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Facility Application for Participation

WHP Credentialing Application Checklist

- Completed Application
- Signed and Dated Attestation and Release of Information page
- Current Valid State License
- Accrediting Body Certificates
- State/CMS Survey Results
- Quality Improvement Plan; ***If not accredited***
- Medical Staff Credentialing Policy; ***If not accredited***
- All Professional Liability Carrier Policy Certificates for the last 5 years
- Brief Summaries for any professional liability/malpractice issues
(during the last 5 years)
- W-9

Equal Employment Commitment: It is the policy of Windsor Health Plan to adhere to all applicable federal, state and local fair employment practice laws, orders and regulations. WHP contracts and credentials without regard to race, color, religion, sex, national origin, veteran status, disability (provided that the organization/individual is able to perform the essential functions of the job with or without accommodation), or age. Decisions regarding credentialing are based upon valid job-related requirements.

Windsor Health Plan considers all credentialing information to be confidential and protects the confidentiality and integrity of its credentialing files.

WHP FACILITY CREDENTIALING APPLICATION

Initial Credentialing **Recredentialing** **Additional Site**

FACILITY INFORMATION (PLEASE PRINT CLEARLY):

Legal Name _____

d/b/a _____

Physical Street Address _____

City _____ State _____ Zip Code _____

County _____

Contact Person for Credentialing _____

Phone _____ Fax _____ Email _____

Other Office Contact _____

Office Telephone # (____) ____ - ____ Office Fax # (____) ____ - ____

COUNTIES SERVED BY THIS ADDRESS: _____

(If additional space is needed, please add a separate page)

Billing Information:

Tax ID # _____ NPI # _____
(Required as of May 2007; contact CMS for more info)

Billing Address (if different) _____

City _____ State _____ Zip Code _____

Contact Person for Billing _____

Billing Telephone# (____) ____ - ____ Billing Fax # (____) ____ - ____

Please complete the Provider Summary by Location sheet for each site that uses the same remittance address and Tax ID number shown on this application.

Other Information:

President/CEO

Name _____ Title _____ Telephone (____) ____ - ____

Medical Director

Name _____ Title _____ Telephone (____) ____ - ____

LICENSE/CERTIFICATION INFORMATION (PLEASE PRINT CLEARLY):

* **Is the Facility Medicare/Medicaid Certified?** Yes No

(If yes, please provide the license number in the table below)

(If no, please provide explanation)

* **Were there any deficiencies from the last survey?** Yes No

(If so, please attach explanations and your action plan to address recommendations)

* **Have deficiencies been removed?** Yes No

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

(If yes, please select the accrediting body below and enter information in the table below)

(If pending, please indicate the date of survey or application date)

JCAHO ___ URAC ___ AAAHA ___ CARF ___ CHAP ___ CCAC ___ CLIA ___ NCQA ___

AASM ___ ACHC ___ AAAHC ___ OTHER ___ Please specify _____

****ALL ORGANIZATIONS WITHOUT ACCREDITATION ARE REQUIRED TO SUBMIT A QUALITY IMPROVEMENT PLAN and A WRITTEN COPY OF THE FACILITY'S MEDICAL STAFF SERVICE PLAN THAT INCLUDES THE PROCESS FOR VERIFYING THE CREDENTIALS OF ALL LICENSED AND CERTIFIED STAFF WHO PROVIDE SERVICES TO MEMBERS** (you may be asked to provide licenses/certificates for staff if necessary. If your organization is NOT accredited nor has a CMS site survey, Windsor Health Group may conduct on an onsite site review in order to meet NCOA standard requirements)**

	ISSUED BY	LICENSE/ CERTIFICATION #	CURRENT DATES
STATE:			
* MEDICARE A:			
* MEDICARE B:			
* MEDICAID:			
ACCREDITATION:			

PLEASE ATTACH current valid state business license along with any additional required licensure depending on type of facility (see appropriate attachments)

PLEASE ATTACH a copy of the accreditation certificate, if applicable.

PLEASE ATTACH a copy of the most recent survey results from the State or CMS.

PLEASE ATTACH a copy of the facility's current and historic malpractice policy. Also enclose claims history summaries (for past 5 years). Accredited organizations are not required to submit claims history.

**** All facilities with the exceptions of hospitals are required to carry liability insurance in the amount of \$1million per occurrence and \$3 million aggregate. Hospitals are required to carry a minimum of \$2 million per occurrence and \$5 million aggregate.****

ADDITIONAL INFORMATION (PLEASE PRINT CLEARLY):

Please answer **all** of the questions.

A. Is your office HIPAA Compliant? Yes *No

* If no, please explain: _____

B. In the past five (5) years, has the corporation, an officer, or a board member:

(1) ever been convicted of a felony? Yes No

If yes, explain: _____

(2) ever had State License (if applicable) limited, denied, suspended, or revoked for any reason?

Yes No NA

If yes, explain: _____

(3) ever had DEA Registration or State Controlled Substance Certificate (if applicable) denied, suspended, or revoked for any reason? Yes No NA

If yes, explain: _____

(4) 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

If yes, explain: _____

(5) ever had any professional liability issues/claims against the corporation, etc.?

** Yes No

**If yes, please list on separate form(s) the following information with regard to each professional liability claim or cause of action in which the corporation has been involved:

(a) plaintiff's/claimant's name;

(b) agency, court, or jurisdiction;

(c) date filed and docket number;

(d) description (i.e. dismissed, settled (include amount), judgment for defendant, judgment for plaintiff (include amount), pending, or in discovery.

Note that the individual managed care organizations will review a minimum of five year's professional liability history.

Organization Specialty

- | | | |
|--|---|--|
| <input type="checkbox"/> Ambulance Service | <input type="checkbox"/> Ambulatory Surgery Center | <input type="checkbox"/> Laboratory |
| <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Hospital | <input type="checkbox"/> Sleep Disorder |
| <input type="checkbox"/> Radiation Center
(Free Standing) | <input type="checkbox"/> Radiology (Diagnostic)
<input type="checkbox"/> Diagnostic Imaging
<input type="checkbox"/> PETS | <input type="checkbox"/> FQHC or RHC Clinic
<input type="checkbox"/> OTHER_____ |
| <input type="checkbox"/> Physical Rehabilitation Center
(Free Standing) | | |

If your organization is an Ambulance Service, please complete the following:

Which service category are you licensed/certified to provide? (check all that apply)

- Class A** – ambulance services provide capabilities for advanced life support or critical care.
- Class B** – ambulance services provide capabilities such as intravenous therapy, but lack paramedic staffing on all ambulances.
- Class C** – ambulance services provide capabilities for basic life support with two EMT.
- Class D** – ambulance services demonstrate compliance with minimum standards
- Special Ambulance Services** – conduct operations only upon a preplanned schedule or as a secondary transport resource.
- Air Ambulance Services** – conduct operations with helicopters or aircraft with special medical requirements.
- Invalid Vehicle Transport Services** – provide only stretcher transport for patients who are not ambulatory and do not require medical treatment while in transit.

If your organization is an Imaging Center, MRI Center or Radiation Oncology Center - please complete the following:

Which service category are you licensed/certified to provide? (check all that apply)

- | | | | |
|--|------------------------------|--|-------------------------------------|
| <input type="checkbox"/> ACR. | <input type="checkbox"/> MRI | <input type="checkbox"/> Mammography | <input type="checkbox"/> Ultrasound |
| <input type="checkbox"/> Radiation Oncology Programs | | <input type="checkbox"/> Breast Biopsy | |

If your facility is not accredited, please provide copies of the certificates for all PET scanners, MRI Megavoltage Radiation Therapy, Cardiac Catheterization including diagnostic, therapeutic, angioplasty and electrophysiology, registration and inspection information for Mammography and all other ionizing equipment.

If your organization is RHC or FOHC -- please submit the following information for providers who will be billing for services: (can submit on a spreadsheet or individually)

NAME	TITLE	DATE of BIRTH	SPECIALTY	SOCIAL SECURITY #
NPI #	UPIN#	LICENSE #	GENDER	DEA# if applicable

HOSPITAL 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? (i.e., home health, hospice, skilled nursing, or dialysis)?

**Yes No

****If yes, please include an attachment providing us with the name, address, phone/fax numbers, NPI #, Tax ID # and Medicare # for each certified facility.****

Do you contract with any facility or provider group to provide services at the hospital?

**Yes No

** If yes, what are the services (i.e., radiology, lab, ER, anesthesiology, DME, or reference lab)

PROVIDER SUMMARY BY LOCATION:

PLEASE COMPLETE THE FOLLOWING FOR EACH LICENSED SITE THAT USES THE TAX I.D. NUMBER SHOWN ON THE APPLICATION. IF ADDITIONAL SPACE IS NEEDED, ADD A SEPARATE PAGE.

A. Site Name: _____
Physical Address: _____
Phone: _____ Fax: _____
Counties Served: _____
Any Unique Site Information: _____
Accreditation Yes No

B. Site Name: _____
Physical Address: _____
Phone: _____ Fax: _____
Counties Served: _____
Any Unique Site Information: _____
Accreditation Yes No

C. Site Name: _____
Physical Address: _____
Phone: _____ Fax: _____
Counties Served: _____
Any Unique Site Information: _____
Accreditation Yes No

D. Site Name: _____
Physical Address: _____
Phone: _____ Fax: _____
Counties Served: _____
Any Unique Site Information: _____
Accreditation Yes No

E. Site Name: _____
Physical Address: _____
Phone: _____ Fax: _____
Counties Served: _____
Any Unique Site Information: _____
Accreditation Yes No

ATTESTATION

The signature by the authorized agent for _____
(**printed** name of your organization/agency/facility) attests to the accuracy of the information herein.

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.

I understand as an authorized agent for this organization/agency/facility, our organization has the right to correct erroneous information and the right to review information obtained to evaluate this credentialing application unless disclosure is prohibited by law or the information is protected by peer review. I further understand that we may contact the WHP Credentialing Department at any time to check the status of our credentialing at 615-782-7800.

Authorized Agent Signature _____

Title _____

Printed Name _____

Date _____

RELEASE OF INFORMATION

The signature by the authorized agent for _____
(**printed** LEGAL NAME of your organization/agency/facility) grants permission to any organization or individual from whom information is requested by Windsor Health Plan to release to WHP, all information in the possession of that individual or organization related to this organization/agency/facility, an officer, or board member.

I release the Federation of State Medical Boards from any liability whatsoever for provision of information to WHP. I release any individual or organization providing information pursuant to this authorization from any and all liability resulting from the release of such information.

I grant permission to any current or previous insurance carriers to release the professional liability insurance claims information to WHP and release the carrier, its officers, employees, directors, and agents from any claims, liabilities, actions, damages, or otherwise, for the release of such information if such information is released in good faith and without malice.

I understand as an authorized agent for this organization/agency/facility, our organization has the right to correct erroneous information and the right to review information obtained to evaluate this credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

Authorized Agent Signature _____

Title _____

Printed Name _____

Date _____