



ANCILLARY/FACILITY CREDENTIALING APPLICATION

*** Any documentation presented to the Health Partners of Kansas (HPK) Credentials Committee for consideration must be current at the time of presentation.

GENERAL INFORMATION

1. Legal Name of Ancillary/Facility _____
2. Ancillary/Facility Specialty _____
3. Legal Owner of Ancillary/Facility _____

4. Year Operation Began _____
5. Federal Tax ID Number _____
6. National Provider Identifier (NPI) _____
7. Address _____
Street City State Zip
8. Billing Address _____
Street City State Zip
9. E-mail Address (Optional) _____
10. Please list the names of counties in which the Ancillary/Facility provides services: _____

11. Office Phone Number _____
12. Office Fax Number _____

13. Contact Person/Title _____

14. Hours/Days of Operation _____
(Indicate 24-Hour emergency provisions)

LICENSURE/CERTIFICATION/ACCREDITATION

1. Kansas Medicare Number (if applicable) 17- _____
(Please enclose a copy of your most recent Medicare Survey, your Ancillary/Facility's plan of corrective action for each deficiency, and follow-up correspondence from Medicare indicating the outcome of their revisit.)

2. Date of last state survey. _____

3. Have any sanctions/disciplinary actions (e.g. expulsion, probation, limitations from receiving payment, etc.) ever been taken against the Ancillary/Facility by Medicare or Medicaid? ____ Yes ____ No

If yes, please provide details. _____

4. Current state license ____ Yes ____ No (Please attach copy)

5. Has the Ancillary/Facility's state license ever been restricted, revoked, surrendered, suspended, stipulated or voluntarily relinquished? ____ Yes ____ No

If yes, please provide details. _____

6. Has the Ancillary/Facility ever received sanctions from any regulatory agency (e.g. OSHA) ____ Yes ____ No (If yes, please explain.) _____

7. Is the Ancillary/Facility accredited (e.g. JCAHO, AAAHC, AAAASF, AOA, CARF, CHAP, CCAC)? ____ Yes ____ No (If yes, indicate name of accrediting agency and attach a copy of the accreditation certificate(s).)

8. Has the Ancillary/Facility lost accreditation, certification, been placed on probation, or been sanctioned in any way during the last 5 years? ____ Yes ____ No (If yes, please explain.) _____

9. Explain the Ancillary/Facility's practice for securing information regarding patient Advanced Directives: _____

INSURANCE INFORMATION

1. General liability insurance carrier _____
(Attach a copy of policy declarations page.)

- a. Type of Coverage (Claims Made or Occurrence) _____
- b. Amount of coverage _____
- c. Policy expiration date _____

2. Professional liability insurance carrier _____
(Attach a copy of policy declarations page.)

- a. Type of Coverage (Claims Made or Occurrence) _____
- b. Amount of coverage _____
- c. Policy expiration date _____

3. Has any carrier ever denied the Ancillary/Facility or failed to renew the Ancillary/Facility's professional liability insurance? ____ Yes ____ No (If yes, attach explanation.)

4. Has any professional liability insurance carrier ever excluded specific procedures or services from the Ancillary/Facility's coverage?

Yes ___ No ___ (If yes, attach complete details.)

5. Please answer the following questions if the Ancillary/Facility is self-insured, and these questions are applicable.

How long has the facility been self-funded? _____

Who was your previous carrier? _____

6. Does the Ancillary/Facility have additional stop-loss coverage?

Yes ___ No ___

a. Amount of Coverage \$ _____

b. Carrier _____

c. Address _____

d. Phone Number _____

7. Are you currently, or have you within the last five years been involved in a malpractice suit or other suit or claim in which your care and treatment of a patient was at issue, including pending or dismissed cases or claims settled before or during trial, or settled to avoid a lawsuit?

Yes ___ No ___ (If yes, please attach complete details. Explain if there are legal restrictions from divulging the requested information.)

OPERATING INFORMATION

1. Does the Ancillary/Facility currently participate with other managed care organizations? ___ Yes ___ No (If yes, please list the organizations.)

2. Has the Ancillary/Facility ceased to participate in any managed care organizations? ___ Yes ___ No (If yes, please list the organizations and explain why this has occurred.) _____

3. Does the Ancillary/Facility have a Utilization Management Plan/Quality Improvement Plan? ___ Yes ___ No (Please attach copy)

HOSPITAL RELATIONSHIPS

1. Does the Ancillary/Facility have any type of relationship(s) with a hospital?
___ Yes ___ No

If yes, please explain: _____

NETWORK MANAGEMENT DATA SHEET

1. Date of incorporation or partnership _____ (Attach complete listing of partners and board of directors. Include addresses and business affiliations.)
- a. President/CEO _____
 - b. Chief Operating Officer _____
 - c. Medical Director _____
 - d. Chief Financial Officer _____

2. Is the Ancillary/Facility owned, operated, or managed by a health system, hospital, or other type of health care institutions? ___ Yes ___ No (If yes, identify by name and location.) _____

3. If applicable, what has been the facility's average daily census for the past two years?

_____	_____
Rate	Year
_____	_____
Rate	Year

4. Are there certain types of cases you do not accept? ___ Yes ___ No (If yes, please list. _____

PROVIDER AGREEMENT

I, the undersigned, agree to abide by the rules and regulations, and policies of Health Partners of Kansas and those of any of its affiliates.

The undersigned applies for consideration as a Health Partners of Kansas provider. As a condition of this application, I agree to cooperate in any inspection of our Ancillary/Facility/facility and practices by any individual or individuals designated by Health Partners of Kansas. I understand that this document is a preliminary application and does not constitute a contract with Health Partners of Kansas. I further understand that Health Partners of Kansas reserves the right to accept or reject this application, and that a formal written contract must be executed between both parties before participation will become effective.

This application will become a part of the contract if one is executed. Any false information could result in immediate termination of the contract by Health Partners of Kansas.

I hereby certify that all information contained in this application is true and complete to the best of my knowledge. I hereby authorize any source named in this application to release information to Health Partners of Kansas at its request in order to verify or provide further details regarding their relationship with our organization.

Signature

Date

Name of Organization

Name (Printed)

Title (Printed)

ATTACHMENTS TO SUBMIT WITH APPLICATION:

- STATE LICENSE
- LIABILITY DECLARATION
- MEDICARE CERTIFICATION
- RECENT STATE SURVEY
- COPY OF QUALITY IMPROVEMENT/ UTILIZATION PLAN
- SIGNED PROVIDER AGREEMENT
- W-9
- SAMPLE BILLING FORM – COMPLETED WITH PROVIDER INFORMATION