

# HEALTH PARTNERS OF KANSAS

## HOSPITAL 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 Facility \_\_\_\_\_
2. Year Operation Began \_\_\_\_\_
3. Federal Tax ID Number \_\_\_\_\_
4. National Provider Identifier (NPI) \_\_\_\_\_
5. Address \_\_\_\_\_  
Street City State Zip
6. Billing Address \_\_\_\_\_  
Street City State Zip
- E-mail Address (Optional) \_\_\_\_\_
7. Home Health Agency and Hospice only – Please name the counties in which you provide services: \_\_\_\_\_  
\_\_\_\_\_
8. Office Phone Number \_\_\_\_\_
9. Office Fax Number \_\_\_\_\_
10. Contact Person/Title \_\_\_\_\_
11. Hours/Days of Operation \_\_\_\_\_  
(Indicate 24-Hour emergency provisions)

LICENSURE

1. Kansas Medicare Number (if applicable) 17- \_\_\_\_\_  
(Please enclose a copy of your most recent Medicare Survey, your 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, limited from receiving payment, etc.) ever been taken against your facility by Medicare or Medicaid? \_\_\_\_ Yes \_\_\_\_ No  
  
If yes, please provide details. \_\_\_\_\_  
\_\_\_\_\_
  
4. Current state license \_\_\_\_ Yes \_\_\_\_ No ( Please attach copy)
  
5. Has your state license ever been restricted, revoked, surrendered, suspended, stipulated or voluntarily relinquished? \_\_\_\_ Yes \_\_\_\_ No  
  
If yes, please provide details. \_\_\_\_\_  
\_\_\_\_\_
  
6. Have you ever received sanctions from any regulatory agency,( e.g. OSHA) \_\_\_\_ Yes \_\_\_\_ No (If yes, please explain.) \_\_\_\_\_  
\_\_\_\_\_
  
7. Are you 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 your 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.) \_\_\_\_\_  
  
\_\_\_\_\_  
\_\_\_\_\_

**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 you or failed to renew your professional liability insurance? \_\_\_Yes\_\_\_ No (If yes, attach explanation.)
  
4. Has any professional liability insurance carrier ever excluded specific procedures or services from your coverage? \_\_\_Yes \_\_\_No (If yes, attach complete details.)
  
5. Please answer the following questions if you are self-insured and these questions are applicable.  
How long has the facility been self-funded? \_\_\_\_\_  
Who was your previous carrier? \_\_\_\_\_
  
6. Do you 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 and if you are not legally restricted from divulging the requested information, please attach complete details.)

**OPERATING INFORMATION**

1. Does your facility currently participate with other managed care organizations? \_\_\_ Yes \_\_\_ No (If yes, please list the organizations.)

\_\_\_\_\_

2. Have you ceased to participate (for cause) in any managed care organizations? \_\_\_ Yes \_\_\_ No (If yes, please list the organizations and explain why this has occurred.)

\_\_\_\_\_

\_\_\_\_\_

**HOSPITAL RELATIONSHIPS**

1. Does the hospital have a medical office building? \_\_\_ Yes \_\_\_ No  
If yes, please indicate the location(s) and the number of physicians who have an office in the building.

Address

# of Physicians

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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. Are you owned or operated by a health system, hospital, or other type of health care institutions? \_\_\_ Yes \_\_\_ No (If yes, identify by name and location.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
  
3. Are there certain types of cases you do not accept? \_\_\_ Yes \_\_\_ No (If yes please list. \_\_\_\_\_
  
4. Does your facility have an urgent care center of services? (Hospital only) \_\_\_ Yes \_\_\_ No (If yes, please list hours of operations.)

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 facilities 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
- W9
- UB92 SAMPLE CLAIM FORM WITH BOXES 1 & 5 COMPLETED WITH HOSPITAL BILLING INFORMATION