

# Facility / Organization Initial Application

**FAILURE TO LEGIBLY COMPLETE ALL SECTIONS OF THIS APPLICATION AND SUBMIT CURRENT COPIES OF ALL REQUIRED DOCUMENTATION WILL RESULT IN PROCESSING DELAYS.**

## Instructions:

- **National Provider Identifier Number (NPI) must be documented on the application**
- **Indicate 'N/A' if question does not apply**
- **Attach copies of ALL requested documents:**
  - A current, valid state license, as applicable to facility type—if facility is not state licensed, a business license or certificate of occupancy (lease agreement) will be needed
  - A current, valid malpractice liability insurance facesheet
  - DEA Certificate, if applicable
  - Non-accredited facilities ***must provide*** the most recent copy of your state site assessment (please include supporting documents); see Section V
  - Taxpayer Identification Number and Certification (W-9) must be submitted

## Section I

Facility/Organization Information			
Name of Facility:			
Street Address:	City:	State:	Zip Code:
Federal Tax ID Number (attach W-9):			NPI Number:
Patient Appointment Telephone Number:			Fax Number:
Credentialing Mailing Address (if different from above):			
Billing Address (if different from above):			
Credentialing/Contact Person:		Credentialing/Contact Telephone Number:	
E-mail Address:		Fax Number:	

## Section II

Type of Facility/Organization (Check appropriate box.)	
<input type="checkbox"/> Ambulatory Surgery Center (ASC)	<input type="checkbox"/> Hospital
<input type="checkbox"/> Applied Behavior Analysis Facility	<input type="checkbox"/> Hospital Laboratory
<input type="checkbox"/> Assisted Living Facility	<input type="checkbox"/> Imaging Facility
<input type="checkbox"/> Behavioral Health Facility	<input type="checkbox"/> Independent Diagnostic Testing Facility
<input type="checkbox"/> Mental Health Residential Facility	<input type="checkbox"/> Independent Laboratory*
<input type="checkbox"/> Substance Abuse Rehabilitation Facility	<input type="checkbox"/> Indian Health Services
<input type="checkbox"/> Birthing Center	<input type="checkbox"/> Lactation Consultant Facility
<input type="checkbox"/> Cancer Center	<input type="checkbox"/> Long-Term Acute Care Hospital
<input type="checkbox"/> County Health Department (Public Health)	<input type="checkbox"/> Medical Transportation Service
<input type="checkbox"/> Dialysis Facility	<input type="checkbox"/> Optical Hardware Center*
<input type="checkbox"/> Durable Medical Equipment Supplier*	<input type="checkbox"/> Pharmacy*
<input type="checkbox"/> Prosthetics and Orthotics*	<input type="checkbox"/> Physical Rehabilitation Facility
<input type="checkbox"/> Eating Disorder Center	<input type="checkbox"/> Radiology Facility
<input type="checkbox"/> Hearing Aid Dispensary*	<input type="checkbox"/> Skilled Nursing Facility
<input type="checkbox"/> Home Health Agency	<input type="checkbox"/> Sleep Disorder Laboratory*
<input type="checkbox"/> Home Infusion Provider	<input type="checkbox"/> Urgent Care Facility
<input type="checkbox"/> Hospice Provider	<input type="checkbox"/> Other:
<p><b>For Facilities noted with an * in Section II above, list other office locations with above information on a separate sheet. For all other Facilities/Organizations, you must submit SEPARATE Facility/Organization Initial Application(s) for each location.</b></p>	

## Section III

Professional Licensure, Registrations, and Certifications (Attach copies of documents.)		
State License Number:	Issue Date:	Expiration Date:
Is your license in good standing with the State? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Expiration Date:
Medicaid Number:	Is your certification in good standing with the State? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare Number:	Is your certification in good standing with the State? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## Section IV

Accreditation Information	
Is your organization accredited by one of the national accrediting bodies listed below?	<input type="checkbox"/> Yes <input type="checkbox"/> No
<ul style="list-style-type: none"> <li>If 'Yes,' please check all of the following that apply and submit a copy of accreditation letter or certification.</li> <li>If pending, please indicate the date of survey (mm/dd/yy): _____ or application date: _____</li> <li><i>If this is a facility type that requires accreditation, we cannot proceed without accreditation or a site survey and approved plan of corrections.</i></li> </ul>	
<ul style="list-style-type: none"> <li>If 'No,' please skip this section.</li> </ul>	
<input type="checkbox"/> Accreditation Association for Ambulatory Health Care (AAAHC)	
<input type="checkbox"/> Accreditation Commission for Home Care (ACHC)	
<input type="checkbox"/> The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)	
<input type="checkbox"/> American Academy of Sleep Medicine (AASM)	
<input type="checkbox"/> American College of Radiology (ACR)	
<input type="checkbox"/> American Osteopathic Association (AOA)	
<input type="checkbox"/> Clinical Laboratory Improvement Amendments (CLIA) (only applies to the laboratory)	
<input type="checkbox"/> College of American Pathologists (CAP)	
<input type="checkbox"/> Commission for the Accreditation of Birth Centers (CABC)	
<input type="checkbox"/> Commission on the Accreditation of Rehabilitation Facilities (CARF)	
<input type="checkbox"/> Community Health Accreditation Program (CHAP)	
<input type="checkbox"/> Det Norske Veritas Healthcare, Inc. (DNV)	
<input type="checkbox"/> Healthcare Facilities Accreditation Program (HFAP)	
<input type="checkbox"/> The Joint Commission (TJC)	
<input type="checkbox"/> Accreditation Commission for Home Health Care (ACHHC)	
<input type="checkbox"/> Continuing Care Accreditation Commission (CCAC)	
<input type="checkbox"/> American Association of Birthing Centers (AABC)	
<input type="checkbox"/> National Board for Certification in Hearing Instrument Sciences (NBCHIS)	
<input type="checkbox"/> Intersocietal Accreditation Commission (AIC)	
<input type="checkbox"/> American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCOPP)	
<input type="checkbox"/> Council on Accreditation (COA)	
<input type="checkbox"/> Accreditation Commission for Health Care (ACHC)	
<input type="checkbox"/> National Dialysis Accreditation Commission (NDAC)	
<input type="checkbox"/> Behavior Analyst Certification Board (BACB)	
<input type="checkbox"/> The Compliance Team (TCT)	
<input type="checkbox"/> Other:	
<b>Were there any deficiencies noted in your last survey?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If 'Yes,' have the deficiencies been removed?</b>	<input type="checkbox"/> Yes (Please provide supporting documentation of removal.) <input type="checkbox"/> No

## Section V

Non-Accredited Facilities
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Date of most recent State/Medicare Survey/Audit (mm/yy):

Please provide the most recent copy of your State and/or Medicare Survey/Audit. Required for the following non-accredited facilities (this is required to proceed):

- Ambulatory Surgery Facilities
- Applied Behavioral Analysis Facilities
- Assisted Living Facilities
- Behavioral Health Facilities
- Birthing Centers
- Cancer Centers
- Dialysis Centers
- Eating Disorder Centers
- Home Infusion Providers
- Home Health Agencies
- Hospice Providers
- Hospitals
- Long-Term Acute Care Hospitals
- Mental Health Residency Facilities
- Skilled Nursing Facilities
- Sleep Disorder Laboratories
- Substance Abuse Facilities

Survey/Audit documents must include:

- Full site survey
- Plan of Correction
- Evidence of removal of deficiencies

## Section VI

Professional Liability (Do not abbreviate.)			
Current Insurance Carrier:			Policy Number:
Mailing Address:	City:	State:	Zip Code:
Aggregate Amount \$:	Per Claim Amount \$:	Date Began:	Expiration Date:

## Section VII

Malpractice Claims History (For questions 1-5, any 'Yes' responses must have details added on a separate sheet.)	
1. Has the facility/organization been disciplined, reprimanded, or fined by a state licensing agency or other agency or by a professional conduct board?	<input type="radio"/> Yes <input type="radio"/> No
2. Has the facility/organization been reprimanded, censured, excluded, suspended, or disqualified by Medicare, Medicaid, or the CLIA program?	<input type="radio"/> Yes <input type="radio"/> No
3. Has the facility/organization had/does it currently have any pending legal actions, excluding medical malpractice?	<input type="radio"/> Yes <input type="radio"/> No
4. Has the facility/organization been convicted of a crime, excluding misdemeanors?	<input type="radio"/> Yes <input type="radio"/> No
5. At any time, has any third party payor revoked, reduced, denied, or suspended your facility's/organization's participation due to inappropriate utilization management or any quality of care issue(s)?	<input type="radio"/> Yes <input type="radio"/> No
Does your facility/organization have a procedure/process in place to deal proactively with preventable patient errors or known potential errors? (For a 'No' response, provide details on a separate sheet.) (Example: Process to prevent wrong side surgeries.)	
	<input type="radio"/> Yes <input type="radio"/> No

## Section VIII

### Release of Information (Modification to the wording or format will invalidate this application.)

I authorize and consent to the release of information to First Choice Health Network (FCHN) or its affiliates necessary for evaluation of this application. I release from liability and agree to hold harmless FCHN and any person or organization for their acts performed in good faith and without malice in connection with gathering information as consented above. I consent to the release of information from the liability insurance carrier regarding my coverage and present and prior claims. I understand and agree that this consent is for the period during which my organization participates as a FCHN provider.

## Section IX

### Attestation

I hereby affirm that the information furnished by me is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatements in, or omissions from, this application, whether intentional or not shall constitute cause for summary dismissal as a FCHN provider. In the event that participation privileges have been granted prior to such misstatement or omission, such discovery may result in termination from FCHN.

I agree that I have a continuing affirmative duty to inform FCHN immediately of any material changes that may affect my organization's status.

I understand that completion and submission of this application does not automatically grant me a contracted status in any First Choice Health Provider Network, but that such status is dependent, in part on evaluation and approval of this application. This application is not a contract.

I understand that until I am notified that this application is approved, and a written contract is in effect with First Choice Health Network, I may not represent myself as a contracted provider. However, if I am already a contracted provider with First Choice Health Network, I may continue in that status while evaluation of this application is pending.

I submit this application in the expectation that confidentiality and privacy will be preserved, and that the information will be used only for credentialing, peer review, and quality assurance activities.

Facility Name:

Your Name:

Authorized  
Signature:

**MUST BE A WET SIGNATURE REQUIRED OR ADOBE SIGNED WITH DATE STAMP**

Title:

Date:

*Plan accreditation guidelines require this application signature date to be no older than 180 days at the time of credentialing.*