Facility Credentialing and Recredentialing Application

Facility identification	
Legal business name (as reported to the IRS)	Medicaid number
Doing business as (DBA) name (if applicable)	Medicare number
Health system affiliation (if any)	Tax identification number (TIN)
Length of time in business with this name and tax ID Years Months	National provider identifier (NPI)

Facility information	
Facility name	
Address line 1	
Address line 2	
City	State
ZIP	County
Website	
Credentialing contact name	Contact title
Phone	Fax
Email	
Facility administrator name	Administrator email

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Mailing and correspondence address

☐ Check here if all correspondence can be directed to the facility location above. If not, complete the section below.

Name	
Mailing address line 1	
Mailing address line 2	
City	State
ZIP	County
Phone	Email

Facility type

☐ Ambulatory surgery center — free-standing only

☐ Home health care agency providing skilled services only — no PCA services

☐ Home health care agency with PCA providing both skilled services and PCA services

☐ Hospital — all types

☐ Skilled nursing facility or nursing home

☐ Durable medical equipment (DME) supplier

☐ Sleep center or sleep lab — free-standing only

☐ Home health hospice

☐ Radiology center

☐ Rural health care

☐ Skilled nursing facility providing subacute services

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Health care licensure		• Attach a copy of each **facility** license. • Do **not** submit practitioner licenses.			
License number	State or city	Licensing agency	Initial issue date	Renewal date	Expiration date
			__ / __ / __	__ / __ / __	__ / __ / __
			__ / __ / __	__ / __ / __	__ / __ / __
			__ / __ / __	__ / __ / __	__ / __ / __

Medicare status

1. Is this facility participating in the Medicare program? ☐ Yes ☐ No ☐ Pending
   If yes, give the Medicare provider number: _____

2. Is this facility Medicare (CMS) certified? ☐ Yes ☐ No ☐ Pending
   If yes, give date of initial CMS certification: __ /__ /_____ and Medicare certification number: _____
   ☐ Check here if facility is **not eligible** for CMS certification.

Accreditation

- At least one box must be checked.
- If accredited, attach copy of the current accreditation certificate.

1. Specify agency of current facility accreditation (if any).
   - Complete questions 2 and 3 below.
   - Skip the Site Visit Requirement section, if accredited.

☐ **AAAAPSF** — American Association for Accreditation of Ambulatory Plastic Surgery Facilities
☐ **AAAASF** — American Association for Accreditation of Ambulatory Surgery Facilities
☐ **AAAHC** — Accreditation Association for Ambulatory Health Care
☐ **AASM** — American Academy of Sleep Medicine
☐ **ACHC** — Accreditation Commission for Health Care
☐ **AOA** — American Osteopathic Association
☐ **CARF** — Commission on Accreditation of Rehabilitation Facilities
☐ **CCAC** — Continuing Care Accreditation Commission
☐ **CHAP** — Community Health Accreditation Program
☐ **NIAHO** — National Integrated Accreditation for Healthcare Organizations
☐ **The Joint Commission** — previously known as the Joint Commission on Accreditation of Healthcare Organizations
☐ **Non-accredited** — Go to Site Visit Requirement section.

2. Date of initial accreditation: ___ /___ /_____

3. Date of last full survey: ___ /___ /_____

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Site visit requirement

Attach copy of most recent on-site survey (with Corrective Action Plan, if citations were issued), **or** attach cover letter from government agency stating facility is in substantial compliance.

1. Has facility had a post-licensing on-site visit by a government agency, such as the Department of Health or CMS within the past 36 months?

☐ Yes — Date of most recent standard survey: ___ /___ /_____

☐ No — **Successful completion of a health plan on-site visit will be required to complete credentialing**.

2. Were any deficiencies cited during the last full survey? ☐ Yes ☐ No ☐ N/A — no recent survey

☐ If yes, have all deficiencies been corrected?

☐ Yes — Provide evidence of state acceptance of your Corrective Action Plan (CAP).

☐ No — Provide explanation and your plan to correct all deficiencies.

☐ If no deficiencies were cited during the last fall survey, submit verification of having no deficiencies.

Practitioner credentialing

Does the facility validate, for each licensed practitioner employed or contracted at the facility, the credentials necessary to perform health care services?

☐ Yes — Indicate how the facility conducts the credentialing process for each practitioner:

☐ Credentialing procedures are performed internally.

☐ Credentialing procedures are outsourced or delegated to: _____

☐ Other, specify: _____

☐ No — Please explain: _____

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Insurance	• Both facility general liability and facility professional liability are required. • Minimum coverage requirement is $1 million per occurrence and $3 million aggregate.
General liability coverage	Attach certificate showing policy number, coverage amounts and effective dates.
Current carrier (not agency) name	Policy number
Street or P.O. box	City
State	ZIP
Effective date ___ /___ / _____	Expiration date ___ /___ / _____
Per incident: $ Aggregate: $	Coverage type ☐ Occurrence based ☐ Claims based

Professional liability coverage	Attach certificate showing policy number, coverage amounts and effective dates.
Current carrier (not agency) name	Policy number
Street or P.O. box	City
State	ZIP
Effective date ___ /___ / _____	Expiration date ___ /___ / _____
Per incident: $ Aggregate: $	Coverage type ☐ Occurrence based ☐ Claims based

Indicate which documents are being included with this completed application.

- ☐ Copy of all federal, state and/or local licenses required to operate as a health care facility.
- ☐ Copy of facility's general liability insurance certificate.
- ☐ Copy of professional liability insurance certificate covering all facility employees.
- ☐ Copy of accreditation certificate(s).
- ☐ Copy of CMS letter certifying or recertifying facility to provider partial hospitalization services.
- ☐ Copy of most recent CMS or Department of Health survey, including your corrective action plan if deficiencies were cited, **or** cover letter from CMS or the Department of Health stating facility is in substantial compliance.

Attestation

- Answer every question "yes" or "no."
- Provide a detailed explanation on a separate sheet for any question(s) answered "yes."

1. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under federal or state law, related to either of the following: (a) The delivery of an item or service under Medicare or state health care program? (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 facility, 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 facility, 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
4. Has this facility, 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 disbarment from participation in any federal executive branch procurement or nonprocurement program?	☐ Yes ☐ No
5. Is this facility, under any current or former name or business identity, currently suspended from Medicare or Medicaid payment under any Medicare or Medicaid billing number?	☐ Yes ☐ No

Arbor Health Plan

I hereby authorize Arbor Health Plan to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation or operations to Arbor Health Plan. I authorize and agree that Arbor Health Plan, its respective agents, employees and representatives may provide Arbor Health Plan subsidiaries and affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing or peer review. I release Arbor Health Plan, its respective agents, employees and representatives of any liability for furnishing any such information that is provided in good faith and without malice. I authorize Arbor Health Plan and its subsidiaries and affiliates to use the information provided in their selection, credentialing and recredentialing process, and to verify such information as appropriate.

_____

Authorized signature

Printed name

_____

Title

Date