

# STANDARDIZED FACILITY CREDENTIALING FORM



This form is designed as a fillable form for facility providers wishing to participate in the Health One Alliance/Alliant Health Plans network. Upon completing the Standardized Facility Credentialing Form, email this form to [providerrelations@alliantplans.com](mailto:providerrelations@alliantplans.com), fax to (706) 529-4275 or mail to Health One Alliance, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722.

## Type of Facility:

- |               |                                |                               |
|---------------|--------------------------------|-------------------------------|
| Hospital      | Home Health Agency             | Intensive Outpatient Facility |
| Nursing Home  | Skilled Nursing Facility       | Behavioral Health Facility    |
| Specialty DME | Outpatient Hyperbaric Facility | Free Standing Surgery Center  |
| Laboratory    | Other (please specify): _____  |                               |

## Section I: Facility Information

Legal Name: \_\_\_\_\_  
NPI: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
Length of time in business under listed Name & TIN (months/years): \_\_\_\_\_  
Date of Incorporation: \_\_\_\_\_ State of Incorporation: \_\_\_\_\_  
List all memberships in professional organizations & trade associations:  
\_\_\_\_\_  
\_\_\_\_\_

## Section II: Contact Information

### Section II-A: Contracting Contact

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
If executed, should the contract be returned to the above address? Yes No

### Section II-B: Credentialing Contact

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
If credentialed, should the decision letter be returned to the above address? Yes No

## Section III: Addresses

Group Name and DBA: \_\_\_\_\_  
TIN: \_\_\_\_\_ Group NPI: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Service Address: \_\_\_\_\_  
Pay To Name: \_\_\_\_\_  
Pay To Address: \_\_\_\_\_  
Vendor Address: \_\_\_\_\_

Group Name and DBA: \_\_\_\_\_  
TIN: \_\_\_\_\_ Group NPI: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Service Address: \_\_\_\_\_  
Pay To Name: \_\_\_\_\_  
Pay To Address: \_\_\_\_\_  
Vendor Address: \_\_\_\_\_

**STANDARDIZED  
FACILITY CREDENTIALING FORM**



HealthOne™



Group Name and DBA: \_\_\_\_\_  
TIN: \_\_\_\_\_ Group NPI: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
Service Address: \_\_\_\_\_  
Pay To Name: \_\_\_\_\_  
Pay To Address: \_\_\_\_\_  
Vendor Address: \_\_\_\_\_

Please attach a full listing of locations if provided space is insufficient.

**Section IV: Medical Director**

Name: \_\_\_\_\_ Degree: \_\_\_\_\_  
Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Address: \_\_\_\_\_

**Section V: Accreditation Status**

Accrediting Agency Name: \_\_\_\_\_  
Accreditation Status: \_\_\_\_\_ Accreditation Date: \_\_\_\_\_  
Have you ever been denied accreditation by any accrediting body? Yes No  
If yes, please provide details.  
\_\_\_\_\_  
\_\_\_\_\_

**Section VI: Licensure and Certifications**

License Number and Status: \_\_\_\_\_ N/A  
CLIA Number: \_\_\_\_\_ N/A

**Section VII: Site Survey**

Surveying Entity Name: \_\_\_\_\_  
Surveying Date: \_\_\_\_\_

**Section VIII: Liability Insurance**

Section VIII-A: General Liability Coverage (attach certificate showing current coverage amounts and effective dates)

Name of Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Coverage Type: Occurrence Based Claims Based  
Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
Per Incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_

Section VIII-B: Professional Liability (Malpractice) Coverage

Name of Carrier: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Address: \_\_\_\_\_  
Coverage Type: Occurrence Based Claims Based  
Effective Date: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Policy Retro Date: \_\_\_\_\_  
Per Incident: \_\_\_\_\_ Aggregate: \_\_\_\_\_

# STANDARDIZED FACILITY CREDENTIALING FORM



## Section IX: Disclosure Questions

Answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate sheet and attach to document.

|   |     |    |
|---|-----|----|
| Have criminal proceedings ever been initiated against the Provider or its authorized representatives?   | Yes | No |
| Has the Provider ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program, include, but not limited to, Medicare, Medicaid and military or Department of Health programs? | Yes | No |
| Has the Provider's general liability or professional liability coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State?  | Yes | No |
| Has the Provider ever been notified that information pertaining to anyone in the Provider's staff has been reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank or professional state licensing boards or registries?                       | Yes | No |
| In the last ten years, have there been any general liability or professional liability suits, or are there currently any pending or threatened suits against the Provider, or have any judgments been made or settlements paid on its behalf?   | Yes | No |
| Is there currently any pending or threatened licensing or disciplinary action against the Provider?   | Yes | No |

## Section X: Attachments

You must include copies of the following documents, as applicable, with the completed application.

|  |                                   |
|--|-----------------------------------|
| Current State License(s), State Permit(s), DCH, DHR, etc., DEA certificate | Copy of W-9 form                  |
| Letter or certificate from any/all accrediting organizations               | <b>Also include:</b>              |
| Copy of most recent State Survey (if not accredited)                       | Any/all information applicable to |
| Copy of current Certificate(s) of Insurance – commercial & professional    | Disclosure Questions              |
| List of all service locations with billing address for each                | Copy of most current CMS letter   |

## Section XI: Standard Authorization, Attestation and Release

By signing this application, I certify, agree, understand and acknowledge the following:

1. The information in this entire application is complete, current, correct and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this application may constitute cause for denial of my application or summary dismissal or termination of my provider participation agreement.
3. A photocopy of this application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this application on the most recent date indicated below and it continues to be true and complete.
5. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.
6. No action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.
7. This attestation statement and application must be signed no more than 180 days prior to the credentialing decision date.

## Authorization of Third-Party Sources to Release Information Concerning Application for Participation

The Applicant hereby authorizes any third party, including, but not limited to, individuals, agencies, medical agencies responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank to release to the Contracting Entity and/or its Agent(s), information, including otherwise privileged or

**STANDARDIZED  
FACILITY CREDENTIALING FORM**



**HealthOne™**



confidential information, concerning the qualifications of this Applicant, its credentials, accreditations, quality assurance and utilization data or any other information reasonably having a bearing on the Applicant's qualifications for Participation with the Contracting Entity. This information shall also include the details of any action taken by a health care organization, Medicare and Medicaid, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition the Applicant's Participation, impose a corrective action plan or terminate any contract to which the Applicant was a party. The Applicant further authorizes its current and past insurance carrier(s) to release the Applicant's history of claims that have been made and/or are currently pending against it. The Applicant specifically waives written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Facility Name: \_\_\_\_\_  
Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_ Date: \_\_\_\_\_