



Universal Facility Application

Name: _____
(Please type full name of facility)

INITIAL CREDENTIALING RECREDENTIALING

- Complete this form in its entirety and attach all requested documentation and explanation.
- If a question does not apply to your facility, answer with "Not-Applicable" or "N/A".
- If additional space is necessary to provide answers, attach additional sheet(s) of paper
- This application must be signed and dated where indicated.

<p>I. PROVIDER INFORMATION: Type of Provider <i>(Choose all that apply)</i> NPI # _____</p> <p><input type="checkbox"/> Ambulatory Surgery Center</p> <p><input type="checkbox"/> Birthing Center <input type="checkbox"/> Institution Affiliated <input type="checkbox"/> Free Standing <input type="checkbox"/> Home Based</p> <p><input type="checkbox"/> Chemical Dependency Treatment Facility</p> <p><input type="checkbox"/> Home Health Agency</p> <p><input type="checkbox"/> Hospice Agency</p> <p><input type="checkbox"/> Hospital <input type="checkbox"/> Acute Care <input type="checkbox"/> Critical Access</p> <p><input type="checkbox"/> Medical Supply Company</p> <p><input type="checkbox"/> Orthotics and Prosthetics Provider</p> <p><input type="checkbox"/> Skilled Nursing Facility (Nursing Home)</p> <p>Other _____</p>
<p>II. DEMOGRAPHIC INFORMATION <i>(Please provide appropriate information for all your services/locations)</i></p> <p>Facility Name: _____</p> <p>Street Address: _____</p> <p>City: _____ County: _____ State: _____ Zip Code: _____</p> <p>Phone #: (____) _____ Fax #: (____) _____ Effective date of location _____</p> <p>Contact Person (the person you wish us to contact regarding information on this application)</p> <p>Contact Name, Title: _____</p> <p>Phone #: _____ Fax #: _____ Email Address _____</p>
<p>III. PAYMENT/BILLING INFORMATION:</p> <p>Tax Identification Number (Tax ID): _____ Reporting Name : _____</p> <p>Corporate Name: _____</p> <p>Street Address: _____</p> <p>City: _____ County: _____ State: _____ Zip Code: _____</p> <p>Billing Contact Name: _____</p> <p>Phone #: (____) _____ Fax #: (____) _____</p> <p><i>Please provide a copy of W-9 IRS form</i></p>

III. OWNERSHIP/MANAGEMENT:

President/CEO: Name: _____ Title: _____ Phone #: _____
 CFO: Name: _____ Title: _____ Phone #: _____
 Medical Director: Name: _____ Title: _____ Phone #: _____

IV. ACCREDITATION/CERTIFICATION/LICENSURE

Agency	License or Certificate or Accreditation Letter (if applicable)	Expiration Date
American Association of Ambulatory Health Centers (AAAHC)		
American College of Radiology (ACR)		
American Osteopathic Hospital Association (AOHA)		
Certification Accreditation for Rehab Facilities (CARF)		
Clinical Laboratory Improvement Act (CLIA)		
Community Health Accreditation Program (CHAP)		
Department of Alcohol and Drug Abuse (DASA)		
Joint Commission on Accreditation of Healthcare Organizations (JCAHO)		
Medicare		
Medicaid		
State Facility Operating License		
Others (please list)		

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

IV. LIABILITY COVERAGE

Current Carrier _____ Phone #: () _____
 \$ Amount Per Occurrence _____ \$ Amount Aggregate _____
 Dates of Coverage: From _____ To: _____

Please provide a copy of Certificate of Liability Insurance for facility

V. SANCTIONS

Has the Facility been sanctioned, placed on probation or stop placement, lost accreditation, licensure or certification status or been on stop payment within the last five years: Yes No
 If "Yes", explain on a separate sheet. Explanation should include a concise summary of all pertinent facts, dates, and current status.

VI. CERTIFICATION AND RELEASE

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Provider's Signature

_____/_____/_____
Date Signed

Name and Title (Print) _____ Phone #: _____