MOUNTAIN HEALTH CO-OP

Organizational Provider Credentialing Application

ORGANIZATION INFORMATION	
Legal name of organization/parent company (legal name listed with IRS)	
DBA Name of organization (if applicable)	
Organization Medicare # *(primary)*	**Organization Medicaid #** *(primary)*
Organization TIN *(primary)*	**Organization NPI** *(primary)*
Ownership type: ◯ Sole proprietorship ◯ City / County / State owned ◯ Corporate/LLC/Partnership ◯ Federally owned	
Credentialing address Street address: _____ Address line 2: _____ City:_____State:_____Zip: _____ Contact:_____ Email:_____ Phone: _____	**Billing address** *(if different than Credentialing address)* Street address: _____ Address line 2: _____ City:_____State:_____Zip: _____ Contact:_____ Email:_____ Phone: _____

LOCATION #1		
Address: (choose both, if applicable) ◯ Primary address ◯ Mailing		
Organization name (DBA):		
Group NPI number:	**Medicare number:**	
Street Address:		
City:	**State:**	**Zip code:**
Location phone number:	**Location fax number:**	
Location contact name:	**Email address:**	
Office hours:	**Virtual visits:** ◯ **Yes** ◯ **No**	
Languages spoken by office personnel:		
Service area: ***(States, Counties, Cities, etc.)***		
Is the location handicap accessible? ◯ **Yes** ◯ **No** **Does the location provide any of the following?** **Language translation/interpretation services** ◯ **Yes** ◯ **No** **Visual impairment accommodations** ◯ **Yes** ◯ **No** **Hearing impairment accommodations** ◯ **Yes** ◯ **No** **Does the location have age restrictions?** ◯ **Yes** ◯ **No Please explain:** _____ **Does the location have gender restrictions?** ◯ **Yes** ◯ **No Please explain:** _____ **Does the location have any other restrictions?** ◯ **Yes** ◯ **No** **Please explain:** _____		

MOUNTAIN HEALTH CO-OP

LOCATION #2

Address: (choose both, if applicable) ◯ Primary address ◯ Mailing		
Organization name (DBA):		
Group NPI number:	**Medicare number:**	
Street Address:		
City:	**State:**	**Zip code:**
Location phone number:	**Location fax number:**	
Location contact name:	**Email address:**	
Office hours:	**Virtual visits:** ◯ **Yes** ◯ **No**	
Languages spoken by office personnel:		
Service area: ***(States, Counties, Cities, etc.)***		

Is the location handicap accessible? ◯ **Yes** ◯ **No**
Does the location provide any of the following?
Language translation/interpretation services ◯ **Yes** ◯ **No**
Visual impairment accommodations ◯ **Yes** ◯ **No**
Hearing impairment accommodations ◯ **Yes** ◯ **No**
Does the location have age restrictions? ◯ **Yes** ◯ **No** **Please explain:** _____
Does the location have gender restrictions? ◯ **Yes** ◯ **No** **Please explain:** _____
Does the location have any other restrictions? ◯ **Yes** ◯ **No**
Please explain: _____

LOCATION #3

Address: (choose both, if applicable) ◯ Primary address ◯ Mailing		
Organization name (DBA):		
Group NPI number:	**Medicare number:**	
Street address:		
City:	**State:**	**Zip code:**
Location phone number:	**Location fax number:**	
Location contact name:	**Email address:**	
Office hours:	**Virtual visits:** ◯ **Yes** ◯ **No**	
Languages spoken by office personnel:		
Service area: ***(States, Counties, Cities, etc.)***		

Is the location handicap accessible? ◯ **Yes** ◯ **No**
Does the location provide any of the following?
Language translation/interpretation services ◯ **Yes** ◯ **No**
Visual impairment accommodations ◯ **Yes** ◯ **No**
Hearing impairment accommodations ◯ **Yes** ◯ **No**
Does the location have age restrictions? ◯ **Yes** ◯ **No** **Please explain:** _____
Does the location have gender restrictions? ◯ **Yes** ◯ **No** **Please explain:** _____
Does the location have any other restrictions? ◯ **Yes** ◯ **No**
Please explain: _____

MOUNTAIN HEALTH CO-OP

STATE LICENSE(S) AND/OR STATE REGISTRATION(S) – *Attach a copy of all*				
Type of credential	**State**	**Number**	**Issue date**	**Expiration date**
State license				
State registration				
CLIA#				

ACCREDITATION / CERTIFICATION (*check all that apply*)

Attach a copy of your most recent accreditation, state survey, or Centers of Medicare and Medicaid (CMS) survey, with any site visit corrections showing that your facility is in compliance.

◯ ***Medicare (CMS) Certification***
◯ ***State Survey*** *(including Dept. of Health and Human Services, State Medicaid, etc.)*
◯ ***Accreditation*** *(indicate accrediting body(bodies) below)*
◯ *Please mark here if your organization is NOT accredited, not certified by CMS, or has not had a state survey. If you check this box, a site visit will be scheduled prior to completing credentialing.*

Name of contact to schedule site visit:_____ ***Phone***:_____

Has your organization ever been put on a Plan of Correction (POC) by CMS, State or Accrediting Body? ☐ Yes ☐ No
If Yes, please provide a written explanation or attach the POC Acceptance Letter or other documentation showing compliance.

Accreditation	**Organization**
◯ (AAAHC)	Accreditation Association for Ambulatory Health Care
◯ (ACHC)	Accreditation Commission for Health Care
◯ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities
◯ (ABCOP)	American Board for Certification in Orthotics/Prosthetics
◯ (ACR)	American College of Radiology
◯ (ASHI)	American Society for Histocompatibility and Immunogenetics
◯ (BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)
◯ (CAP)	College of American Pathologists
◯ (CARF)	Commission on Accreditation of Rehabilitation Facilities
◯ (COLA)	Committee of Laboratory Accreditation
◯ (CHAP)	Community Health Accreditation Program
◯ (CT)	The Compliance Team
◯ (COA)	Council on Accreditation
◯ (DNV)	Det Norske Veritas
◯ (HFAP)	Healthcare Facilities Accreditation Program - AOA
◯ (HQAA)	Healthcare Quality Association on Accreditation
◯ (IAC)	The Intersocietal Accreditation Commission
◯ (NABP)	National Association of Boards of Pharmacy
◯ (NBAOS)	National Board of Accreditation for Orthotics Suppliers
◯ (NCQA)	National Commission for Quality Assurance
◯ (NDAC)	National Dialysis Accreditation Commission
◯ (TJC)	The Joint Commission
◯ (URAC)	Utilization Review Accreditation Commission
◯ (CABC)	Commission for the Accreditation of Birth Centers
◯ (PPFA)	Planned Parenthood Federation of America

MOUNTAIN HEALTH CO-OP

LIABILITY INSURANCE	
Insurance carrier:	**Phone number:**
Policy number:	**Dates of coverage:**
Dollar amount:	**Dollar amount aggregate:**
Please provide a copy of your current professional and general liability insurance.	

ORGANIZATIONAL PROVIDER TYPE

◯ Hospital
- ☐ Acute Care
- ☐ Critical Access
- ☐ Psychiatric
- ☐ Physical Rehabilitation

◯ Residential Treatment Facility
- ☐ Chemical Dependency/Substance Abuse: Indicate level of care provided:_____
- ☐ Mental Health: Indicate level of care provided: _____

◯ Agencies
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Personal Care

◯ Skilled Nursing Facility

◯ Sleep Study Center/Lab

◯ Laboratory

◯ Laboratory Draw Station

◯ Ambulatory Specialties
- ☐ Ambulatory Surgical Center
- ☐ Birthing Center
  - ○ Institution-affiliated ○ Free Standing ○ Home Based
- ☐ Endoscopy
- ☐ End-Stage Renal Disease (ESRD)/Dialysis Center
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Hearing Center
- ☐ Lithotripsy
- ☐ Mental Health – Outpatient
- ☐ Medicaid Prepaid Mental Health Plan (please include roster of all providers)
- ☐ Occupational Therapy
- ☐ Ophthalmologic Surgery
- ☐ Physical Therapy
- ☐ Public Health – Federal
- ☐ Public Health – State or Local
- ☐ Radiology / Medical Imaging Center
  - ○ Mobile ○ Free Standing
- ☐ Rural Health Clinic
- ☐ Urgent Care

◯ Suppliers
- ☐ Diabetes Supply Center
- ☐ Durable Medical Equipment (DME)
- ☐ Eyewear
- ☐ Hearing Aid Equipment
- ☐ Prosthetics

◯ Other:_____

MOUNTAIN HEALTH CO-OP

ATTESTATION AND RELEASE OF INFORMATION

SITE REVIEW AUTHORIZATION

I hereby grant permission for the Mountain health Co-Op, its affiliates or representatives, to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support quality improvement and utilization review programs conducted by Mountain Health Co-Op

ATTESTATION QUESTIONNAIRE

1. ☐ Yes ☐ No This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.
2. ☐ Yes ☐ No Has the facility ever had or currently have pending any legal actions excluding medical malpractice?
3. ☐ Yes ☐ No Has the facility ever been convicted of a crime, excluding misdemeanors?
4. ☐ Yes ☐ No Has any government agency ever investigated, suspended, revoked, or taken other actions against this facility's license to conduct business?
5. ☐ Yes ☐ No At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now underway?
6. ☐ Yes ☐ No At any time, has the facility been assessed a penalty, conviction or suspension or is the facility currently under investigation by the Medicaid or Medicare programs?
7. ☐ Yes ☐ No At any time, have the third party payers ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality-of-care issues?
8. ☐ Yes ☐ No Has any managing employee or person with an ownership or controlling interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?

EXCLUSION CERTIFICATION

I hereby certify that the online exclusions lists for the Health and Human Services, Office of Inspector General (OIG), and General Services Administration (GSA) are checked for all new hires, and monthly for existing employees, to ensure that no excluded employees work on any jobs related to any Federal healthcare programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal healthcare program. The OIG exclusion list can be found at **exclusions.oig.hhs.gov**. The GSA exclusion list can be found at **sam.gov**.

Authorized signature ▶	**Date**
Print name	**Title**

RELEASE OF INFORMATION AND AUTHORIZATION

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant Mountain Health Co-Op its affiliates or representatives permission to contact any individual, institution, facility, or agency identified on, or relative to, this application. Further, I hereby consent and authorize the health plan to request, receive, and inspect any and all records pertinent to consideration of this application. I, the undersigned authorized agent of the applicant facility/organization, agrees Mountain Health Co-Op may share this provider application and related credentialing information with any group or entity that has delegated or contracted with Mountain Health Co-Op to provide such activities on their behalf. Information cannot be shared for any reason other than for provider directory/demographic and credentialing activities.

As a Mountain Health Co-Op facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply Mountain Health Co-Op, its affiliates or representatives with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Authorized signature ▶	**Date**
Print name	**Title**