Facility Credentialing Application

PO Box 91110
Sioux Falls, SD 57109
(605) 328-6800 | 1-800-752-5863
Fax: (605) 328-6840
sanfordhealthplan.com

SANFORD HEALTH PLAN

Thank you for your interest in Sanford Health Plan. This application will need to accompany a signed and dated Participating Provider Agreement (not required for re-credentialing). Please follow the instructions to ensure you have all the necessary items to avoid processing delays.

In order for your application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each legal entity/Tax ID
3. The application must be signed and dated. Signature dates must not be more than 60 days old upon receipt for application to be accepted.
4. NPI matches NPPES and NPI's used on the app are consistent throughout.
5. If necessary, use a separate sheet of paper to provide additional information.

Documents you will need to provide:

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

If these documents cannot be provided please explain:

_____

_____

☐ Initial Credentialing/Recredentialing ☐ Addition of new site to current contract

Initial and Addition of New Site to Current Contract Applications
Return to Sanford Health Plan Provider Contracting
Email:sanfordhealthplanprovidercontracting@sanfordhealth.org
Fax: 605-328-7224
Mail: PO Box 91110, Sioux Falls SD 57109-1110
For Questions Call: 855-263-3544

Recredentialing Applications
Return to Sanford Credentialing Services
Email: credentialing@sanfordhealth.org
Fax: 605-312-9801
Mail: PO Box 91407, Sioux Falls SD 57109
For Questions Call: 605-312-7600

Important Notice: Failure to legibly complete all sections of this Application and submit current copies of ALL required documentation will result in processing delays. Initial credentialing applications WILL be discontinued if requested information is NOT provided within 30 days of Sanford's receipt of an application. Sanford Credentialing will obtain information from various outside sources (e.g., state licensing agencies, accreditation sources) to evaluate your application. You have the right to review any primary source information the Plan collects during this process. However, this does not include references or recommendations or other information that is peer review protected

CONTACT INFORMATION: If questions about this application, contact:

Contact Name: _____ Email address: _____

Phone number: (_____) _____ - _____ Fax Number: (_____) _____ - _____

LEGAL ENTITY INFORMATION (Name on income tax return)

Tax ID Holder/Facility Name: _____

Federal Tax ID Number: __ __ __ - __ __ - __ __ __ __

Legal Tax Address (where you want the 1099 sent): _____

City _____ State _____ Zip:_____

Phone Number: (_____) _____ - _____ Fax: (_____) _____ - _____

Ownership: _____

Legal type: ☐ Nonprofit Corporation ☐ Professional Corporation ☐ Subsidiary

BILLING INFORMATION same as Legal Entity

Pay To Name (issues check to): Note: may be different than name on the 1099.

Federal Tax ID Number: __ __ __ - __ __ - __ __ __ __NPI(s):_____

Pay to Address (send remittance to):_____

City _____ State _____ Zip:_____

Phone Number: (_____) _____ - _____ Fax: (_____) _____ - _____

Billing Contact Person: _____

Billing Contact email address: _____

Complete for each service location that is part of this application.

Service Location 1 of _____(Must be a street address, not a post office box)

Facility Name (to be displayed in the directory): _____

Federal Tax ID Number: __ __ __ - __ __ - __ __ __ __ Same as Legal Entity NPI(s): ☐ _____

State License Number: _____ Medicaid Number:_____

Medicare Number: _____

Service Location Address: ☐ Same as Legal Entity _____

City _____ State _____ Zip:_____

County: _____

Main Switchboard Phone Number: (_____) _____ - _____

Service Location Fax Number: (_____) _____ - _____

Web address: _____

Service Location Handicap Access? ☐ Yes ☐ No

Service Location Accepting new patients ☐ Yes ☐ No

ADA Compliant (including offices, exam rooms and equipment) ☐ Yes ☐ No

Is American Sign Language or other auxiliary aid services available ☐ Yes ☐ No

Please list any foreign languages spoken at this location: _____

Number of Beds _____

ECP PROVIDERS (EXCHANGE/COMMERCIAL ONLY)

Are you considered an Essential Community Provider as defined by CMS? ☐ Yes ☐ No

SITE VISIT REQUIREMENT

1. Has the Department of Human Services (DHS) or a government agency delegated by DHS
☐ completed a post-licensing onsite survey within the past 36 months?
☐ (YES) Date of most recent full survey _____/_____/_____
(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.
2. Were any deficiencies cited during the last survey? ☐ (YES) ☐ (NO) ☐ (N/A) (no recent survey)
If (NO), submit verification of no deficiencies.
If (YES), have all deficiencies been corrected?
YES - Provide evidence of acceptance letter by DHS.

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

- ☐ Ambulatory Surgical Clinic/Center (261QA1903X)
- ☐ Ambulance, Air Transport (3416A0800X)
- ☐ Ambulance, Land Transport (341600000X)
- ☐ Chronic Disease Hospital (281P00000X)
- ☐ Clinical Medical Laboratory (219U00000X)
- ☐ Critical Access Hospital (261QC0050X)
- ☐ DME & Medical Supplies (332B00000X)
- ☐ Federal Qualified Health Center (FQHC) (261QF0400X)
- ☐ General Acute Care Hospital (282N00000X)
- ☐ Hearing and Speech Clinic/Center (261QH0700X)
- ☐ Home Health Agencies (251E00000X)
- ☐ Hospice, Inpatient (315D00000X)
- ☐ Hospice Care, Community Based Agencies (251G00000X)
- ☐ Indian Health Service Facility
- ☐ Long Term Care Hospital (282E00000X)
- ☐ Magnetic Resonance Imaging Clinic/Center 261QM1200X)
- ☐ Opioid (Methodone) Treatment Program
- ☐ Ophthalmologic Surgery Clinic/Center (261QS0132X)
- ☐ Physical Therapy Clinic/Center (261QP2000X)
- ☐ Radiology, Mammography Clinic/Center (261QR0206X)
- ☐ Rehabilitation Clinic/Center (261QR0400X)
- ☐ Rehabilitation Hospital (283X00000X)
- ☐ 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

Services offered

Please indicate 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.

- ☐ Alzheimer Unit
- ☐ Ambulance Service (Air)
- ☐ Ambulance Service (Ground)
- ☐ Anesthesia Service Given byCRNA
- ☐ Anesthesia Service Given byPhysician
- ☐ Assisted Living
- ☐ Blood Bank - Collection & Process
- ☐ Burn Intensive Care
- ☐ Cardiac Rehabilitation
- ☐ Cardiology
- ☐ 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 Health Care
- ☐ Home Health Care with (LTSS) Services: ☐ PT ☐ OT ☐ ST
- ☐ Home Infusion
- ☐ Home Dialysis Training
- ☐ Home Nursing Care
- ☐ Hospice Care
- ☐ Intensive Care Unit
- ☐ Long Term Service and Support (LTSS)
- ☐ Mammography
- ☐ Meals on Wheels Program
- ☐ Medical Intensive Care

- ☐ Medical Research
- ☐ MRI Services
- ☐ 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 TermCare
- ☐ Pulmonary Intensive Care
- ☐ Pulmonary Laboratory Services
- ☐ Radiologist
- ☐ Renal Dialysis Services
- ☐ Renal Dialysis TrainingClass
- ☐ Skilled Nursing/ Extended Care
- ☐ SocialWorker
- ☐ Speech Therapy
- ☐ Surgical Acute Care
- ☐ Surgical Intensive Care
- ☐ Telemedicine Services
- ☐ Telemonitoring Services
- ☐ Urgent Care Center
- ☐ Urinalysis Service
- ☐ X-Ray Exam
- ☐ Other: _____

Long Term Service & Support Provider
Please select service type:

LTSS Service

- ☐ Adult Day Care (X1)
- ☐ Primary Home Care/PAS (X2)
- ☐ TAS (Transitional Assistant Services) (XY)
- ☐ FMS (Financial Management Services) (XU)
- ☐ Value Added (X3)
- ☐ Assisted Living/Respite Care (X4)
- ☐ Adult Foster Care (X5)
- ☐ Emergency Response System (X6)
- ☐ Nursing Facility (X7)
- ☐ Home Delivered Meals (X8)
- ☐ Adaptive Aides/Medical Equipment (X9)
- ☐ Minor Home Modifications (XA)
- ☐ Physical Therapy (XB)
- ☐ Occupational Therapy (XC)
- ☐ Speech Therapy (XD)
- ☐ Employment Assistance Services (XE)
- ☐ Habilitation (XH)
- ☐ PAS for CFC only (XN)
- ☐ Supported Employment (XS)

LICENSURE * Provide copy of licensure

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

If yes, please provide the following information:

Name (as it appears on the license): _____

License number: _____ Expiration date: _____

Date of most recent CMS Survey: _____

Accreditation/Certification Type

Please provide a copy of these documents; including the Survey Results and a report that shows the effective or survey date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name _____

☐ Accreditation Commission for Health Care (AHCH)

☐ 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)

☐ College of American Pathologists (CAP)

☐ Commission on Accreditation for Rehab Facilities (CARF)

☐ Community Health Accreditation Program (CHAP)

☐ 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)

☐ State Facility Operating License

☐ The National Board of Accreditation for Orthotic Suppliers (NBAOS)

☐ Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)

☐ Other (please list) _____

Disclosure Questions & Sanctions

If yes, to any question below, please explain on a separate sheet of paper.

1. Have there been any settled malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?
   ☐ Yes ☐ No
2. 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
3. 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
4. Has your Organization license ever been restricted, conditioned, suspended or terminated?
   ☐ Yes ☐ No
5. Does your Organization have any current state or federal sanctions or limitations?
   ☐ Yes ☐ No

LIABILITY INSURANCE COVERAGE: Sanford Health Plan requires 1,000,000/3,000,000 or 2,000,000/2,000,000.

Please provide your liability insurance coverage information below:

Carrier Name: _____

Single Occurrence Amount: _____ Aggregate Amount: _____

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

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 or omissions may constitute cause for denial of 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.

_____ _____

Printed Name of Authorized Representative

_____ _____

Signature

_____ _____

Authorized Representative's Title Date signed

SANFORD HEALTH PLAN