# UNIFORM FACILITY CREDENTIALING APPLICATION

☐ Initial Credentialing ☐ Re-credentialing

## APPLICATION INSTRUCTIONS

- ALL fields must be completed unless otherwise directed
- Please do not use abbreviations when completing the application
- **If any of your locations has a unique license, unique NPI and/or a unique Tax ID number, a separate credentialing event and application will be required**. If you have multiple locations that bill under the same license/NPI/Tax ID, please complete and attach a Secondary Locations Excel Worksheet
- Submit completed application along with **all** required documentation
- Please E-mail Completed Application to credentialingahp@optum.com

## APPLICATION NOTES

- For the purposes of this application, "facility" is defined as a hospital; home health agency; skilled nursing facility; ambulatory surgery center; and inpatient, residential, ambulatory behavior health facility, or any organizational provider to which health plan members can be directed for service.
- As required by the facility contract and accrediting agencies, one unique application is required for each facility type and location as listed on pages three and four
- Failure to complete this application in its entirety, including submission of required documentation may delay or suspend network participation

## ATTACHMENTS

**THE PROCESSING OF YOUR APPLICATION WILL BE DELAYED IF ALL REQUIRED INFORMATION IS NOT SUBMITTED**

| | |
|---|---|
| ☐ | Copy of all current State and/or local licenses required to operate as a health care facility. If your State / provider type does not require a State / local license [Explanation Needed] |
| ☐ | Current copy of your onsite governmental agency site survey including facility's corrective action plan if deficiencies were cited, OR cover letter/e-mail from licensing agency stating facility is in substantial compliance with licensing standards |
| ☐ | Current copy of facility Commercial Liability Insurance Certificate |
| ☐ | Current copy of facility Professional Liability Insurance Certificate covering all facility employees |
| ☐ | Copy of current accreditation letter or certificate is required please note all CMS accrediting organizations are accepted |
| ☐ | Signed copy Medicare certification documents from CMS |

# UNIFORM FACILITY CREDENTIALING APPLICATION

## 1. FACILITY IDENTIFICATION

<table>
<tr><th colspan="5">CORPORATE IDENTIFICATION INFORMATION</th></tr>
<tr><td colspan="2">LEGAL BUSINESS NAME (as reflected on W-9)</td><td colspan="3">FEDERAL TIN/TAX ID (application cannot be processed without valid 9-digit TIN)</td></tr>
<tr><td colspan="2">BUSINESS ADDRESS (if different than facility address)</td><td colspan="3">TYPE-2 NPI (application cannot be processed without valid 10-digit NPI)</td></tr>
<tr><td colspan="2">ORGANIZATION CLASSIFIED AS:<br>☐ Corporation ☐ Partnership<br>☐ Not-For-Profit Corp ☐ Sole Proprietorship<br>☐ Other (Specify)</td><td colspan="3">Is facility owned in whole or in part or managed by a hospital or health care system/facility?<br>☐ Yes, owned in whole or in part by<br>☐ Yes, managed by<br>☐ No, not affiliated with a hospital or health care system/Facility</td></tr>
<tr><th colspan="5">FACILITY INFORMATION</th></tr>
<tr><td colspan="5">FACILITY DOING BUSINESS AS NAME (as reflected on W-9)</td></tr>
<tr><td colspan="2">STREET ADDRESS:</td><td>CITY:</td><td>STATE:</td><td>ZIP CODE:</td></tr>
<tr><td>COUNTY:</td><td>PHONE:</td><td>FAX:</td><td colspan="2">WEBSITE:</td></tr>
<tr><td colspan="5">OFFICE ADMINISTRATOR (Name, Title, Email, Phone, Fax)</td></tr>
<tr><td colspan="5">APPLICATION CONTACT PERSON (Name, Title, Email, Phone, Fax)</td></tr>
<tr><th colspan="5">MAILING/CORRESPONDENCE ADDRESS</th></tr>
<tr><td colspan="5">☐ Check here if all correspondence can be directed to the facility location directly above.<br>Otherwise, complete the section below.</td></tr>
<tr><td colspan="5">FACILTY NAME</td></tr>
<tr><td colspan="5">FACILITY ADDRESS</td></tr>
<tr><td colspan="5">FACILITY COUNTY AND PHONE NUMBER</td></tr>
<tr><td colspan="5">OFFICE ADMINISTRATOR (Name, Title, Email, Phone, Fax)</td></tr>
<tr><td colspan="5">APPLICATION CONTACT PERSON (Name, Title, Email, Phone, Fax)</td></tr>
</table>

# UNIFORM FACILITY CREDENTIALING APPLICATION

| OFFICE HOURS | | | | | | |
|---|---|---|---|---|---|---|
| Monday | Tuesday | Wednesday | Thursday | Friday | Saturday | Sunday |
| | | | | | | |
| | | Required After-hours coverage: | | | | |
| ☐ 24/7 Service | | ☐ Answering Service | | ☐ Voicemail with Instructions | | |

| ADA REQUIREMENTS | | |
|---|---|---|
| Access & Availability | Appropriate Equipment Available | |
| ☐ Yes ☐ No | ☐ Yes | ☐ No |

## 2. MEDICAL DIRECTOR OR EQUIVALENT

***A specific physician Medical Director or equivalent must clearly be identified and must be licensed in good standing.***

Name: MD ☐ DO ☐ Other ☐ Specialty:

License Number: NPI Number:

Phone Number: Email Address:

## 3. FACILITY TYPE

***One box must be checked based on licensure status.***

**Medical**

- ☐ Ambulance Service/Transportation Company
- ☐ Ambulatory Surgical Center
- ☐ Audiology/Hearing Center
- ☐ Birthing Center
- ☐ Cardiac Rehab Center
- ☐ Comprehensive Outpatient Rehab Facility
- ☐ Diabetes Education Center
- ☐ Diagnostic and Treatment Center
- ☐ Durable Medical Equipment (DME)
- ☐ Stage Renal Disease Facility (ESRD)
- ☐ Endoscopy Facility
- ☐ Federal Qualified Health Center (FQHC)
- ☐ Home Health Agency
- ☐ Home Infusion
- ☐ Hospice
- ☐ Hospital
- ☐ Independent Lab/Privately Owned Lab
- ☐ Infertility Center
- ☐ Infusion Therapy Clinic Laboratory
- ☐ Magnetic Resonance Imaging (MRI)
- ☐ Mobile X-Ray/Mobile Diagnostic Provider
- ☐ Non-Emergent Transportation Services
- ☐ Nursing Home
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Rehab Facility (ORF)
- ☐ Radiation / Cancer Treatment Centers
- ☐ Rural Health Clinic (RHC)
- ☐ Skilled Nursing Facility (SNF)
- ☐ Sleep Medicine Center
- ☐ Urgent Care Center ( U C )
- ☐ Other Medical Provider type: ________

**Behavioral Health**

- ☐ Behavioral Health Facility
- ☐ Behavioral Health Unit
- ☐ Hospital, Behavioral Health
- ☐ Local Behavioral Health Authority (LBHA)
- ☐ Local Mental Health Authority (LMHA)
- ☐ Mental Retardation Diagnostic Services (MRDA)
- ☐ Opioid Treatment Program (OTP)
- ☐ Physiological-Independent Diagnostic Testing (IDTF)
- ☐ Psychiatric Clinic
- ☐ Psychiatric Residential Treatment Facility
- ☐ Rehab Behavioral Health Service Assisted Long-Term Care
- ☐ Residential Treatment Facility/Program
- ☐ Targeted Case Management Provider LMHA/LBHA)
- ☐ Chemical Dependency Treatment Facility (CDTF)
- ☐ Community Mental Health Center (CMHC)
- ☐ Other Behavioral Health Provider type: _______

***FOR HOSPITALS ONLY***
**Does your Facility provide any of the following services?**

| Service | Yes | No | Service | Yes | No |
|---|---|---|---|---|---|
| Critical Access Hospital | ☐ Yes | ☐ No | Cardiac Surgery Program | ☐ Yes | ☐ No |
| Outpatient Dialysis | ☐ Yes | ☐ No | Physical Therapy | ☐ Yes | ☐ No |
| Critical Care Services - Intensive Care Unit (ICU) | ☐ Yes | ☐ No | Occupational Therapy | ☐ Yes | ☐ No |
| Diagnostic Radiology | ☐ Yes | ☐ No | Outpatient Infusion / Chemotherapy | ☐ Yes | ☐ No |
| Mammography | ☐ Yes | ☐ No | Speech Therapy | ☐ Yes | ☐ No |
| Genetic Counseling and Testing | ☐ Yes | ☐ No | Laboratory Services | ☐ Yes | ☐ No |
| Cardiac Catheterization Services | ☐ Yes | ☐ No | | | |

## 4. FACILITY LICENSURE

***Attach a copy of each Facility license for the facility listed on page three or four***

| Licensing Agency | License Number | Effective date | Expiration Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

## 5. MEDICARE STATUS

Is this facility/program/agency Medicare certified? ☐ YES ☐ NO

If Yes: Medicare number: Date of initial Certification:

☐ Check here if facility is not eligible for Medicare certification.

## 6. ACCREDITATION

*The Facility being credentialed must be listed in the accreditation and a copy of each accreditation is required*

| | |
|---|---|
| ☐ | **AAAASF - American Association for Accreditation of Ambulatory Surgery Facilities** |
| ☐ | **AAAHC - Accreditation Association for Ambulatory Health Care** |
| ☐ | **ACHC - Accreditation Commission for Health Care** |
| ☐ | **American Board for Certification in Orthotics & Prosthetics** |
| ☐ | **ACR - American College of Radiology** |
| ☐ | **CARF - Commission on Accreditation of Rehabilitation Facilities** |
| ☐ | **CCAC - Continuing Care Accreditation Commission** |
| ☐ | **Center for Improvement in Healthcare Quality** |
| ☐ | **CLIA - Clinical Laboratory Improvement Amendments** |
| ☐ | **COA - Council on Accreditation** |
| ☐ | **Commission on Office Laboratory Accreditation** |
| ☐ | **DNV / NIAHO - Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations** |
| ☐ | **Healthcare Quality Association on Accreditation** |
| ☐ | **HFAP - Healthcare Facilities Accreditation Program** |
| ☐ | **National Board of Accreditation for Orthotic Suppliers** |
| ☐ | **RadSite** |
| ☐ | **TJC - The Joint Commission (Formerly known as JCAHO)** |
| ☐ | **Other** |

**1. Date of last full site survey by accrediting body:**

**2. Site survey is scheduled:**

**3. Effective date of accreditation:** **through**

**Facility is not currently accredited.** ***Complete Non-Accredited Facility Section below.***

## 7. NON ACCREDITED FACILITY

*Complete this section if facility is not accredited.*

**Medical Facility: Has your State completed an onsite licensing review or has CMS certification survey within the past 36 months?**

☐ **YES - Date of most recent onsite survey:**

***Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.***

☐ **NO - *Successful completion of a health plan onsite visit will be required to complete re/ credentialing.* You will be contacted by health plan to schedule the visit.**

**If your State has not had a Services Site survey within the past 36 months, please note when your next site survey is scheduled:**

**Behavioral Health Facility: Has your State completed an onsite licensing site review within the past 36 months?**

☐ **YES- Date of most recent onsite survey:**

***Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.***

☐ **NO – *Successful completion of a health plan onsite visit will be required to complete re/credentialing.* You will be contacted by health plan to schedule the visit.**

**If you have not had a State site survey within the past 36 months, please note when your next site survey is scheduled:**

## 8. HEALTH PLAN SITE VISIT:

**Does your branch or satellite location(s) follow the same policies and procedures as your main facility?**

☐ Yes - Fill out the attached Policy and Procedure Attestation on page 7.

☐ No - When the health plan contacts you to schedule the health plan site visit, it will be determined if site visits are required for the branch/satellite locations.

# POLICY ATTESTATION

Please list any other facilities under the same name and/or tax id number as name of facility, specialty and location listed on this application.

If your facility follows the same policies and procedures as your main facility, the **Aspirus Health Plan** may limit a site visit.

## Attestation:

I, the undersigned authorized agent, hereby attest and certify that (name of facility, specialty and location) shares the same policies and procedures as: (list all facilities, specialty and locations)

| Facility Name | Specialty | Location | TIN | NPI |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

_______________________________________________ ________/________/________

Signature of Authorized Representative Date Signed

_________________________________________ ____________________________

Printed Name Title

## 9. CREDENTIALING PROGRAM

Indicate how credentialing is ensured for all health care professionals employed or contracted at the facility:

☐ Credentialing procedures are performed internally

☐ Credentialing procedures are outsourced/delegated to:

Name: Phone Number:

## 10. INSURANCE COVERAGE

1. This facility is covered by **Commercial General** liability insurance in the minimum amount of

$ per occurrence and $ aggregate? (Excess liability/Umbrella coverage can count toward the

$ aggregate amount.)

☐ YES - Attach copy of insurance certificate. We prefer the Acord® Certificate of Liability Coverage

☐ Facility is covered by Government insurance. – Attach documentation detailing coverage.

2. Is this facility covered by **Professional** liability insurance in the minimum amount of $1 million per

occurrence and $3 million aggregate? Policy must state it covers all facility employees.
(Excess liability/Umbrella coverage can count toward the $3 million aggregate amount.)

☐ YES - Attach copy of insurance certificate. We prefer the Acord® Certificate of Liability Coverage form.

☐ Facility is covered by Government insurance - Attach documentation detailing coverage.

*NOTE: Hospitals may be required to have additional insurance cover amounts*

3. Is this facility required to carry automobile insurance?

☐ No

☐ Yes – attach a copy of the certificate

# UNIFORM FACILITY CREDENTIALING APPLICATION

## FACILITY CREDENTIALING APPLICATION LANGUAGES

- ***Languages Spoken by Provider Staff other than English:***

| ☐ | SPANISH | ☐ | HMONG | ☐ | DUTCH |
|---|---|---|---|---|---|
| ☐ | CHINESE | ☐ | GERMAN | ☐ | FRENCH |
| OTHER: | | | | | |
| ☐ | AMERICAN SIGN LANGUAGE | ☐ | INTERPRETER SERVICE UTILIZED BY FACILITY | | |

## 11. NON -MEDICARE CERTIFIED HOME CARE AGENCY SECTION

***Complete this section ONLY if the facility is a Home Care Agency that is not Medicare (CMS) certified. Answer ALL questions.***

1. Indicate the age range of clients accepted. to

2. Number of agency employees in each category:

- Registered Nurses (RN):
- Licensed Practical Nurses (LPN):
- Home Health Aide:
- Other

3. Give reason(s) this home care agency has not pursued/been granted Medicare certification.

## 12. PROFESSIONAL DISCLOSURE QUESTIONS

**Please include an explanation on a separate sheet for any question(s) answered Yes.**

1. Has the organization ever been reprimanded, fined by any state agency that disciplines allied health professionals or health organizations? ☐Yes ☐No
2. Has the organization's license to practice or operate in any jurisdiction (state or county) ever been denied, revoked, suspended, sanctioned or subject to probation or any conditions or limitations? ☐Yes ☐No
3. Have any disciplinary proceedings ever been instituted against the organization by any medical organization or medical institute? ☐Yes ☐No
4. Has the organization ever been convicted of a felony? ☐Yes ☐No
5. Have any malpractice suits, arbitration or other proceeding ever been instituted against the organization (regardless of outcome)? ☐Yes ☐No
6. Has the organization ever been investigated, reprimanded, censured, excluded, suspended or disqualified by Medicare or Medicaid program? ☐Yes ☐No
7. Has the organization's liability insurance policy ever been canceled? ☐Yes ☐No
8. Has the organization ever been denied renewal of the liability insurance policy or had any limitations placed on the scope of coverage? ☐Yes ☐No

Note: This impacts the section called "Enclosures."

**Explanation of "Yes" answers to attestation questions Credentialing Questionnaire**

# UNIFORM FACILITY CREDENTIALING APPLICATION

## 13. PROVIDER INTEGRITY ATTESTATION OR ELECTRONIC SIGNATURE

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a participating provider.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

**Signature of Authorized Representative** | **Printed Name of Authorized Representative**

**Date Signed** | **Authorized Representative's Title**

70079 11-24 ©2024 Aspirus Health Plan, Inc. All rights reserved.