First Choice Health

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.)	
❑ Ambulatory Surgery Center (ASC)	❑Hospital
❑ Applied Behavior Analysis Facility	❑Hospital Laboratory
❑ Assisted Living Facility	❑Imaging Facility
❑ Behavioral Health Facility	❑Independent Diagnostic Testing Facility
❑ Mental Health Residential Facility	❑Independent Laboratory*
❑ Substance Abuse Rehabilitation Facility	❑Indian Health Services
❑ Birthing Center	❑Lactation Consultant Facility
❑ Cancer Center	❑Long-Term Acute Care Hospital
❑ County Health Department (Public Health)	❑Medical Transportation Service
❑ Dialysis Facility	❑Optical Hardware Center*
❑ Durable Medical Equipment Supplier*	❑Pharmacy*
❑ Prosthetics and Orthotics*	❑Physical Rehabilitation Facility
❑ Eating Disorder Center	❑Radiology Facility
❑ Hearing Aid Dispensary*	❑Skilled Nursing Facility
❑ Home Health Agency	❑Sleep Disorder Laboratory*
❑ Home Infusion Provider	❑Urgent Care Facility
❑ Hospice Provider	❑Other:
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.	

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? ❑Yes ❑No		
Drug Enforcement Administration (DEA) Registration Number (if applicable):		Expiration Date:
Medicaid Number:	Is your certification in good standing with the State? ❑Yes ❑No	
Medicare Number:	Is your certification in good standing with the State? ❑Yes ❑No	

Section IV

Accreditation Information
Is your organization accredited by one of the national accrediting bodies listed below? ☐ Yes ☐ No • If 'Yes,' please check all of the following that apply and submit a copy of accreditation letter or certification. • If pending, please indicate the date of survey (mm/dd/yy): or application date: • *If this is a facility type that requires accreditation, we cannot proceed without accreditation or a site survey and approved plan of corrections.*
• If 'No,' please skip this section.
❑ Accreditation Association for Ambulatory Health Care (AAAHC)
❑ Accreditation Commission for Home Care (ACHC)
❑ The American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
❑ American Academy of Sleep Medicine (AASM)
❑ American College of Radiology (ACR)
❑ American Osteopathic Association (AOA)
❑ Clinical Laboratory Improvement Amendments (CLIA) (only applies to the laboratory)
❑ College of American Pathologists (CAP)
❑ Commission for the Accreditation of Birth Centers (CABC)
❑ Commission on the Accreditation of Rehabilitation Facilities (CARF)
❑ Community Health Accreditation Program (CHAP)
❑ Det Norske Veritas Healthcare, Inc. (DNV)
❑ Healthcare Facilities Accreditation Program (HFAP)
❑ The Joint Commission (TJC)
❑ Accreditation Commission for Home Health Care (ACHHC)
❑ Continuing Care Accreditation Commission (CCAC)
❑ American Association of Birthing Centers (AABC)
❑ National Board for Certification in Hearing Instrument Sciences (NBCHIS)
❑ Intersocietal Accreditation Commission (AIC)
❑ American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABCOPP)
❑ Council on Accreditation (COA)
❑ Accreditation Commission for Health Care (ACHC)
❑ National Dialysis Accreditation Commission (NDAC)
❑ Behavior Analyst Certification Board (BACB)
❑ The Compliance Team (TCT)
❑ Other:
Were there any deficiencies noted in your last survey? ☐ Yes ☐ No
If 'Yes,' have the deficiencies been removed? ☐ Yes (Please provide supporting documentation of removal.) ☐ No

Section V

Non-Accredited Facilities

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? ◯ Yes ◯ No
2. Has the facility/organization been reprimanded, censured, excluded, suspended, or disqualified by Medicare, Medicaid, or the CLIA program? ◯ Yes ◯ No
3. Has the facility/organization had/does it currently have any pending legal actions, excluding medical malpractice? ◯ Yes ◯ No
4. Has the facility/organization been convicted of a crime, excluding misdemeanors? ◯ Yes ◯ 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)? ◯ Yes ◯ 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.) ◯ Yes ◯ No (Example: Process to prevent wrong side surgeries.)

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.

First Choice Health

Facility / Organization Application

BEHAVIORAL HEALTH FACILITIES ONLY: Mental Health /Substance Abuse Residential Facilities

Instructions:

- **This form is IN ADDITION to the Facility Credentialing Form which must be completed**
- **Complete the fields below**
- **Indicate 'N/A' if question does not apply**

Section I

Facility/Organization Information			
Name of Facility:			
Street Address:	City:	State:	Zip Code:
Business Website URL:		Facility Phone Number:	
Credentialing/Contact Person:		Credentialing/Contact Phone Number:	
E-mail Address:		Fax Number:	

Section II

Types of Treatment Offered (Check all appropriate boxes.)	
☐ Medical Detox	
☐ Medically Assisted Treatment (MAT)	
☐ Suboxone	
☐ Vivitrol	
☐ Other:	
☐ Residential Treatment	
☐ Partial Hospitalization	
☐ Intensive Outpatient (IOP)	
☐ Mental Health	
☐ Gambling	☐ Eating Disorders
☐ Other:	

Section III

Types of Patients Accepted (Check all appropriate boxes. Include additional details, such as age limitations, where needed.)
☐ Men:
☐ Women:
☐ Adolescent Boys:
☐ Adolescent Girls:
☐ Children:
☐ Other:

Section IV

Additional Information (Use this space if you'd like to provide additional details or requirements for treatment.)