Facility Credentialing Application

SANFORD HEALTH PLAN

Return this completed form in the enclosed envelope along with copies of the following:

1. Copy of State Facility License
2. Most recent CMS or State Department of Health survey report, (or)
3. Approval letter from CMS or State Department of Health stating facility's review date and inspection results
4. Copy of JCAHO Accreditation Letter and Accreditation Decision Grid, (or)
5. Copy of the most recent survey results from the State Department of Health if not currently accredited by JCAHO, AAAHC, or AAAASF
6. Copy of Professional Liability and General Liability Insurance Certification, which list amounts and coverage dates

Please indicate type of organization (Choose all that apply):

- ☐ Ambulatory Surgical Clinic/Center (261QA1903X)
- ☐ Chronic Disease Hospital (281P00000X)
- ☐ Clinical Medical Laboratory (219U00000X)
- ☐ DME & Medical Supplies (332B00000X)
- ☐ General Acute Care Hospital (282N00000X)
- ☐ Hearing and Speech Clinic/Center (261QH0700X)
- ☐ Home Health Agencies (251E00000X)
- ☐ Hospice, Inpatient (315D00000X)
- ☐ Hospice Care, Community Based Agencies (251G00000X)
- ☐ Long Term Care Hospital (282E00000X)
- ☐ Magnetic Resonance Imaging Clinic/Center 261QM1200X)
- ☐ Ophthalmologic Surgery Clinic/Center (261QS0132X)
- ☐ Physical Therapy Clinic/Center (261QP2000X)
- ☐ Radiology, Mammography Clinic/Center (261QR0206X)
- ☐ Rehabilitation Clinic/Center (261QR0400X)
- ☐ Rehabilitation Hospital (283X00000X)
- ☐ Rural Health Clinic/Center (261QR1300X)
- ☐ Skilled Nursing Facility (314000000X)
- ☐ Substance Abuse Rehabilitation Facility (324500000X)
- ☐ Urgent Care Clinic/Center (261QU0200X)
- ☐ Other _____
- ☐ Taxonomy Code____

Please reference the NPPES website to find your specialty/taxonomy: https://nppes.cms.hhs.gov/NPPES/Welcome.do

General Information

Facility Name: _____

Federal Tax ID Number:_____NPI(s):_____

Address:_____ City, State, Zip:_____

Phone Number:_____Fax:_____

Billing Address: _____

Contact Person:_____Email address: _____

If the facility operates more than one patient site (inpatient or outpatient), please indicate additional Names, Tax ID numbers, NPI numbers, addresses and phone numbers on the second page.

Licensure and Accreditation

Ownership: _____

Legal type:

- ☐ Nonprofit Corporation
- ☐ Professional Corporation
- ☐ Subsidiary
- ☐ Wholly Owned Subsidiary
- ☐ Limited Liability Corporation

Is the facility licensed by the state? *(Please check one)* ☐ Yes ☐ No

If yes, name (as it appears on the license):_____

License number:_____Expiration date: _____

General Information

Facility Name: _____

Federal Tax ID Number: _____ NPI(s): _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax: _____

Billing Address: _____

Contact Person: _____ Email address: _____

General Information

Facility Name: _____

Federal Tax ID Number: _____ NPI(s): _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax: _____

Billing Address: _____

Contact Person: _____ Email address: _____

Is the facility accredited? ☐ Yes ☐ No

Accrediting Body: _____ Date of last accreditation: _____

Date of most recent CMS Survey: _____

Have there been any Medicare/Medicaid sanctions in the last 3 years? ☐ Yes ☐ No

Medicare #: _____ Medicaid #: _____

Liability Insurance Coverage

Carrier Name: _____

Single Occurrence Amount: _____ Aggregate Amount: _____

Beginning Date (Mo/Day/Yr): _____ End Date (Mo/Day/Yr): _____

Beds

Type of Bed	Med./Surg.	Special Care	Obstetrical	Pediatric	Swing Bed	Other	Total
Licensed							

Average Admits per (choose one of the following):
Day _____ Month _____ Year _____ ☐ Not Applicable

Radiology

If the facility has a contractual relationship for Radiology, list contracting party: ☐ Not Applicable

Pathology

If the facility has a contractual relationship for Pathology, list contracting party: ☐ Not Applicable

Referral Patterns

If physicians affiliated with the facility refer most of their tertiary care to one or more other institutions, please indicate:

Is your facility a teaching facility? ☐ Yes ☐ No

Name of teaching affiliation: _____

Disclosure Questions

Please provide a complete explanation if any of the following questions are answered in the affirmative.

Has your license ever been restricted, conditioned, suspended or terminated? ☐ Yes ☐ No

Does your organization have any current state or federal sanctions or limitations? ☐ Yes ☐ No

Attestation

All information and documentation submitted here within is correct and complete to my best knowledge and belief. I acknowledge and understand that any material misstatements in or omissions from this application may constitute cause for denial of my application for participation in the health plan. A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

I authorize Sanford Health Plan the right to obtain documents, recommendations, reports and statements relating to the Credentialing process of this facility and the associated facilities that intend to contract with the Sanford Health Plan. In addition, I also authorize the right to verify my standing with state & federal regulatory bodies relating to the Credentialing process.

Name (print): _____

Signature: _____ Date: _____

Phone Number: _____ Fax Number: _____

Please indicate on Attachment (A), all programs or services provided by your institution. If these programs or services are billed for under a different name and address, please indicate. If these services have been accredited or licensed by an agency which is different from those above, please provide the name of the accrediting agency and the date of accreditation.

Services offered

- ☐ Alzheimer Unit
- ☐ Ambulance Service
- ☐ Anesthesia Service Given by CRNA
- ☐ Anesthesia Service Given by Physician
- ☐ Assisted Living
- ☐ Blood Bank - Collection & Process
- ☐ Burn Intensive Care
- ☐ Cardiology
- ☐ Cardiac Rehabilitation
- ☐ Chemical Dependency Program
- ☐ Chemotherapy
- ☐ Child Diagnosis
- ☐ Child Treatment
- ☐ Communicable Disease
- ☐ Coronary Intensive Care
- ☐ CT Scanner
- ☐ Ct Scanner (Mobile)
- ☐ Dental
- ☐ Dental Surgery
- ☐ Dermatology
- ☐ Diabetes
- ☐ Diabetes Training Class
- ☐ Diabetic Counseling
- ☐ Emergency Helicopter Service
- ☐ Emergency Service (24 hrs)
- ☐ Family Planning
- ☐ Family Therapy
- ☐ Geriatric Acute Care
- ☐ Hematological Service
- ☐ Home Dialysis Training
- ☐ Home Nursing Care
- ☐ Hospice Care
- ☐ Intensive Care Unit
- ☐ Mammography
- ☐ Meals on Wheels Program
- ☐ MRI Services
- ☐ Medical Intensive Care
- ☐ Medical Research
- ☐ Neonatal Acute Care
- ☐ Obstetrics
- ☐ Occupational Therapy
- ☐ On Site Medical/Surgical Services
- ☐ Open Heart Surgery Services
- ☐ Ophthalmology
- ☐ Organ Bank
- ☐ Orthopedic Surgery
- ☐ Otolaryngology
- ☐ Parent Training Class
- ☐ Pediatric
- ☐ Pediatric Intensive Care
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Plastic Surgery
- ☐ Podiatry
- ☐ Post Partum Care
- ☐ Premature Nursery Care
- ☐ Psychiatric
- ☐ Psychiatric Long Term Care
- ☐ Pulmonary Intensive Care
- ☐ Pulmonary Laboratory Services
- ☐ Radiologist
- ☐ Renal Dialysis Services
- ☐ Renal Dialysis Training Class
- ☐ Skilled Nursing/Extended Care
- ☐ Social Worker
- ☐ Speech Therapy
- ☐ Surgical Acute Care
- ☐ Surgical Intensive Care
- ☐ Urinalysis Service
- ☐ X-Ray Exam