Hospital/Facility Provider Credentialing Application

INSTRUCTIONS: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. The Application must be signed and dated.
3. If necessary, use a separate sheet of paper to provide additional information.

PROVIDER CHECKLIST:

- ☐ **ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION**
- ☐ **STATE OPERATING LICENSE**: including license number and expiration date, if applicable
- ☐ **PROFESSIONAL/FACILITY LIABILITY INSURANCE:** Certificate detailing amounts & dates of coverage; or attest within application. Minimum Requirement: $1M per occurrence and $3M per aggregate
- ☐ **ACCREDITATION CERTIFICATE:** Accreditation letter or certificate by a nationally recognized accrediting body, e.g., TJC, JCAHO, CARF, COA, AOA, if applicable
- ☐ **SITE EVALUATION RESULTS:** If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency, if applicable
- ☐ **OTHER APPLICABLE STATE/FEDERAL LICENSURES:** e.g., CLIA, DEA, Pharmacy Permit
- ☐ **OWNERSHIP AND DISCLOSURE FORM**

Facility Information	
Group or Facility Name	
Tax ID Number:	**NPI # (Group/Type 2):**
Medicare ID:	**Medicaid ID:**

Service Type:

- ☐ **Hospital Facility**
- ☐ **Skilled Nursing Facility**
- ☐ **Home Health**
- ☐ **Ambulatory Surgical Center**
- ☐ **Durable Medical Equipment Supplier**
- ☐ **Other: _____**

Return to:
Western Sky Community Care Contracting Department
5300 Homestead Rd. NE
Albuquerque, NM 87110

Contact Information	
If questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**
Mailing Address:	**City, State, Zip:**

Credentialing Contact Information ☐ Same as Contact Information	
If questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**
Mailing Address	**City, State, Zip:**

Insurance Information – complete or attach insurance certificate	
Professional Carrier:	**Amount of Coverage:** **Per Occurrence:** **Per Aggregate:**
Policy Number:	**Coverage Dates:**

Facility Information		
Service Location Address:		
Physical Street Address:	**City, State, Zip:**	**County:**

Accreditation/Certification Type *Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.*			
Agency Name	✓	**Effective Date**	**Expiration Date**
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP)			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Sanctions	
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐ **Yes** ☐ **No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐ **Yes** ☐ **No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐ **Yes** ☐ **No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐ **Yes** ☐ **No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐ **Yes** ☐ **No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐ **Yes** ☐ **No**

If you answered yes to any of the above, please explain below, or in a separate document.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Facility: _____ **Date:** _____

Print or type name

_____

Signature of Authorizing Representative **Title**

A stamp signature is not acceptable