STANDARDIZED FACILITY CREDENTIALING FORM

This form is designed as a fillable form for providers wishing to participate in the Health One Alliance/Alliant Health Plans network. Upon completing the Standardized Facility Credentialing Form, email this form to ProviderRelations@AlliantPlans.com, fax to (706) 529-4275 or mail to Health One Alliance, Attn: Provider Relations, PO Box 1128, Dalton, GA 30722.

Type of Facility:

- ☐ Hospital
- ☐ Nursing Home
- ☐ Specialty DME
- ☐ Laboratory
- ☐ Substance Abuse Facility
- ☐ Home Health Agency
- ☐ Skilled Nursing Facility
- ☐ Outpatient Hyperbaric Facility
- ☐ Federally Qualified Health Center
- ☐ Other (please specify): _____
- ☐ Intensive Outpatient Facility
- ☐ Behavioral Health Facility
- ☐ Freestanding Surgery Center
- ☐ Rural Health Clinic

Please list specialized services performed:

Section I: Facility Information

Corporation Name: _____

NPI: _____ CCN: _____

*All NPIs submitted for billing purposes must be listed and credentialed to ensure that claims process correctly.

Specialty: _____ Taxonomy: _____

Length of time in business under listed Name & TIN (months/years): _____

Date of Incorporation: _____ State of Incorporation: _____

Section II: Contact Information

Section II-A: Contracting Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

If executed, should the contact be returned to the above address? ☐ Yes ☐ No

Section II-B: Credentialing Contact

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

If credentialed, should the decision letter be returned to the above address? ☐ Yes ☐ No

Section II-C: Medical Record Requests (specific to HEDIS, Risk Adjustment, RAD-V, etc.)

Name: _____

Phone: _____ Fax: _____

Email: _____

Address: _____

Preferred Method: ☐ Mail ☐ Phone ☐ Fax ☐ Email

STANDARDIZED
FACILITY CREDENTIALING FORM

HealthOne ALLIANT HEALTH PLANS

Section III: Addresses

Location/DBA Name: ______ Offers TeleHealth: ☐ Yes ☐ No

TIN: ______ NPI: ______

Phone: ______ Fax: ______

Service Address: ______

Hours of Operation: ______

Show in Directory: ☐ Yes ☐ No

Pay to Name: ______

Pay to Address: ______

Vendor Address: ______

Location/DBA Name: ______ Offers TeleHealth: ☐ Yes ☐ No

TIN: ______ NPI: ______

Phone: ______ Fax: ______

Service Address: ______

Hours of Operation: ______

Show in Directory: ☐ Yes ☐ No

Pay to Name: ______

Pay to Address: ______

Vendor Address: ______

Location/DBA Name: ______ Offers TeleHealth: ☐ Yes ☐ No

TIN: ______ NPI: ______

Phone: ______ Fax: ______

Service Address: ______

Hours of Operation: ______

Show in Directory: ☐ Yes ☐ No

Pay to Name: ______

Pay to Address: ______

Vendor Address: ______

Please attach a full listing of locations if provided space is insufficient.

Section IV: Medical Director

Name: ______ Degree: ______

Specialty: ______ NPI: ______

Phone: ______

Address: ______

Section V: Accreditation Status

Accrediting Agency Name: ______

Accreditation Status: ______ Accreditation Date: ______

Have you ever been denied accreditation by any accrediting body? ☐ Yes ☐ No

If yes, please provide details.

STANDARDIZED FACILITY CREDENTIALING FORM

Section VI: State Site Survey

Survey Entity Name: _____

Surveying Date: _____

Section VII: Licensure and Certifications

License/Permit number: _____ ☐ N/A State(s) of Licensure: _____

CLIA Number: _____ ☐ N/A

Section VIII: Liability Insurance

Section VIII-A: Professional/General Liability Coverage (attach certificate showing current coverage amounts and effective dates)

Name of Carrier: _____

Policy Number: _____

Address: _____

Coverage Type: _____

Effective Date: _____ Expiration Date: _____

Per Incident: _____ Aggregate: _____

Section IX: Disclosure Questions

Answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate sheet and attach to document.

Have criminal proceedings ever been initiated against the Provider or its authorized representatives?	☐ Yes	☐ No
Has the Provider ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program, include, but not limited to, Medicare, Medicaid and military or Department of Health programs?	☐ Yes	☐ No
Has the Provider's general liability or professional liability 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?	☐ Yes	☐ No
Has the Provider ever been notified that information pertaining to anyone in the Provider's staff has been reported to the National Practitioner Data Bank, Healthcare Integrity and Protection Data Bank or professional state licensing boards or registries?	☐ Yes	☐ No
In the last ten years, have there been any general liability or professional liability suits, or are there currently any pending or threatened suits against the Provider, or have any judgments been made or settlements paid on its behalf?	☐ Yes	☐ No
Is there currently any pending or threatened licensing or disciplinary action against the Provider?	☐ Yes	☐ No

Section X: Attachments

You must include copies of the following documents, as applicable, with the completed application.

Current State License(s), State Permit(s), DCH, DHR, etc., DEA certificate
Letter or certificate from any/all accrediting organizations
Copy of most recent State Survey (if not accredited)
Copy of current Certificate(s) of Insurance – commercial & professional
List of all service locations with billing address for each
Copy of W-9 form

Also Include:

Any/all information applicable to Disclosure Questions
Copy of most current CMS letter

STANDARDIZED FACILITY CREDENTIALING FORM

Section XI: Standard Authorization, Attestation and Release

By signing this application, I certify, agree, understand and acknowledge the following:

1. The information in this entire application is complete, current, correct and not misleading.
2. Any misstatements or omissions (whether intentional or unintentional) on this application may constitute cause for denial of my application or summary dismissal or termination of my provider participation agreement.
3. A photocopy of this application, including this attestation, the authorization and release of information form and any or all attachments has the same force and effect as the original.
4. I have reviewed the information in this application on the most recent date indicated below and it continues to be true and complete.
5. While this application is being processed, I agree to update the information originally provided in this application should there be any change in the information.
6. No action will be taken on this application until it is complete and all outstanding questions with respect to the application have been resolved.
7. This attestation statement and application must be signed no more than 120 days prior to the credentialing decision date.

For hospitals with fifty (50) or more beds, please attest to the following:

- Facility utilizes a safety utilization system as defined in 42 CFR 3.20. _____ (Initial)
- Facility has implemented a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; _____ (Initial)

OR

Facility has implemented an evidence-based initiative to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmissions, or improves care coordination. _____ (Initial)

To the extent permitted by law, we recognize a provider's right to review submitted information supporting the credentialing application. Providers may obtain information regarding their initial or re-credentialing application status by contacting Provider Relations at (706) 629-8848 or ProviderRelations@AlliantPlans.com. This number can also be used to request information regarding general requirements for participation and correct any erroneous information.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation

The Applicant hereby authorizes any third party, including, but not limited to, individuals, agencies, medical agencies responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank to release to the Contracting Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning the qualifications of this Applicant, its credentials, accreditations, quality assurance and utilization data or any other information reasonably having a bearing on the Applicant's qualifications for Participation with the Contracting Entity. This information shall also include the details of any action taken by a health care organization, Medicare and Medicaid, their administrators or their medical or other committees to revoke, deny, suspend, restrict or condition the Applicant's Participation, impose a corrective action plan or terminate any contract to which the Applicant was a party. The Applicant further authorizes its current and past insurance carrier(s) to release the Applicant's history of claims that have been made and/or are currently pending against it. The Applicant specifically waives written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Facility Name: _____

Signature: _____

Printed Name: _____ Date: _____