Hospital/Facility Provider Application

Instructions: In order for the 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/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following to the completed application:

- State Operational License
- Other applicable State/Federal Licensures
- Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/DNV/AAAASF/ AAAHC/AOA or equivalent) Accreditation letter with dates of accreditation
- Site Evaluation Results from a governmental agency to be licensed
- Ownership and Disclosure Form
- Other applicable State/Federal Licensures (See last page for list of state-required documents)

☐ **Initial Credentialing/ Assessment**
☐ **Re-Credentialing/ Re-Assessment**
☐ **Addition of new site to current contract**

Legal Entity/TIN: _____

This application applies to the following **Provider Types**: (Choose all that apply)

☐ Hospital (Critical Access) NPI:	☐ Ambulatory Surgical Center ; NPI:	☐ Hospital (General Acute Care; NPI:

Contact Information:

If questions about this application, contact:	**Phone Number:**
Name: **Email:**	**Fax Number:**

Credentialing Contact Information: ☐ Same as Contact Information

If questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**

Legal Entity Information (Name on Income Tax Return)

Tax ID Holder Name:	**Federal Tax ID Number:**	☐ **Profit** ☐ **Non-Profit**
Legal Address:		

Insurance Information (Both facility general and professional liability if required). Minimum coverage requirement is $1 million per occurrence and $3 million aggregate)

Carrier:	**Amount of Coverage:**	**Coverage Dates:**

Tax ID Number:_____

Service Location 1 of ____ Duplicate this page for additional facilities

Facility Name (to be displayed in the Directory)

Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID # (Group/Type 2):**
State License Number:		**Medicare ID:**

Service Location Address:

☐ **Same as Legal Entity**

Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**

Website:

Service Location Hours:

Business Hours	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

☐ **24 Hours** ☐ **8 – 5**

ADA Compliant? ☐ **Yes** **Are you located on a Public Transportation route?** ☐ ☐

Please list any languages (including American Sign Language) offered by the Provider or Skilled Medical Interpreter:

Tax ID Number:_____

Insurance Information for Service Location 1 of _____:

☐ **Same as indicated on Page 3 (If different, complete below)**

Professional Carrier:	**Amount of Coverage:** **Per Occurrence:** **Per Aggregate:**	**Coverage Dates:**
Worker's Compensation Carrier:	**Coverage Dates:**	

Has the Provider Office completed Cultural Training? ☐ **Yes** ☐ **No**

If Yes, did the training include the following?

African American ☐ **Yes** ☐ **No** **Asian** ☐ **Yes** ☐ **No**
Alaskan Native ☐ **Yes** ☐ **No** **Hispanic/Latino** ☐ **Yes** ☐ **No**
American Indian ☐ **Yes** ☐ **No** **Pacific Islander** ☐ **Yes** ☐ **No**
Other_____ ☐ **Yes** ☐ **No**

Service Location 1 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

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	**ID #**	**Applied Date**	**Expiration Date**
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
The American Association for Accreditation of Ambulatory Surgery Facilities			
Healthcare Facilities Accreditation Program (AOA/HFAP)			
The Joint Commission			
DNV			
Planetree Designation			
State Facility Operating License			
Medicare-Certified			
ASC licensed for 23 hour stay			
DEA Certificate			
Others: (please list):			

Service Location 1 of _____ – Sanctions ☐ **Same as Legal Entity** *If yes, to any question below, please explain on a separate sheet of paper.*	
Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐**Yes** ☐ **No**
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**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current **SurgeryShopper.com** provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to **SurgeryShopper.com** Credentials Committee for their review and approval, and, absent such affirmative approval, **SurgeryShopper.com** members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice/my facility without prior written approval from **SurgeryShopper.com**. Further, from time to time, such licensed practitioners may change, as my practice/our facility associates. In all such cases, I accept responsibility for notifying **SurgeryShopper.com** in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy **SurgeryShopper.com** credentials/re-credentials requirements for all such individuals associated with my practice/our facility.

By applying for participation to **SurgeryShopper.com**, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the SurgeryShopper.com and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by SurgeryShopper.com and its representatives of all documents that may be material to an evaluation of qualifications and competence.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of SurgeryShopper.com for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from SurgeryShopper.com.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in SurgeryShopper.com, the Facility hereby gives permission to SurgeryShopper.com 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 SurgeryShopper.com will use this information in a confidential manner on its own behalf and, if applicable, as an agent for any affiliated network(s) in connection with the administration of SurgeryShopper.com.

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 SurgeryShopper.com 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 SurgeryShopper.com 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 SurgeryShopper.com programs or any program or one of its affiliated programs 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 Facility or Authorizing Representative **Title**

A stamp signature is not acceptable

Tax ID Number:_____