



3200 Highlands Parkway, Suite 300 • Smyrna, GA 30082 • 1-866-874-0633 • Fax: 1-678-556-2442

ANCILLARY/FACILITY PROVIDER CREDENTIALING APPLICATION

Please attach a copy of the following with this COMPLETED application:

- Copy of Georgia State License
- Copy of Quality Improvement Plan
- Copy of other applicable State/Federal Licensures (ie. CLIA, Bureau of Radiation Control, Pharmacy)
- Copy of accreditation/certification (by a governmental accrediting body, ie. CMS, JCAHO)
- Copy of Current General Liability coverage (document showing the amounts and dates of coverage)
- Copy of Medicare/Medicaid Certification (if not certified, provide proof of participation)
- Copy of Site Evaluation Results by a governmental agency (If not accredited by a governmental agency)

A. PROVIDER DEMOGRAPHIC INFORMATION

Facility/Group Name _____

Professional Category (Specialty) _____

Address _____ City _____ ST _____ Zip _____

Phone Number (_____) _____ Fax Number (_____) _____

Office Manager _____ Email _____

Hours of Operation: _____ Mon. Tues. Wed. Thur. Fri. Sat.: _____

Federal Tax ID Number _____ Georgia Medicaid Provider Number(s) _____

Medicare Provider Number(s) _____ Medicare Certification No. _____

Multiple Office Location(s)

Street Address _____

City _____ State _____ Zip _____ Phone _____ Fax _____

Street Address _____

City _____ State _____ Zip _____ Phone _____ Fax _____

Street Address _____

City _____ State _____ Zip _____ Phone _____ Fax _____

Billing office (if different from primary office information above)

Street Address _____

City _____ State _____ Zip _____ Phone _____ Fax _____

LANGUAGES spoken (other than English) _____

Does the facility have a credentialing program in place for the health care practitioners, which the facility employs?

- Yes No N/A



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B. LICENSES/CERTIFICATIONS/SPECIALTIES---List all current and past licenses:

STATE	LICENSE NO.	DATE ISSUED	EXPIR. DATE	TYPE OF LICENSURE

If the answer is YES to any of the following questions, please provide details on separate sheet.

- Has your facility license ever been limited, suspended, revoked, denied or subjected to conditions of probation?
 Yes No
- Has the facility or representative of the facility ever been notified to appear before any licensing agency for a hearing or complaint of any nature?
 Yes No
- Has the facility or representative of the facility ever been a defendant in a criminal proceeding related to the practice of medicine or the privileges you are requesting?
 Yes No

C. DIAGNOSTIC IMAGING FACILITIES

If the answer is No to any of the following questions, please provide details on separate sheet.

- Diagnostic Imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction or supervision of physicians qualified to perform those procedures?
 Yes No
- Diagnostic Imaging machines are registered and inspected according to state law?
 Yes No
- Technicians, physicians, and other personnel who work with imaging machines comply with state law regarding monitoring?
 Yes No

D. LABORATORIES

If the answer is Yes to the following question, please provide a copy of the CLIA Certificate.

If the answer is No to the following question, please provide details on separate sheet.

- Does the laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)?
 Yes No

E. LIABILITY COVERAGE

Name of Insurance Company _____

Policy number _____ Amount of coverage _____ From Mo/Yr ____ / ____ To ____ / ____

Street Address _____

City _____ State ____ Zip _____ Phone _____ Fax _____



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Amounts of Coverage: Each/Specific \$ _____ Aggregate \$ _____

F. RELEASE OF INFORMATION AND ATTESTATION

I AGREE:

1. To assist the Credentialing Department and its representatives in gathering the information necessary to credential my facility. In this regard, I recognize that I have the burden of resolving any reasonable doubts about the facility's credentials;
2. To be bound by the terms of the contract in all matters relating to the consideration of this application. If an adverse ruling is made with respect to the facility's credentials, the facility will exhaust the administrative remedies afforded by the Contract and Provider Manual before resorting to formal legal action.
3. To release from liability any persons or entities that provide information in furtherance of the above-described purposes, to the fullest extent allowed by applicable statutes, regulations and judicial decisions.
4. To update this application while it is being processed should there be any change in the information provided that could effect the application or its outcome.

I hereby attest that the information furnished by me to the Corporate Credentialing Department is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatement in, or omission from this application will constitute cause for denial or revocation of membership.

I Present this application, and arrange for the submission of other information as part of the credentialing process, in the expectation that confidentiality and privacy will be preserved, and that the information will only be used for medical staff credentialing, peer review and quality improvement activities.

Signature:

Printed Name:

Date: