical records.
17					Policies and procedures for credentialing and re-credentialing of providers for purposes of network participation.

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18					Policies and procedures for the provider to update information with the carrier outside of the re-credentialing cycle, including changes in office hours, panel closings, changes in practitioners at an office, reduction in services, etc.
19					Term of the contract, including specificity about whether the contract is automatically renewable.
20					Standards and procedures for termination of health care professionals, which shall include at least 90-days prior notice by the carrier except in instances of nonrenewal of the contract on its anniversary date (or other specified date of renewal), breach, believed fraud, or believed imminent danger to the health and welfare of a patient or the public.
21					An explanation of a health care professional's right to obtain in writing a reason for the termination, and to request and have granted a hearing before a panel, except in instances of nonrenewal of the contract on its anniversary date (or other specified date of renewal), breach, believed fraud, or believed imminent danger to the health and welfare of a patient or the public.
22					An explanation of a health care professional's obligation to abide by all of the terms of the contract for an extended period of time following the contract's termination in accordance with N.J.S.A. 26:2S-9.1.
23					Standards and procedures for termination of hospitals.
24					An explanation of a hospital's obligation to abide by all of the terms of the contract for an extended period of time following the contract's termination in accordance with N.J.S.A. 26:2J-11.1
25					Standards and procedures for termination of other health care providers, including any rights and obligations that may exist for the health care provider with respect to the termination and extension of the contract terms.
26					An explanation as to whether there is an opportunity to cure deficiencies and avoid termination on the basis of breach.
27					An explanation of the applicable quality assurance standards and procedures, and the provider's obligation to comply with the requirements of such standards and procedures.
28					An explanation of the utilization management standards and procedures, and the provider's obligation to comply with the requirements of such standards and procedures.
29					An explanation of the process by which physicians and dentists have an opportunity to review and comment on all medical and surgical and dental protocols used by the carrier.
30					Explanation of the complaint and appeal process that providers may use to resolve non-claims or compensation issues the providers may have with the carrier, a carrier's vendor, a member, or other participating health care providers, etc.
31					Explanation of the complaint and appeal processes designed for use by members to resolve various types of complaints as well as adverse utilization management appeals, which may be accessed by providers when acting on behalf of a member with the member's consent.
32					A schedule of rates page/addendum/attachment (this schedule may be blank)