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, fax to (706) 529-4275 or mail to Health One Alliance, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722.

Type of Facility:

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

Please list specialized services performed:

_____

Section I: Facility Information

Legal Name: _____

NPI: _____ CCN: _____

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 II-C: Medical Record Requests (specific to HEDIS, Risk Adjustment, RAD-V, etc.)

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

Preferred Method: ☐ Mail ☐ Phone ☐ Fax ☐ Email

Section III: Addresses

Group Name and DBA: _____ Offers Telehealth: ☐

TIN: _____ Group NPI: _____

Phone: _____ Fax: _____

Service Address: _____

Pay To Name: _____

Pay To Address: _____

Vendor Address: _____

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Group Name and DBA: _____ Offers Telehealth: ☐
TIN: _____ Group NPI: _____
Phone: _____ Fax: _____
Service Address: _____
Pay To Name: _____
Pay To Address: _____
Vendor Address: _____

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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

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Effective Date: _____ Expiration Date: _____ Policy Retro Date: _____

Per Incident: _____ Aggregate: _____

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
- ☐ Letter or certificate from any/all accrediting organizations
- ☐ Copy of most recent State Survey (if not accredited)
- ☐ Copy of current Certificate(s) of Insurance – commercial & professional
- ☐ List of all service locations with billing address for each
- ☐ Copy of W-9 form

Also include:

- ☐ Any/all information applicable to Disclosure Questions
- ☐ 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.

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For hospitals with fifty (50) or more beds, please attest to the following:

- Facility utilizes a safety utilization system as defined in 42 CFR 3.20. _____ (Initial)
- Facility has implemented a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; _____ (Initial)

  OR

  Facility has implemented an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmissions, or improves care coordination. _____ (Initial)

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 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: _____