FACILITY CREDENTIALING APPLICATION

I. INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

- Accreditation Certificate
- State License (Business License, if applicable)
- Medicare Acceptance Letter (HCFA) (If applicable)
- Sanction Information (If applicable)
- General & Professional Liability Insurance Certificate
- Latest DHS or CMS Site Survey (Required, if not accredited)
- Latest CLIA Waiver/PPMP (If applicable)
- W-9

II. IDENTIFYING INFORMATION *Those with asterisk require section VII to be fully completed.

Please select the type of facility:

☐ Ambulatory Surgery Center*
☐ Behavioral Health Organization – Inpatient*
☐ Clinical Laboratories
☐ Comprehensive Outpatient Rehabilitation Facility
☐ Federally Qualified Health Center
☐ Home Health Agency
☐ Hospice*
☐ Hospital*
☐ Outpatient Diabetes Self-Management Training
☐ Outpatient Physical Therapy Facility
☐ Outpatient Speech Pathology Facility
☐ Portable X-Ray Supplier
☐ Renal Dialysis Facility
☐ Rural Health Clinic
☐ Skilled Nursing Facility*
☐ Urgent Care Facility
☐ Other:_____

FACILITY INFORMATION	
Facility Name:	DBA:
Primary Address:	Mailing Address:

Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	Holiday
From:								
To:								

Telephone:	Fax:	Email Address:

CHIEF ADMINISTRATIVE OFFICER	**CHIEF MEDICAL OFFICER**
Name:	Name:
Phone:	Phone:
Email:	Email:

CREDENTIALING CONTACT INFORMATION		
Name:	Phone:	Email:

Please attach a sheet containing additional affiliated entity/locations you wish to include under this application.

Arizona Priority Care™
One Goal. One Priority. Your Healthcare.

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III. TAX IDENTIFICATION NUMBER

In order to ensure that our files contain accurate information for reporting IRS Form 1099 payments made to your organization, please provide your Tax Identification Number and your reporting Name and Address as they appear on your W-9 IRS Form.

BUSINESS REPORTING NAME:	
Billing Address:	Tax ID #:
	State/Local License:
	Phone:
	Email:

IV. ACCREDITATIONS & CERTIFICATIONS (Attach copies of documents)

Is Facility Medicare Certified? ☐ YES ☐ NO	Medicare Provider Number:
Is Facility Medicaid Certified? ☐ YES ☐ NO	Medicaid Provider Number:
Business License Number:	Business License Expiration:
NPI Number:	CLIA Number:
Accredited? ☐ YES ☐ NO	Accreditation Expiration Date:
Accredited by? ☐ The Joint Commission (TJC) ☐ DNV ☐ AOA ☐ AAAHC ☐ CARF ☐ CCAC ☐ Other:	
Site Review? ☐ CMS ☐ ADHS ☐ Self	Site Review Date:

V. SANCTIONS (Attach copies of documents)

Has the institution been fined, sanctioned, placed on probation or lost its accreditation, licensure or certification status during the last five (5) years by any of the following:

If you answered **YES** to any of the below, please describe the nature, and reason on an attached sheet.

TJC/AAAHC/CARF/AOA/CCAC/DNV	☐ YES	☐ NO	☐ N/A	SANCTIONS DATE:
Medicare	☐ YES	☐ NO	☐ N/A	SANCTIONS DATE:
Medicaid	☐ YES	☐ NO	☐ N/A	SANCTIONS DATE:
State Licensure:	☐ YES	☐ NO	☐ N/A	SANCTIONS DATE:
Reportable or Sentinal Events:	☐ YES	☐ NO	☐ N/A	SANCTIONS DATE:
Professional Review Organization (PRO):	☐ YES	☐ NO	☐ N/A	SANCTIONS DATE:

VI. PROFESSIONAL & GENERAL LIABILITY

GENERAL LIABILITY INSURANCE *(attach a five (5) year claims history from carrier)*	
Insurance Carrier:	Policy Number:
Mailing Address:	$: Per Occurrence $ aggregate
	Effective Date:
	Expiration Date:

FACILITY CREDENTIALING APPLICATION

PROFESSIONAL LIABILITY INSURANCE *(attach a five (5) year claims history from carrier)*	
Insurance Carrier:	Policy Number:
Mailing Address:	$: Per Occurrence $ aggregate
	Effective Date:
	Expiration Date:

VII. ADDITIONAL INFORMATION FOR INPATIENT SETTING

1. Do you have a Quality Assurance Program? ☐ YES ☐ NO
2. Number of licensed and staffed beds and occupancy rate during the most recent fiscal year for A, B, and C below:

	Total Licensed Beds	**Total Staffed Beds**	**Licensed Bed Occupancy Rate**
Facility Type:			
Facility Type:			
Facility Type:			
Total			

3. Specify Timeframe: From: (mm/yy)_____ To: (mm/yy)_____
4. Indicate overall occupancy for the fiscal year indicated above: Occupancy Rate: _____

VIII. ATTESTATION (REQUIRED)

1. I attest that this facility complies with Federal requirements prohibiting employment contracts with individuals excluded from participation under either Medicare or Medicaid.
   ☐ **YES** ☐ **NO**

2. I attest that this facility complies with State, Federal and Local requirements for handicap access, as well as the standards required by the 1992 Federal American Disability Act.
   ☐ **YES** ☐ **NO**

3. I attest to the fact that all of the information submitted by me in this document is true, correct and complete to the best of my knowledge and believe. I fully understand that any significant mis-statement or omission on this application may constitute cause for denial of participation or cause for summary dismissal from Arizona Priority Care.
   ☐ **YES** ☐ **NO**

4. I attest that I am duly authorized representative of the above-named entity with the authority to release any requested information, documents, and execute this attestation.
   ☐ **YES** ☐ **NO**

_____ _____

SIG NATURE OF AUTHORIZED REPRESENTATIVE *DATE SIGNED*

_____ _____

PRINT NAME OF AUTHORIZED REPRESENTATIVE *TELEPHONE NUMBER*