

Organizational Provider Initial Credentialing Application

Demographic / General Information

D.B.A. (as signage indicates): _____

Corporate Name (as assigned TIN on W-9): _____

Facility Tax Identification Number: _____

Is the facility owned in whole or in part by a hospital system? Yes No Hospital System: _____

Is the facility a participating Medicare provider? Yes No Medicare Number: _____

Is the facility a participating Medicaid provider? Yes No Medicaid Number: _____

Please indicate the service type(s) at each address:

- | | | |
|--|--|---|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Hospitals | <input type="checkbox"/> Substance Abuse - Inpatient |
| <input type="checkbox"/> Free Standing Surgical Center | <input type="checkbox"/> Long Term Acute Care (LTAC) | <input type="checkbox"/> Substance Abuse – Outpatient |
| <input type="checkbox"/> Home Health Care | <input type="checkbox"/> Mental Health – Inpatient | <input type="checkbox"/> Urgent Care Facility (Include Clinic Staff Roster) |
| <input type="checkbox"/> Home Infusion | <input type="checkbox"/> Mental Health – Outpatient | |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Skilled Nursing Facility | |

Address Information – Address #1

Please indicate the facility’s main office, mailing, secondary, and payment address(es) by completing the appropriate information and checking one or more address type. See page 2 for additional locations.

Is this location handicap accessible? Yes No **NPI#** _____

Street: _____

City: _____

State: _____ Zip Code _____ County _____

Phone: _____ Fax: _____

Contact(s) at this address:

Name _____ e-mail _____

Address Type	
<small>(choose more than one, if applicable)</small>	
Mailing	<input type="checkbox"/>
Primary Office	<input type="checkbox"/>
Payment	<input type="checkbox"/>

Indicate the facility or program’s hours for patient care for Address #1 in the appropriate boxes:

(Examples)	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
9 – 5, or 24 hrs							

Copy this page, prior to completing, for additional offices.

Address # _____

Is this location handicap accessible? Yes No

NPI# _____

Service Types(s): _____

Street: _____

City: _____

State: _____ Zip Code _____ County _____

Phone: _____ Fax: _____

Contact(s) at this address:

Name e-mail

Address Type	
(choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Secondary office	<input type="checkbox"/>
Payment	<input type="checkbox"/>

Indicate the facility or program's hours for patient care for Address # _____ in the appropriate boxes:

(Examples)

9 – 5, or 24 hrs

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Address # _____

Is this location handicap accessible? Yes No

NPI# _____

Service Types(s): _____

Street: _____

City: _____

State: _____ Zip Code _____ County _____

Phone: _____ Fax: _____

Contact(s) at this address:

Name e-mail

Address Type	
(choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Secondary office	<input type="checkbox"/>
Payment	<input type="checkbox"/>

Indicate the facility or program's hours for patient care for Address # _____ in the appropriate boxes:

(Examples)

9 – 5, or 24 hrs

Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.

Licensure and Accreditation

List all states / provinces in which program is currently licensed / certified and **attach a copy of the license(s)**:

<u>State</u>	<u>License/Certification Number</u>	<u>Type of License</u>	<u>Expiration Date</u>
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Please indicate any accreditations the facility/program holds and **attach a copy of all applicable certificates for all applicable locations, and any plan of correction information**:

AAAHC AAASF AOA CARF CHAP COA JCAHO

Effective Date: _____ Expiration Date: _____

N/A – If not accredited by one of the above facilities/programs, please provide a copy of your most recent **CMS survey with any site visit corrections** showing that your facility is in compliance.

Insurance

Yes No Does the facility carry general office / premise liability insurance? If no, please explain below.
 Yes No Has the facility or program ever had professional liability insurance refused, declined, canceled, or accepted on special terms? If yes, please explain below.

List current policies and **attach a copy of your current professional and general liability insurance**.

Carrier Name _____

Policy Number _____ Coverage Limits _____ Expiration Date _____

By attesting to this application, the organization understands and meets the liability insurance requirements.

Accessibility

Does your facility or program provide appropriate and necessary emergency or non-emergency medical treatment within the scope of its services to any patient seeking treatment, regardless of the patient's ability to pay?

Yes No, please explain: _____

Historical Questions

If any of the following questions are answered "Yes", please provide details on a separate sheet.

1. Yes No Has the facility or program ever had or currently have pending, any legal actions excluding medical malpractice?
2. Yes No Has the facility or program ever been convicted of a crime, excluding misdemeanors?
3. Yes No Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4. Yes No At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the program, or are any actions which may lead to such conclusions now under way?
5. Yes No At any time, has the program been assessed a penalty, conviction or suspension or is the program currently under investigation by the Medicaid or Medicare programs?
6. Yes No At any time, has any third party payor ever revoked, reduced, denied, or suspended your program's participation due to inappropriate utilization management or any quality of care issues?

Staffing

A specific physician Medical Director must clearly be identified as responsible for management. The Medical Director must be licensed and in good standing in the State of Michigan

Medical Director Name: _____ License #: _____

Credentials (MD/DO; specialty): _____

Are the medical staff credentialed through an: Internal Process: Outside Agency: N/A_____

If an Outside Agency was used, please provide the name of the Agency: _____

