

# Organization Provider Initial Credentialing Application

## Demographic / General Information

D.B.A. (signage on your door indicates) \_\_\_\_\_

Corporate name (as assigned TIN on W-9) \_\_\_\_\_

Facility tax identification number \_\_\_\_\_ Claim filing:  HCFA 1500  UB

Is facility a participating Medicare provider?  Yes  No Medicare number \_\_\_\_\_

Is facility a participating Medicaid provider?  Yes  No Medicaid number \_\_\_\_\_

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> End stage renal dialysis      | <input type="checkbox"/> Long term acute care (LTAC)           | <input type="checkbox"/> Skilled nursing facilities |
| <input type="checkbox"/> Free standing surgical center | <input type="checkbox"/> Mental health                         | <input type="checkbox"/> # of CMS beds _____        |
| <input type="checkbox"/> Home health care              | <input type="checkbox"/> Inpatient services                    | <input type="checkbox"/> Sleep disorder centers     |
| <input type="checkbox"/> Tele-monitoring svcs.         | <input type="checkbox"/> # of CMS beds _____                   | <i>AASM accreditation is required</i>               |
| <input type="checkbox"/> Home infusion (specify)       | <input type="checkbox"/> Outpatient services                   | <input type="checkbox"/> Substance abuse            |
| <input type="checkbox"/> Chemotherapy                  | <input type="checkbox"/> Rehab outpatient facilities (specify) | <input type="checkbox"/> Inpatient services         |
| <input type="checkbox"/> Outpatient infusion           | <input type="checkbox"/> Occupational therapy                  | <input type="checkbox"/> # of CMS beds _____        |
| <input type="checkbox"/> Hospitals*                    | <input type="checkbox"/> Physical therapy                      | <input type="checkbox"/> Outpatient services        |
| <input type="checkbox"/> Hospice                       | <input type="checkbox"/> Speech therapy                        | <input type="checkbox"/> Rural health clinic        |
| <input type="checkbox"/> Laboratories                  |  | <input type="checkbox"/> Urgent care facilities     |

**\*Hospital services – please list any additional services from above on the list below:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Ambulance                     | <input type="checkbox"/> Critical care services / ICU | <input type="checkbox"/> Radiology / imaging centers (specify) |
| <input type="checkbox"/> Dialysis                      | <input type="checkbox"/> # of beds _____              | <input type="checkbox"/> Diagnostic radiology                  |
| <input type="checkbox"/> Prosthetics/orthotics         | <input type="checkbox"/> Durable medical equipment    | <input type="checkbox"/> Mammography                           |
| <input type="checkbox"/> Cardiac surgery program       | <input type="checkbox"/> Prosthetics / orthotics      | <input type="checkbox"/> Therapeutic radiology                 |
| <input type="checkbox"/> Cardiac catheterization svcs. | <input type="checkbox"/> Bathroom safety bars         |  |
|  | <input type="checkbox"/> Independent diagnostic svcs. |  |

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. Copy this page if needed 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 email

Address type	
(choose more than one, if applicable)	
Mailing	<input type="checkbox"/>
Primary office	<input type="checkbox"/>
Payment (REMIT)	<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# \_\_\_\_\_

Specify additional service types(s) \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_ Zip code \_\_\_\_\_ County \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Contact(s) at this address:

\_\_\_\_\_  
Name email

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

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 revisits and CMS letters** showing that you facility is in compliance. Please also include a copy of your Cred/Recred policies and QI policies.

**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.

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

Carrier name \_\_\_\_\_

Policy number \_\_\_\_\_ Coverage limits \_\_\_\_\_ Expiration date \_\_\_\_\_

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*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 \_\_\_\_\_

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**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 in licensed 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, provide the agency name \_\_\_\_\_

**Send completed form to:**

Email: *ph-providernetworkmanagement-providerapplications@priorityhealth.com*

Fax:    Attn: Provider Network Management  
616 975-8851

**Remember to sign the Consent and Release Form for Organizational Providers on page 5.  
This must be included with you application.**

## Consent and release form for organizational providers

\_\_\_\_\_ (hereafter the "Facility / Group) hereby applies for privileges to participate with Priority Health (hereafter the "Plan") as requested in the application. The Facility / Group and its staff will be available for interviews in regard to said application.

On behalf of Facility / Group as an applicant, it is understood that the Plan must have adequate information in order to properly evaluate Facility / Group's qualifications. Therefore, Facility / Group and its directors, officers, employees, and agents shall cooperate with the Plan to produce or have third parties provide any and all information which the Plan may need for the evaluation of the Facility / Group. Facility / Group also agrees to update the Plan with any and all current information regarding all questions contained in this application as such information becomes available and any additional information as requested by the Plan or its authorized representatives. Facility / Group acknowledges and agrees that failure to produce such information will prevent the Facility / Group's application from being evaluated and acted upon.

All information given in or attached to this application is accurate and complete to the best of the undersigned's knowledge. It is a condition to making this application that any misrepresentation or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of request for participation. In the event that participation has been granted prior to the discovery of such misrepresentation, misstatement or omission, such discovery may result in immediate termination of such participation. As a component of the credentialing and recredentialing process, Facility / Group accepts the following conditions:

- A. Facility / Group specifically authorizes the Plan and its authorized representatives to consult with any third party who may have information including, but not limited to, otherwise privileged or confidential information, bearing on the Facility / Group and/or its staff's professional qualifications, credentialing, clinical competence, character, mental or emotional stability, physical condition, ethics, behavior or any other matter bearing on the Facility / Group's satisfaction of the criteria for initial or continued participation with the Plan. Facility / Group also specifically authorizes said third parties, which shall include, but not be limited to:
- ◆ insurance companies;
  - ◆ the national data bank
  - ◆ hospital or facilities of which the Facility / Group's staff has been in association
  - ◆ state licensing boards;
  - ◆ other health care plans;

to release said information to the Plan and its authorized representatives upon request and receipt of a copy, or the original, of this Consent and Release Form.

- B. Facility / Group extends absolute immunity to, and release from any and all liability, the Plan, its authorized representatives and any third parties, as defined in Subsection C below, for; (i) any acts performed in good faith and without malice with regard to this application; and (ii) for any communications, reports, records, statements, documents, recommendations or disclosures made, requested or received by the Plan, its authorized representatives and any third parties involving the Facility / Group; including otherwise privileged or confidential information, or acts relating, but not limited to matters concerning the Facility / Group or its staff's professional qualification, credentials, clinical competence, character, ethics or behavior; matters of inquiries concerning the Facility / Group staff's mental or emotional stability, physical condition; and any other matter which might directly or indirectly impact on the Facility / Group staff's competence, on patient care or on the orderly operation of a health care facility.
- C. The term "Plan and its authorized representatives" means the corporation(s) with which the Facility / Group has applied for participation, and any of the following individuals who may have any responsibility for obtaining or evaluating the Facility / Group's credentials, or acting upon the Facility / Group's application: the members of the Plan's Board and their appointed representatives, the Chief Executive Officer or designees, other Plan employees, consultants to the Plan, the Plan's attorney and his/her partners, associates or designees. The term "third parties" means all individuals, including appointees to the Plan's credentialing staff or other physicians or health care corporations, whether hospitals, health care facilities or not, from whom information has been requested by the Plan or its authorized representative or who have requested such information from the Plan and its authorized representatives.

The foregoing shall be privileged to the fullest extent permitted by law. Facility / Group's release and immunity shall extend to the Plan and its authorized representatives, and to any third party, regardless of whether the Facility / Group's application is accepted; and if accepted, regardless of whether the Facility / Group's membership and privileges as hereafter aforementioned are terminated, either voluntarily or involuntarily.

\_\_\_\_\_  
Date

By: \_\_\_\_\_

Title: \_\_\_\_\_