AMERICAN HEALTH ADVANTAGE OF OKLAHOMA

909 S. Meridian Avenue, Suite 425
Oklahoma City, OK 73108
P: 405.602.5488
F: 405.601.5627

Facility Request for Credentialing

Credentialing Application Checklist

- ☐ Completed Application
- ☐ Signed and Dated Attestation
- ☐ Signed and Dated Release of Information
- ☐ Licenses/Certifications for the Facility as well as all active licensed personnel (employed & contracted), including professional liability insurance and continuing education certificates
- ☐ Accrediting Body Survey Results
- ☐ State/CMS Survey Results
- ☐ Current Professional Liability Carrier Policy along with any previous carriers' name, address, policy #, and phone or fax # (during the last 5 years)
- ☐ Case description(s) and Current status of any professional liability/malpractice cases or issues (during the last 5 years)
- ☐ W-9

Send application checklist, completed application and all relevant items to any of the following:

Mail	Fax	Email
American Health Plans 201 Jordan Rd., Ste 200 Franklin, TN 37067	615.656-8036	networkservices@amhealthplans.com

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Facility Credentialing Application

FACILITY INFORMATION (PLEASE PRINT CLEARLY):

Name of Facility:							
Street Address:							
City:		State:		Zip:		County:	
Office Contact:		Office Phone #:					
Office Fax #:		Office Email:					
Credentialing Contact:							
Credentialing Phone #:				Fax:			

Billing Information:

Billing address (if different):							
City:		State:		Zip:		County:	
Billing Contact Name:							
Billing phone #:		Billing Fax #:					

Other Information:

President/CEO Name:			
Title:		Phone:	
Medical Director Name:			
Title:		Phone:	

LICENSE/CERTIFICATION INFORMATION (PLEASE PRINT CLEARLY):

Is the Facility Medicare/Medicaid Certified? *Yes ☐ No ☐

* If yes, please provide the license number in the table below.

Has the Facility been approved by an accrediting body? **Yes ☐ No ☐

If yes, please select the accrediting body below and enter information in the table below.

JCAHO ☐ URAC ☐ AAAHA ☐ CARF ☐ CHAP ☐

OTHER ☐ Please specify: ☐

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	ISSUED BY	LICENSE/ CERTIFICATION #	CURRENT DATES
STATE:			
* MEDICARE A:			
* MEDICARE B:			
* MEDICAID:			
ACCREDITATION:			

PLEASE ATTACH copies of all Licenses/Certifications for the facility as well as for all active licensed personnel (employed & contracted), including: professional liability insurance and continuing education certificates.

PLEASE ATTACH a copy of the most recent survey results from the accrediting body, if applicable.

PLEASE ATTACH a copy of the most recent survey results from the State or CMS.

PLEASE ATTACH a copy of the facility's current and historic malpractice policy. Also enclose brief case description(s) and current status of each case (for past 5 years)

ADDITIONAL INFORMATION (PLEASE PRINT CLEARLY):

Please answer **all** of the questions.

A. Is your office HIPAA Compliant? Yes ☐ *No ☐

* If no, please explain:

B. In the past five (5) years, has the corporation, an officer, or a board member:

(1) ever been convicted of a felony? Yes ☐ No ☐

If yes, explain:

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(2) ever had State License (if applicable) denied, suspended,

or revoked for any reason? Yes ☐ No ☐ N/A ☐

If yes, explain:

(3) ever had DEA Registration or State Controlled Substance Certificate (if applicable)

denied, suspended, or revoked for any reason? Yes ☐ No ☐ N/A ☐

If yes, explain:

(4) ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO),

the Medicare/Medicaid Program, a Third Party Payor, or a Regulatory agency (CLIA,

OSHA, etc.)? Yes ☐ No ☐

If yes, explain:

(5) ever had any professional liability issues/claims against the corporation, etc.?

** **Yes** ☐ No ☐

****If yes, please list on separate form(s) the following information with regard to each professional liability claim or cause of action in which the corporation has been involved:**

(a) plaintiff's/claimant's name;
(b) agency, court, or jurisdiction;
(c) date filed and docket number;
(d) brief case description and current status of each case

Note that the individual managed care organizations will review a minimum of five year's professional liability history.

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ADDENDUM:

Beds:			
Total Licensed Bed Capacity:		Total # of Medicaid Certified Beds:	

☐ Air Ambulance	☐ Neonatal ICU	☐ Radiation Therapy
☐ Alcohol/Chemical Dependency	☐ Nuclear Medicine	☐ Speech Pathology
☐ Inpatient	☐ Nursery	☐ Inpatient
☐ Outpatient	☐ Nursing Facility	☐ Outpatient
☐ Adolescent	☐ Obstetrics	☐ Tissues Transplant
☐ Alzheimer's Diagnosis and Assessment	☐ Occupational Therapy	☐ Trauma Facility/ER Dept.
☐ Birthing Rooms	☐ Inpatient	☐ Resource
☐ Blood Bank	☐ Outpatient	☐ Regional
☐ Burn Unit	☐ Open Heart Surgery	☐ Area
☐ Cardiac Care Unit	☐ Organ Transplant	☐ Community
☐ Cardiac Rehab Program	Specify:	☐ Ultrasound
☐ CT Scanner	☐ Outpatient Surgery	☐ Urgent Care Center
☐ Diabetic Education Program	☐ Pain Management	☐ Ventilator Care –Long Term
☐ Dialysis	☐ Pediatrics	☐ Residential Day Care
☐ Geriatric Services	☐ PET Scanner	☐ Skilled Nursing Facility
☐ Home Health Services	☐ Physical Therapy	☐ Sports Medicine
☐ Home Infusion	☐ Inpatient	☐ Swing Bed Program
☐ Hospice	☐ Outpatient	
☐ Hospital Based Ambulance	☐ Psychiatric Services	
☐ Intensive Care Unit	☐ Inpatient	
☐ Lithotripsy	☐ Outpatient	
☐ MRI Scanner	☐ Pediatric	
	☐ Adolescent	

Other Services:

Are there services provided off-campus that would fall under the hospital outpatient billing and Tax ID?

**Yes ☐ No ☐

**If yes, please list these services, names, and locations: *(use additional sheet if necessary)*

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Services	Names	Locations

Are there any other certified facilities based at your hospital?

**Yes ☐ No ☐ (If yes, list below)

Home Health	Hospice	Skilled Nursing	Dialysis

Do you contract with any facility or provider group to provide services at the hospital?

**Yes ☐ No ☐ (If yes, list below)

Radiology	Lab	ER	DME

Other (e.g., anesthesiology, reference labs, etc.

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ATTESTATION

The signature by the authorized agent for the name listed below and organization/agency/facility) attests to the accuracy of the information herein.

Uses or disclosure of data contained in or attached to this document are subject to the restriction for use as indicated on the Title Page of the proposal and Quotation.

I further acknowledge that this application will be incorporated by reference into the Participating Provider Agreement if the facility is accepted as a Participating Provider.

I understand as an authorized agent for this organization/agency/facility, our organization has the right to correct erroneous information and the right to review information obtained to evaluate this credentialing application unless disclosure is prohibited by law or the information is protected by peer review. I further understand that we may contact the - Credentialing Department at any time to check the status of our credentialing at 866-583-4649.

Authorized Agent Signature:	
Title:	
Printed Name:	
Date:	

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RELEASE OF INFORMATION

The signature by the authorized agent for: _____

Print LEGAL NAME of your organization/agency/facility)

hereby grants permission to any organization or individual from whom information is requested by The Health Plan to release to THE PLAN, all information in the possession of that individual or organization related to this organization/agency/facility, an officer, or board member.

I release the Federation of State Medical Boards from any liability whatsoever for provision of information to THE PLAN. I release any individual or organization providing information pursuant to this authorization from any and all liability resulting from the release of such information.

I grant permission to any current or previous insurance carriers to release the professional liability insurance claims information to THE PLAN and release the carrier, its officers, employees, directors, and agents from any claims, liabilities, actions, damages, or otherwise, for the release of such information if such information is released in good faith and without malice.

I understand as an authorized agent for this organization/agency/facility, our organization has the right to correct erroneous information and the right to review information obtained to evaluate this credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

Authorized Agent Signature:	
Title:	
Printed Name:	
Date:	