Elite Health

Organizational Provider Facility Form

SECTION A

Organization Information	**Service Location____of_____** **(If applicable)** **Copy pages for each additional location**
Legal Name of Organization:	
DBA Name of Organization: (If applicable)	
Organization Type:	
Organization Medicare Number:	Organization Medicaid Number:
Organization Tax Identification Number (TIN):	Organization National Provider Identifier (NPI):
Organization Physical Address:	Billing Contact Name: Billing Contact Phone Number: Billing Physical Address:
City, State ZIP	☐ ***Check here to use Organization Address as Billing Information.***
Organizational Contact Name:	Organizational Contact E-mail:
Organizational Contact Phone Number:	Organizational Contact Fax Number:

List all counties where services are provided		
1._____	4._____	7._____
2._____	5._____	8._____
3._____	6._____	9._____

Services Rendered

Entity Type/Services:

☐ Hospital ☐Orthotics/Prosthetics
☐ DME ☐ Outpt PT/OT/Rehab
☐ Infusion ☐ Psychiatric Inpt/Outpt
☐ Hospice ☐ Speech Therapy
☐Clinical Lab ☐ Rural Health Clinic
☐ Skilled Nursing Facility ☐ Home Health
☐ Dialysis Center ☐ Cardiac Monitoring
☐ Surgery Center ☐ Urgent Care
☐ Other_____

Radiology Providers: ☐ Diagnostic ☐Mammography ☐ MRI ☐ CT scan ☐ Ultrasound ☐ PET ☐ Mobile Unit

Hours of Operation

Monday:
Tuesday:
Wednesday:
Thursday:
Friday:
Saturday:
Sunday
After hours accessibility is provided by:
☐24 Hour Phone coverage ☐ Beeper ☐ Answering Service ☐ Not Available

Foreign language spoken by staff:
Is this Location handicapped accessible:
Interpreter services available: ☐ Yes ☐ No **ALS/sign Language available: ☐ Yes ☐ No**

SECTION B

Please provide Copies of *ALL* items that are applicable to your entity(s)

Accredited Providers
☐Proof of Medicare participation if applying for Medicare Product (s)
☐Proof of Medicaid participation if applying for Medicaid products(s)
☐If organization provides a multitude of services, provide a detailed description of all services that you wish to include in the contract.
☐Accreditation certificates for Radiology providers who perform CT, MRI and Nuclear/PET studies****Note, this is a CMS requirement for freestanding sites & practitioner offices effective 1/1/12****
☐All current state licenses
List Accreditation/Certification Organization and Attach Copies of Current Certification: (If more than one accrediting entity, please provide copies of current status and expiration date with each accrediting entity). _____ _____ _____ _____ _____
☐Check here if the facility is NOT accredited.
If not accredited, please attach copy of last full state or Medicare Survey Results. If deficiencies were identified, provide a copy of the corrective action plan and confirmation of acceptance of the corrective action plan by the surveying entity:
Date of last full state/CMS survey: _____ **Corrective Action Required? ☐ Yes ☐ No**
Non-Accredited Providers
☐ If your organization/entity is not required to have a facility license, you must submit a list of the professionally licensed staff with their license numbers. List should be limited to physicians, NPs, PAs, PT/OTs. (Please refer to the list on last page).
☐ All current state and federal licenses

☐ Pharmacy dispensing license(s)
☐ DEA and state controlled substance certificates if applicable
☐ Current CLIA or CLIA waiver
☐ Mammography or other radiology certificate/Radioactive Material handling license
☐ Proof of Medicare participation if applying for Medicare product(s)
☐ Proof of professional liability insurance
☐ Proof of general liability insurance
☐ Auto/vehicle insurance coverage for transport companies
☐ Results summary of most recent state or Medicare survey(s). If deficiencies, should include evidence of corrective action submission and approval.
☐ If multiple locations, listing of each site including tax ID, NPI, Medicare and Medicaid Numbers for each site/entity. **(If applicable Copy pages for each additional location)**
☐ If organization provides a multitude of services, provide a detailed description of all services that you wish to include in the contract: _____ _____ _____ _____ _____ _____

SECTION C Professional Liability Insurance	
Current Carrier Name:	
Policy Type: (malpractice, general, standard, etc)	
Policy Number:	
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

SECTION D License and Credentials

Please provide information for *all* of your State and/or Federal licenses (to include pharmacy, DEA, CLIA, etc.) If you hold more than three, please provide current copies of all applicable licensure.

Licensures	State	Number	Expiration Date
State License			
DEA			
CLIA			

SECTION E Organizational Service Provider Screening

1. Please select the method used to verify the license/certification of individuals rendering services for your organization:
   - ☐ Online directory with the appropriate state and/or federal licensure or certification board
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe):
     _____
   - ☐ No process (please explain):
     _____

2. Please indicate the method used to verify the identity of individuals rendering services for your organization:
   - ☐ Verification of a state driver's license or other government identification
   - ☐ Background check agency, contacted organization or vendor
   - ☐ Other process (please describe):
     _____
   - ☐ No process (please explain):
     _____

3. Please indicate the method used to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:
   - ☐ Online directly with the appropriate state and/or federal licensure or certification board
   - ☐ Obtaining a current copy of the license/certification
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe):
     _____
   - ☐ No process (please explain):
     _____

4. Please indicate the method used to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a healthcare-related crime (including but not limited to healthcare fraud; patient abuse; and the unlawful manufacture, distribution, prescription or dispensing of controlled substance) are rending services:
   - ☐ Federal and/or state criminal background check(s)
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Search a state "misconduct registry" or equivalent
   - ☐ Other process (please describe): _____
   - ☐ No process (please explain):
     _____

5. Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?
   ☐No ☐ Yes (provide an explanation):
   _____
   _____

6. Has your organization or any of its authorized representatives ever been convicted of, pleaded guilty to or pleaded nolo contendere to any legal actions (excluding medical malpractice and misdemeanors)?
   ☐No ☐ Yes (provide an explanation):
   _____
   _____
   _____

7. Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military or state Department of Health program?
   ☐ No ☐ Yes (provide an explanation):
   _____
   _____

8. At any time, has any third-party payer ever revoked, reduced, denied or suspended your organization's participation due to inappropriate utilization management or quality-of-care issues?
   ☐No ☐ Yes (provide an explanation):
   _____
   _____

9. At any time, has any license or certification held by the organization or its branch locations ever been revoked, denied, or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are any actions or investigations underway that may lead to one of these outcomes?
   ☐ No ☐Yes (provide an explanation):
   _____
   _____
   _____

10. Has your organization's liability insurance 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 within the las 5 years?
    ☐ No ☐ Yes (provide an explanation): _____
    _____

11. At any time, has any third-party payer ever revoked, reduced, denied or suspended your organization's participation due to inappropriate utilization management or quality-of-care issues?

☐ No ☐Yes (provide an explanation)

_____

_____

12. Has the facility been denied accreditation by its selected body (e.g., TJC), or has its accreditation status been reduced, suspended, revoked, or in any way revised by the accrediting body?

☐No ☐Yes (provide an explanation):

_____

_____

13. Does each service location associated with the facility follow the policies and procedures as defined by the facilities service location?

☐No ☐ Yes (provide an explanation):

_____

_____

14. Has the Organization ever been disciplined, debarred, suspended, sanctioned or otherwise restricted from participating in any private, federal or state program (e.g.Medicare, Medicad, CLIA) in the last five (5) years or is an investigation for fraud and abuse or any other such action pending? (If this is/has occurred at the corporate level but does not pertain to your individual facility/entity, please note).

_____

_____

ATTESTATION AND RELEASE OF INFORMATION FORM

RELEASE OF INFORMATION:
As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant Elite Heath Plan, INC., permission to contact any individual, institution, facility, or agency identified on, or relative to, this application. Further, I hereby consent and authorize Elite Heath Plan, INC.to request, receive and inspect all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply Leon Heath Plan, INC., with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for Elite Heath Plan, INC., Health Plan to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support Leon Heath Plan, INC., quality improvement and utilization review programs.

ATTESTATION:
I certify the information on this entire application is complete, accurate and current. I acknowledge that any misstatements in or omissions fromthis application constitute grounds for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process and decision.

I acknowledge that a decision about participation for the organization on this application will be delayed until all required information is receivedand/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with Leon Heath Plan, INC., and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by Elite Heath Plan, INC., All services rendered to its members must be individually authorized until a written notice of participation and conditions of participation is issued by Elite Heath Plan, INC., This facility complies with all federal, state and local handicapped access requirements as well as the standards required by the 1992 federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contractedservice providers to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify that the applicant does not employ or contract with any individual convicted of a felony for a healthcare-related crime, including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

I certify that the on-line exclusion lists for the Department of Health and Human Services Office of Inspector General (**http://oig.hhs.gov/exclusions/exclusions_list.asp**) and System for Award Management (**https://sam.gov/content/exclusions**) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthlybasis to ensure that no state or federally excluded individuals perform any function related to any state or federal healthcare program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal healthcare program.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Authorized Signer:_____ Date: _____

Printed Name of Signer: _____

Authorized Signer Title: _____ Signer's Email Address: _____

Printed Facility Name: _____

Professional Staff Listing

(Please complete, only if facility is *not* required to be licensed by state)

Name	Title	Phone Number	Medicare Number	License Number

Please e-mail the documents requested above along with the W9 form to credentialing@elitehealthplan.com.