nh healthy families

HOSPITAL / ANCILLARY PROVIDER CREDENTIALING APPLICATION

INSTRUCTIONS: In order to be considered complete:

1. **All information must be legible. Please print or type all information**
2. **Application must be completed in its entirety**
3. **Must be signed and dated**
4. **If necessary, use a separate sheet of paper to provide additional information**
5. **The original application with attachments should be attached to your NH Healthy Families provider agreement**

☐ **Initial Credentialing** ☐ **Re-Credentialing** ☐ **Addition of a new site to current contract**

Facility credentialing is required for the following facility types – Choose all that apply:

☐ **Hospital**	☐ **Skilled Nursing Facility**	☐ **Diagnostic Imaging Center**
☐ **Rehabilitation Center**	☐ **Adult Living Facility**	☐ **Assisted Long-Term Care Facility**
☐ **Surgical Center**	☐ **Home Health Agency**	☐ **Durable Medical Equipment (DME)**
☐ **Clinic- FQHC, RHC, Other**	☐ **Other _____**	

OWNERSHIP/MANAGEMENT

President/CEO Name:	**Phone:**
Vice President Name:	**Phone:**
CFO Name:	**Phone:**
Medical Director:	**Phone:**
Medical Director License #:	**Medical Director DEA #:**

LEGAL INFORMATION

Entity Legal Name:	**Fed. Tax ID Numbers:**	**Medicaid Numbers:**
State License No.	**National Provider ID# (NPI):**	**Medicare Numbers:**

FACILITY INFORMATION

Group or d/b/a Name:		**Group Fed. Tax ID No.:**
Location Telephone:	**Primary Contact:**	**E-Mail/Phone:**
Physical Address:	**City/State/Zip:**	**County:**

BILLING INFORMATION

Pay To:		
Pay to Address:	**City/State/Zip:**	**Phone:**
Credentialing/Billing Contact:	**Fax:**	**E-Mail:**

Office Hours:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Is this facility open at least 5 days per week? ☐**Yes** ☐ **No**	**Handicap Access?** ☐**Yes** ☐ **No**
Are PAs, CNMs and/or Nurse Practitioners used? ☐**Yes** ☐ **No**	**Will you be accepting new patients?** ☐**Yes** ☐ **No**
Please list any Foreign Languages Spoken at this location:	
Is your practice limited to certain ages? ☐**Yes** ☐ **No**	

If Yes, specify age restrictions. Please Check One.

☐ **None**	☐ **0-2 years**	☐ **0-12 years**	☐ **0-17 years**	☐ **0-20 years**	☐ **13+ years**
☐ **13-17 years**	☐ **13-20 years**	☐ **21+ years**	☐ **3+ years**	☐ **17+ years**	

AFFILIATIONS

Is your facility affiliated with any other health care organization(s) through corporate linkage or other formal arrangement? If so, please provide the following information (*List additional affiliations on a separate page.*)	
Facility Name:	TIN:
Address:	
Services Provided (IP/OP):	

DIAGNOSTIC IMAGING

If the answer is NO to any of the following questions, please provide details on separate sheet.	
1. Diagnostic Imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction or supervision of physicians qualified to perform those procedures?	☐ Yes ☐ No ☐ N/A
2. Diagnostic Imaging machines are registered and inspected according to state law?	☐ Yes ☐ No ☐ N/A
3. Technicians, physicians, and other personnel who work with imaging machines comply with state law regarding monitoring?	☐ Yes ☐ No ☐ N/A
4. Screening and Diagnostic Mammography services are provided?	☐ Yes ☐ No

LABORATORY

If the answer is YES to the following question, please provide a copy of the CLIA Certificate. If the answer is No to the following question, please provide details on separate sheet.	
1. Does the laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)?	☐ Yes ☐ No ☐ N/A

PHARMACY

If the answer is YES to the following questions, please provide a copy of any DEA Registration Certificates, State DEA/CSR Certificates, and Pharmacy Licenses. If the answer is NO to the following question, please provide details on separate sheet.	
1. Does this Facility dispense medication?	☐ Yes ☐ No ☐ N/A
2. Can a patient fill a prescription at this Facility?	☐ Yes ☐ No ☐ N/A

INSURANCE COVERAGE

Please attach copy of declaration pages			
Current Professional Carrier:			
Amount per Occurrence: $		**Amount per Aggregate: $**	
Dates of Coverage	**From:**	**To:**	
Current Liability Carrier:			
Amount per Occurrence: $		**Amount per Aggregate: $**	
Dates of Coverage	**From:**	**To:**	
Current Worker's Compensation Carrier:			

ACCREDITATION / CERTIFICATION TYPE

Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective date of accreditation or certification, deficiencies and approved plan for corrective action.

Agency Name	Acronym	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Board for Certification in Orthotics & Prosthetics, Inc	ABCOP		
American College of Radiology	ACR		
American Osteopathic Hospital Association	AOHA		
Board of Orthotist / Prosthetist Certification	BOCUSA		
Commission on Accreditation for Rehab Facilities	CARF		
Clinical Laboratory Improvement Act	CLIA		
Community Health Accreditation Program	CHAP		
Agency Name	**Acronym**	**Applied Date**	**Expiration Date**
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
Others (please list)			

SANCTIONS

If yes to any question below, please explain on a separate sheet	
Have there been or are there currently pending any malpractice claims, suits, settlements or proceedings involving your professional practice?	☐ **Yes** ☐ **No**
Have you ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐ **Yes** ☐ **No**
Have you ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct?	☐ **Yes** ☐ **No**
Have you ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payor, or a Regulatory Agency (CLIA, OSHA, etc.)?	☐ **Yes** ☐ **No**
Has your DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?	☐ **Yes** ☐ **No**
Has an officer ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse or a sexual offense?	☐ **Yes** ☐ **No**
Has the corporation, an officer or a board member ever been convicted of a felony?	☐ **Yes** ☐ **No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current NH Healthy Families provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to NH Healthy Families Credentials Committee for their review and approval, and, absent such affirmative approval, NH Healthy Families members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from NH Healthy Families. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying NH Healthy Families in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy NH Healthy Families credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Not withstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection. All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ Date: _____

Print or type name

_____

Signature of Provider or Authorizing Representative **Title**

A stamp signature is not acceptable