Prior to completing this credentialing application, please read and observe the following:

INSTRUCTIONS
This form should be **typed (using a different font than the form) or legibly printed in black or blue ink**. If more space is needed than provided on original, attach additional sheets and reference the question being answered.
• Modification to the wording or format of the Organizational Provider Credentialing Application will invalidate the application. • Complete the application in its entirety. Please sign and date pages 6 and 8. Mail application to: **Health Plan or Group Name and Mailing Address** • Identify the health care related organization(s) to which this application is being submitted in the space provided below.

IMPORTANT

Current copies of all applicable documentation requested in Section VIII, *Attachments*, must accompany this Application. Failure to complete all sections of this Application or submit all required documentation will constitute and incomplete Application and will be returned to the provider without processing.

I am applying to (please list: Hospital Staff, HMO, IPA)_____

_____

_____for

_____(i.e., staff membership, network participation, if applicable).

PLEASE USE A SEPARATE APPLICATION FOR MULTIPLE LOCATIONS

I. PROVIDER IDENTIFICATION

A. Corporate Identification Information

Furnish the provider's legal business name (as reported to the IRS) "doing business as" name (name provider generally known by to the public), and the various operating dates and places of formal business registration and/or incorporation. All payments will be issued in the provider's legal business name in compliance with IRS regulations.

1. Legal Business Name as Reported to the IRS (claims will be paid to this name)	
2. "Doing Business As" (DBA) Name (if applicable)	County where DBA Name Registered (if applicable)
3. Address:	**4**. Tax Identification Number:

B. Current Practice Location(s)

Practice Location Name:			
Practice Location Address Line 1:			
Practice Location Address Line 2:			
City:	State:	Zip:	County:
Phone: ( )	Fax: ( )		E-mail:
Primary Contact Name:			Contact Title:
Phone: ( )	Fax: ( )		E-mail:
Administrator (Full Name):			

C. Mailing/Correspondence Address

This must be an address where provider can be contacted directly.

Check here ❑ if all correspondence can be directed to the practice location in Section B.

Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	Zip:	County:

D. Type of Provider

Provider Type (*check all boxes that apply)*: ❑ Hospital ❑ Home Health Agency ❑ Skilled Nursing Facility ❑ Free Standing Surgical Center ❑ Free Standing Laboratory ❑ Other (explain):	❑ Behavioral Health Facility Mental Health: ❑ Inpatient ❑ Residential ❑ Ambulatory Setting Substance Abuse: ❑ Inpatient ❑ Residential ❑ Ambulatory Setting

E. Scope of Services

List all services provided at this facility:	❑ Acute Care ❑ Emergency Department (Level I, II, III, IV, V) ❑ PT, OT, Speech Therapy ❑ Imaging Department ❑ Laboratory/Pathology Department ❑ Skilled Nursing	❑ Outpatient Surgery ❑ Hospice ❑ Infusion Therapy ❑ Home Health ❑ Other _____ _____ _____

II. CERTIFICATION AND ACCREDITATION

A. Certification

1. Is this provider participating in the Medicare program? ❑ Yes ❑ No ❑ Pending
If Yes, please provide the following:

2. Date of initial **Medicare** certification (MM/DD/YYYY): _____

3. Date of last full CMS survey* (MM/DD/YYYY): _____

***if the provider is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accredited organization meets this requirement.**

4. Were any deficiencies identified during the last full CMS/accreditation survey? ❑ Yes ❑ No
If Yes, have all deficiencies been corrected?
❑ Yes (please provide evidence)
❑ No (please provide a complete copy of the most recent survey and any or all corrective action plans)

B. Accreditation

1. Is this provider accredited by a national accreditation organization? ❑ Yes ❑ No ❑ Pending
If Yes, please complete the following:

2. Check One:	❑ TJC ❑ AOA ❑ URAC	❑ AAAHC ❑ AAAASF ❑ CARF	❑ CHAP ❑ CLIA ❑ _____

Date of initial accreditation (MM/DD/YYYY): _____

3. Date of last survey (MM/DD/YYYY): _____

4. Name of Accreditation Organization: _____

5. Has the accreditation organization been granted deeming authority by CMS for this provider type?

❑ Yes ❑ No

6. Has this provider ever been denied accreditation by any accrediting body? ❑ Yes ❑ No

7. If Yes, please provide details below.

Details:

III. HEALTHCARE LICENSURE, REGISTRATION, CERTIFICATES, AND ID NUMBERS

	License #	Issue Date	Expiration Date	Licensing Agency
State of Oregon				
State of Washington				
Other:				

Medicare Number	Medicaid Number	UPIN:	NPI:

DEA Number (if applicable)	Expiration Date:

If the organizational provider does not have a Medicare Number, please submit an explanation:

IV. LIABILITY INSURANCE

This section is to be completed with information about the provider's professional liability and/or medical malpractice insurance including, but not limited to General Liability, Excess Liability, Umbrella and/or Reinsurance policies. If there is more than one carrier, copy and complete this section for each.

A copy of all face sheets showing current coverage amounts and expiration dates must be attached.

A. Current Coverage

Current Carrier Name:	Policy #:
Carrier Address:	Coverage Type: ❑ Occurrence Based ❑ Claims Based

City:	State:	Zip:

A. Current Coverage continued

Effective Date:	Expiration Date:
Aggregate: $	Per Incident: $

V. CREDENTIALING PROGRAM

Contact Name:		Contact Title:
Phone: ( )	Fax: ( )	Email:

Is there a formal credentialing program in place for health care professionals? ❑ Yes ❑ No

Include a description of your credentialing and clinical staff privileging program

VI. RESTRAINT AND SECLUSION

Attach a copy of your policy & procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations (CFR), 438.100

*policy must include:

- Measures to ensure patients are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation

VII. PATIENT VISITATION - HOSPITALS ONLY

Attach a copy of your policy & procedure* regarding the visitation rights of patients as required under the Code of Federal Regulations (CFR), 482.013

*policy must include:

- Identifying any clinically necessary or reasonable restriction or limitation the hospital may need to place on such rights and
- The reasons for the clinical restriction or limitation

VIII. ATTACHMENTS

This section is a list of documents that, if applicable, should be submitted with this completed enrollment application

Place a check next to each document (as applicable or required) from the list below that is being included with this completed application:

- ❑ Copy(s) of all Federal, State, and/or local professional licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ❑ Copy(s) of all Federal, State, and/or local business licenses, certifications and/or registrations specifically required to operate as a health care facility.
- ❑ Copy(s) of all Accreditation Certificates and copy of most recent survey results.
- ❑ Copy(s) of Federal Register Final Notice documenting deeming authority to any applicable accrediting organization which exempts provider from the CMS survey process.
- ❑ Copy(s) of most recent CMS survey, including corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
- ❑ IRS documents confirming the tax identification number and legal business name (e.g., CP 575).
- ❑ Description of credentialing and clinical staff privileging program for health care professionals.
- ❑ Copy of your policy and procedure for Restraint and Seclusion and Patient Visitation
- ❑ Copy of your policy and procedure for Patient Visitation Rights at hospitals (applicable to hospitals)

IX. SITE REVIEW (as required)

I hereby grant permission for the Health Care Organization or its designated agent to conduct on-site and/or medical record reviews as necessary. I further agree that this provider will participate in, and support the Healthcare Organization(s) Credentialing, Quality Improvement and Utilization Review Programs.

X. ATTESTATION QUESTIONS

Please answer the following questions"**YES**" or "**NO**". If your answer to any of the following questions is "yes", please provide details and reasons, as specified in each question, on a separate sheet. Please sign and date each additional sheet. ***Modification to the wording or format will invalidate the application.***

1.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?	❑ Yes ❑ No
2.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	❑ Yes ❑ No
3.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?	❑ Yes ❑ No
4.	Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	❑ Yes ❑ No
5.	Has this provider, under any current or former name or business identity, ever had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	❑ Yes ❑ No
6.	Has this provider, under any current or former name or business identity, ever had accreditation revoked or suspended?	❑ Yes ❑ No
7.	Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?	❑ Yes ❑ No
8.	Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	❑ Yes ❑ No

_____ _____
Printed Name of Authorized Representative Signature of Authorized Representative

_____ _____
Authorized Representative's Title Date Signed

AUTHORIZATION AND RELEASE OF INFORMATION FORM

By submitting this application, it is agreed and understood that:

1. As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.

2. I further understand and acknowledge that The Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the HIPDB reporting and information as required by law as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with The Healthcare Organization(s) or designated agent.

4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of The Healthcare Organization(s) or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to The Healthcare Organization(s) cycle of recredentialing provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with The Healthcare Organization(s).

6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of The Healthcare Organization(s) or its respective agent(s) before initiating judicial action.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with The Healthcare Organization.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as The Healthcare Organization(s) Participating Provider or cause for summary dismissal from The Healthcare Organization(s) or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with The Healthcare Organization(s) and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by The Healthcare Organization(s) .

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

*This provider complies with all federal, state, and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).

Signature: _____ **Date:** _____

Title: _____

Printed Name_____

As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions for the following provider(s)/supplier(s):

(Facility Name)	**City, State**
(Facility Name)	**City, State,**