



**ANCILLARY/HEALTH CARE DELIVERY ORGANIZATION
CREDENTIALING APPLICATION FORM**

Ancillary applicant:

Diagnostic Center, Diagnostic Imaging Center, Durable Medical Equipment Supplier, Hearing Aid Supplier, Laboratory Service, Optical Supplier, Orthotics/Prosthetics Supplier, Pharmacy, Personal Emergency Response System Provider; Rehabilitation Therapy Services Center:(Physical, Massage, Speech/Language, Occupational, Audiology, Nutrition), Fitness Center, Transportation Service, Outpatient Dialysis, Vascular Laboratory.

Health Care Delivery Organizational applicant:

Ambulatory Surgery Center, CORF, Hospital, Hospice, Home Health Agency, Nursing Home, Skilled Nursing Facility, Community Mental Health Center, Long Term Care Delivery Organization (ALF), Health Center; Behavioral Health & Substance Abuse Treatment Center; Crisis Stabilization Center; Convenient Care Clinic.

NAME OF COMPANY: _____ TYPE OF SERVICE: _____

In order to expedite processing, please complete every item on this application. Please enclose copies of the documentation listed below, and the application should be signed and dated by an authorized representative of the organization. . If you are an Administrator who is not licensed or licensed by a licensing board that does not perform background checks, please review and complete the Criminal History request form at the end of the application Thank you for your assistance!

“X” if enclosed

APPLICATION CHECKLIST

- Listing of all locations included under the contract;
- Current Liability Insurance Certificate per location;
- Evidence of approval to participate in Medicaid/Medicare; (site review) (if applicable)
- W9 Form.

FOR PLAN USE ONLY – To be completed by Provider Representative:

- Site Inspection Evaluation (SIE) (non-accredited facilities) attached /not applicable; (please circle)
- Application information and supporting documentation has been reviewed;
- All information meets Plan criteria and documentation is current and complete.

Signature of Health Plan Provider Representative

Date

Signature of Health Plan In-house Representative

Date



Name of Organization & Authorized Representative Last Name	First	Middle	
Primary Office Address	County	Wheelchair Accessible?	
City, State, Zip	Office Phone #	Office Fax #	
Patient Age Range	Languages Spoken		
Practice or Group Name			
Name to whom checks should be made payable (<i>if different than Organization/Practice/Group name</i>)			
Billing Address (Location where payments will be sent)	City	State	Zip
Billing Office Telephone Number	Billing Office Fax Number		

Correspondence Address (for credentialing purposes only)	City	State	Zip
Office Telephone Number	Office Fax Number	Contact name	

REGULATORY

UPIN #	Tax ID #	Medicaid Provider #	Medicare Provider #	License #
National Provider Identification #		Status:	Status:	Status:

TYPE OF FACILITY/SERVICES

Type of Facility/Services	# of Title XVIII beds (medical)
# of Beds total(if applicable)	# of Title XVIII beds (psychiatric)

SPECIALTY OF SERVICES/TAXONOMY

Name of Specialty	Taxonomy Code

COVERING PHYSICIAN INFORMATION (if applicable) - Nursing Home providers please provide name, address and phone number of the Plan practitioner who will provide coverage for our patients on your behalf. Diagnostic Facilities please provide name of Plan physician who will read studies:

Last Name	First	Middle	Degree	Specialty
Office Address,	City,	State, Zip Code	Office Phone #	Office Fax #

HOURS OF SERVICE

Day of Week	Hours	Person Providing Services
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		



Provider Name: _____

Information Sheet Required for Additional Locations

(PLEASE PRINT)

Name of Provider/ Group / Practice Name: _____

List any additional Office Locations: Please include all necessary information listed below.

Second Physical Address: _____

Practice/Group Name: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____
Tax Identification Number: _____
Contact Name: _____
Handicapped Access Yes___ No___ Handicapped Assistance Yes___ No___ Bus Rte. Yes___ No___
Office Hours _____

Second Billing Address: _____

Checks payable to: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____
Tax Identification Number: _____
Contact Name: _____

Third Physical Address: _____

Practice/Group Name: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____
Tax Identification Number: _____
Contact Name: _____
Handicapped Access Yes___ No___ Handicapped Assistance Yes___ No___ Bus Rte. Yes___ No___
Office Hours _____

Third Billing Address: _____

Checks payable to: _____
Telephone Number: _____
Fax Number: _____
Email Address: _____
Tax Identification Number: _____
Contact Name: _____

Please attach additional location information as necessary.



Provider Name: _____

ACCREDITATION STATUS (Organizational Providers only)

<i>Accrediting Agency Name</i>	<i>Accreditation Status</i>	<i>Accreditation Date</i>	<i>Expiration Date</i>

GENERAL LIABILITY DATA - Please provide full address

<i>Name & Address of Carrier</i>	<i>Policy # Effective and end dates</i>	<i>Policy Limits of Coverage</i>	<i>Retroactive date of coverage</i>

QUESTIONNAIRE - If the answer to any of the questions is yes, please provide details on a separate sheet.

<i>Please answer the following questions by checking the appropriate box:</i>	YES	NO
Have criminal proceedings ever been initiated against your Company or its authorized representative(s)		
Has your Company ever been the subject of an investigation or ever been suspended, sanctioned or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicare or Medicaid)?		

AFFIRMATION OF ACCURACY AND COMPLETENESS

I affirm that information provided in or attached to this application is current, correct and complete. I understand that a condition of this application is that any misrepresentation or omission from this application, whether intentional or not, is cause for automatic and immediate rejection of this application and it shall not be processed any further.

RELEASE AND HOLD HARMLESS

By applying for provider participation, the following conditions are accepted as legally binding. These conditions shall remain in effect for the duration of any term of provider participation:

To the extent permitted by law, applicant shall release and hold harmless from liability, the Company, its authorized representatives and any third parties, as defined below, for any actions, recommendations, reports, statements, communications, or disclosures, that are made, taken or received in good faith by the Company or its authorized representatives relating to the following:

- a. applications for participation;
- b. periodic reappraisals undertaken for renewal thereof.

Authorization is given to the Company and its authorized representatives to consult with any third party who may have information bearing on services as a provider.

SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE

DATE

PRINTED NAME