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Facility Application for Participation

WHP Credentialing Application Checklist

- Completed Application
- Signed Attestation
- Licenses/Certifications for the Facility as well as all active licensed personnel (employed & contracted), including professional liability insurance and continuing education certificates
- Accrediting Body Survey Results
- State/CMS Survey Results
- Malpractice Carrier Policy
- W-9

FACILITY CREDENTIALING APPLICATION

Please indicate which network(s) you are applying for:

Windsor MedicareExtra ____ VHP CommunityCare ____

Facility Information:

Name of Facility _____

Physical Street Address _____

City _____ State ____ Zip Code _____ County _____

Billing Address (if different) _____

City _____ State ____ Zip Code _____

Telephone Number (____)- _____ Fax Number(____) _____

Federal Tax I.D. Number _____

Billing Telephone Number (____)- _____

Billing Fax Number (____)- _____ Office E-Mail _____

Contact Person For Billing: _____

President/CEO

Name: _____ Title: _____ Telephone(____)- _____

Medical Director

Name: _____ Title _____ Telephone(____)- _____

LICENSE/CERTIFICATION INFORMATION:

Is the Facility Medicare/Medicaid Certified? Yes No

Has the Facility been approved by an accrediting body? Yes No

If yes, please check the accrediting body:

JCAHO__ URAC__ AAAHA__ CARF__ CHAP__

OTHER__ Please specify_____

Issued By	License/Certification Number	Current Dates
STATE:		
MEDICARE A:		
MEDICARE B:		
MEDICAID:		
ACCREDITATION:		

Please attach copies of all Licenses/Certifications for the facility as well as for all active licensed personnel (employed & contracted), including professional liability insurance and continuing education certificates.

Please attach a copy of the most recent survey results from the accrediting body, if applicable.

Please attach a copy of the most recent survey results from the State or CMS.

Please attach a copy of the current facility's malpractice policy.

Name of Primary Contact Person_____ Telephone(____)-_____

ADDITIONAL INFORMATION:

Please answer all of the questions, explaining any “Yes” answers on the space provided below.

In the past five years:

Has the corporation, an officer or a board member ever been convicted of a felony?

Yes No

Has your State License (if applicable) ever been denied, suspended or revoked for any reason?

Yes No NA

Has your DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?

Yes No NA

Have you ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), the Medicare/Medicaid Program, a Third Party Payor, or a Regulatory agency (CLIA, OSHA, etc.)?

Yes No

Explanation:

Is your office HIPAA Compliant? Yes No

ADDENDUM:

Beds

Total Licensed Bed Capacity: _____ Total Number of Medicare Certified Beds: _____

Services Available

HOSPITAL ADDENDUM (Complete only if you are a hospital provider):

- | | | |
|---|---|---|
| <input type="checkbox"/> Air Ambulance | <input type="checkbox"/> Neonatal ICU | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Alcohol/Chemical Dependency | <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Speech Pathology |
| <input type="checkbox"/> Inpatient | <input type="checkbox"/> Nursery | <input type="checkbox"/> Inpatient |
| <input type="checkbox"/> Outpatient | <input type="checkbox"/> Nursing Facility | <input type="checkbox"/> Outpatient |
| <input type="checkbox"/> Adolescent | <input type="checkbox"/> Obstetrics | <input type="checkbox"/> Tissues Transplant |
| <input type="checkbox"/> Alzheimer’s Diagnosis and Assessment | <input type="checkbox"/> Occupational Therapy | <input type="checkbox"/> Trauma Facility/ER Dept. |
| <input type="checkbox"/> Birthing Rooms | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Resource |
| <input type="checkbox"/> Blood Bank | <input type="checkbox"/> Outpatient | <input type="checkbox"/> Regional |
| <input type="checkbox"/> Burn Unit | <input type="checkbox"/> Open Heart Surgery | <input type="checkbox"/> Area |
| <input type="checkbox"/> Cardiac Care Unit | <input type="checkbox"/> Organ Transplant | <input type="checkbox"/> Community |
| <input type="checkbox"/> Cardiac Rehab Program | Specify _____ | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> CT Scanner | <input type="checkbox"/> Outpatient Surgery | <input type="checkbox"/> Urgent Care Center |
| <input type="checkbox"/> Diabetic Education Program | <input type="checkbox"/> Pain Management | <input type="checkbox"/> Ventilator Care –Long Term |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Pediatrics | <input type="checkbox"/> Residential Day Care |
| <input type="checkbox"/> Geriatric Services | <input type="checkbox"/> PET Scanner | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Home Health Services | <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Sports Medicine |
| <input type="checkbox"/> Home Infusion | <input type="checkbox"/> Inpatient | <input type="checkbox"/> Swing Bed Program |
| <input type="checkbox"/> Hospice | <input type="checkbox"/> Outpatient | |
| <input type="checkbox"/> Hospital Based Ambulance | <input type="checkbox"/> Psychiatric Services | |
| <input type="checkbox"/> Intensive Care Unit | <input type="checkbox"/> Inpatient | |
| <input type="checkbox"/> Lithotripsy | <input type="checkbox"/> Outpatient | |
| <input type="checkbox"/> MRI Scanner | <input type="checkbox"/> Pediatric | |
| | <input type="checkbox"/> Adolescent | |

Other Services:

Are there services provided off-campus that would fall under the hospital outpatient billing and Tax ID?
Yes No

If yes, please list these services, names, and locations: (use additional sheet if necessary)

Are there any other certified facilities based at your hospital and if so, what are they (i.e., home health, hospice, skilled nursing, dialysis)?

Do you contract with any facility or provider group to provide services at the hospital? If so, what are the services, i.e., radiology, lab, ER, anesthesiology, DME, reference lab)

ATTESTATION:

The signature by the authorized agent for your organization/agency/facility attests to the accuracy of the information herein. Signature also grants Windsor Health Plan permission to verify information with primary sources.

Uses or disclosure of data contained in or attached to this document are subject to the restriction for use as indicated on the Title Page of the proposal and Quotation.

I further acknowledge that this application will be incorporated by reference into the Participating Provider Agreement if the facility is accepted as a Participating Provider.

Signature: _____

Printed Name: _____

Date: _____

Title: _____