Hospital and Ancillary Credentialing Application

To expedite processing of your application, please complete this application in its entirety and attach the following documentation, as appropriate:

Copy of current unexpired state license

Professional liability insurance certificate

Medicare Certification Letter (participating or certified)

Accreditation Certificate, if applicable (example: JCAHO, CARF, AAAHC, ACR, ACRO, IAC)

HHA – Unskilled, provide P&Ps that demonstrates; Work History, Criminal Background Disclosure, Professional References and Operate within the scope of their license

Applicants have the right to review the information submitted in support of their credentialing application. Please contact the TriWest Credentialing Department if you would like to review your credentialing documentation.

Please type or print legibly, ensure that the attestation and release forms are signed and dated by the practitioner. Please do not use whiteout. If the application is not complete, signed and dated or if whiteout is used, it will not be processed. Please use additional sheets if you need to provide additional information.

The application can be submitted to the contact information (email, fax or by mail) on the cover letter.

Pursuant to Department of Veteran Affairs imposed guidelines and procedures, TriWest must adhere to certain specialty specific requirements. Please refer to theTriWest Healthcare Alliance Provider Eligibility Requirements included in contracting introduction email, or contact a Direct Contracting Specialist for more details.

Hospital and Ancillary Credentialing Application

Please complete a separate application for <u>each location</u>

Facility Name:_____
(Please type or print full name of the facility)

- Complete this form in its entirety and attach all requested documentation and explanations.
- If a question does not apply to your facility, answer with "Non-Applicable" or "NA".
- If additional space is necessary to provide answers, attach additional sheet(s) of paper.
- Incomplete applications will be returned.
- **This application must be signed and dated where indicated.**
- The application can be submitted to the contact information (email, fax or by mail) on the cover letter.

PROVIDER INFORMATION (Choose all that apply)

Type of Hospital Provider:

- ☐ Acute Care
- ☐ Cancer
- ☐ Childrens
- ☐ Critical Access
- ☐ Long Term/Extended Care
- ☐ Psychiatric
- ☐ Rehabilitation
- ☐ Sole Community
- ☐ Other (please specify)

Hospital Based Units/Services:

- ☐ Cardiac Catheterization Lab
- ☐ Cardiac Rehabilitation
- ☐ End Stage Renal Disease (Dialysis)
- ☐ Home Health
- ☐ Psychiatric Unit
- ☐ Psychiatric Partial Hospitalization Program
- ☐ Rehabilitation Unit
- ☐ Residential Treatment Center
- ☐ Skilled Nursing Unit
- ☐ Substance Use Disorder Rehabilitation
- ☐ Swing Bed Unit
- ☐ Transplant Program (indicate type of program)

Type of Ancillary or Freestanding Facility Provider:

- ☐ Ambulance
- ☐ Ambulatory Surgery Center
- ☐ Birthing Center
- ☐ Bone Marrow Transplant
- ☐ Cardiac Catheterization Lab
- ☐ Cardiac Rehabilitation Facility
- ☐ Clinical Medical Laboratory
- ☐ Comprehensive Outpatient Rehab Facility (CORF)
- ☐ Dialysis/Kidney Center
- ☐ Durable Medical Equipment
- ☐ Home Health Agency – Skilled & Unskilled
- ☐ Home Health Agency – Skilled
- ☐ Home Health Agency – Unskilled
- ☐ Home Infusion
- ☐ Hospice
- ☐ Magnetic Resonance Imaging Center
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Rehabilitation Clinic (OT, PT, ST)
- ☐ Pain Management Clinic
- ☐ Palliative Care
- ☐ PET Center
- ☐ Pharmacy (special)
- ☐ Pharmacy with DME
- ☐ Portable X-Ray
- ☐ Psychiatric Partial Hospitalization Program
- ☐ Radiation Therapy Clinic
- ☐ Radiology Center
- ☐ Residential Treatment Center
- ☐ Skilled Nursing Facility
- ☐ Sleep Study Center
- ☐ Substance Use Disorder Rehabilitation

DEMOGRAPHIC INFORMATION

Facility Name _____

DBA name _____
(if different than business name)

Street Address _____

_____

City _____ County _____ State _____ Zip Code _____

Phone # _____ Fax # _____ Website URL _____

Contact Person (the person you wish us to contact regarding information on this application)

Contact Name _____ Title _____

Phone # _____ Fax # _____ Email _____

Federal TIN _____ NPI _____
(submit copy of W-9) (Include all applicable NPI #'s)

PAYMENT/BILLING INFORMATION

Corporate/Pay to Name _____
(if different than facility name)

Address _____

_____

City _____ County _____ State _____ Zip Code _____

Phone # _____ Fax # _____

Billing Contact Name _____

Phone # _____ Fax # _____ Email _____

OWNERSHIP/MANAGEMENT

President/CEO
Name _____ Phone # _____ Title _____

CFO
Name _____ Phone # _____ Title _____

Medical Director
Name _____ Phone # _____ Title _____

Facility Ownership Type: ☐ Government ☐ Non-Profit ☐ For Profit ☐ Other (indicate type) _____

Organizational Structure: ☐ Corporation ☐ Partnership ☐ Single Owner ☐ Public Agency ☐ Professional Corp

LICENSURE/ACCREDITATION/CERTIFICATION

- **Please provide a copy of all applicable documents**
- If not accredited or certified, please note where you are in the process of obtaining accreditation or certification and by what date you expect to complete the process

Agency	License, Certification or Accreditation Number (if applicable)	Last Review/ Renewal Date	Expiration Date
AAAHC – Accreditation Assoc. for Ambulatory Health Care, Inc.			
ACR – American College of Radiology ARCO – American College of Radiation Oncology			
AOA – American Osteopathic Assoc			
CARF – Commission on Accreditation of Rehabilitation Facilities			
Chemical Dependency Certification			
CLIA – Clinical Laboratory Improvement Act			
Commission on Cancer (CoC) of the American College of Surgeons			
DEA Registration			
FDA – Mammography Facility Certification			
IAC – Intersocietal Accreditation Commission			
Medicare Part A			
Medicare Part B			
Medicaid			
State Controlled Substance Certificate			
State License			
The Joint Commission			
Other (specify name)			

- Facilities performing Cardiac Surgery report to the Society for Thoracic Surgery (STS) National Adult Cardiac Surgery Database. ☐ Yes ☐ No ☐ N/A

- Facilities performing Cardiac Catheterization and/or Percutaneous Coronary Intervention participate in the National Cardiovascular Data Registry (NCDR) CathPCI Registry. ☐ Yes ☐ No ☐ N/A

- Facilities implanting Cardioverter Defibrillators (ICDs) participate in the National Cardiovascular Data Registry (NCDR) ICD Registry. ☐ Yes ☐ No ☐ N/A

- Facility participates in the National Disaster Medical System (NDMS). ☐ Yes ☐ No ☐ N/A

LIABILITY COVERAGE

- **Please provide a copy of a current Liability Insurance Face sheet**

Current Carrier _____

Agency Name _____

City: _____ State _____ Phone # _____

$ Amount per occurrence _____ $ Amount Aggregate _____

Dates of Coverage: From: _____ To: _____
(Include month, day and year)

OTHER INFORMATION

List the days and hours your facility is open:

Mon_____ Tues _____Wed_____Thur_____Fri_____Sat_____Sun_____

Total licensed bed capacity: _____

Are you a teaching facility? ☐ Yes ☐ No Do you have an intern or residency program? ☐ Yes ☐ No

What steps do you take to ensure that all individuals who provide services maintain a current license and provide services within the scope of their license?_____
_____
_____
_____
_____

ADDITIONAL INFORMATION

Please answer all the questions and provide a concise summary on a separate sheet for any "Yes" answer. In the past five years:

1. Has the corporation, an officer or a board member ever been convicted of a felony? ☐ Yes ☐ No
2. Had your State License (if applicable) ever been denied, suspended or revoked for any reason? ☐ Yes ☐ No
3. Have you ever been subjected to sanctions or disciplinary actions by a Professional Review Organization, the Medicare/Medicaid Program, a Third Party Payor or a Regulatory agency? ☐ Yes ☐ No

ATTESTATION AND RELEASE OF INFORMATION

On behalf of the facility, I hereby certify and attest that information contained herein is true and correct and that any omission or misrepresentation may void this application or be cause for termination of this organization's participation as a TriWest network provider. Further, I give permission to TriWest and or its designee to verify the facility's credentials and by doing so hereby authorize release of the requested information concerning the facility's licensing, certification and accreditation. I attest that this facility ensures all individuals contracted or employed by the facility meet credentialing requirements, appropriate accreditation or certification and maintain Medicare approval for payment and unrestricted current state licensure to practice.

On behalf of the facility, I release all individuals and organizations from all liability for any damages which may result from issuing such information.

Print Name: _____

Signature: _____

Title: _____

Date: _____

INSERT DEPARTMENT OF THE TREASURY INTERNAL REVENUE SERVICE FORM W-9