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 the TriWest 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 each location

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 __________________

(Include all applicable NPI #’s)

PAYMENT/BILLING INFORMATION

Corporate/Pay to 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

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