Hospital/Facility Provider Application

Instructions: In order for the application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each Legal Entity/TIN.
3. The Application must be signed and dated.
4. If necessary, use a separate sheet of paper to provide additional information.
5. The original application with attachments should be attached to the Provider Agreement.
6. Fill-in the Tax ID# at the bottom of every page for reference purposes.

Attach the following to the completed application:

- State Operational License
- Other applicable State/Federal Licensures (e.g., CLIA, DEA, Pharmacy or Department of Health)
- Accreditation/Certification (by a nationally recognized accrediting body, e.g., TJC/JCAHO)
- If not accredited by a nationally recognized accrediting body, attach the Site Evaluation Results from a governmental agency
- W-9
- Ownership and Disclosure Form
- Other applicable State/Federal Licensures (See last page for list of state-required documents)

☐ **Initial Credentialing/ Assessment**

☐ **Re-Credentialing/ Re-Assessment**

☐ **Addition of new site to current contract**

Legal Entity/TIN: _____

This application applies to the following **Provider Types**: (Choose all that apply)

☐ Hospital (Critical Access) NPI:	☐ Hospital (Swing Bed); NPI:	☐ Hospital (General Acute Care; NPI:
☐ Hospital (Rehabilitation) NPI:	☐ Hospital (Psychiatric) NPI:	☐ Hospital; NPI:
☐ Adult Day Care Center; NPI:	☐ Clinic –Federally Qualified Health Center (FQHC); NPI:	☐ Intensive Family Intervention; NPI:
☐ Adult Living Facility/Assisted Living Facility; NPI:	☐ Clinic – Indian Health Center (IHC); NPI:	☐ Laboratory; NPI:
☐ Agency (Dept. of Health, State Health); NPI:	☐ Clinic – Rural Health Center (RHC); NPI:	☐ Outpatient Clinic; NPI:
☐ Ambulance; NPI:	☐ Community Mental Health Center (CMHC); NPI:	☐ Pediatric Day Health Care Facilities (PDHC) ; NPI:
☐ Assisted Long-Term Care Facility; NPI:	☐ Diagnostic Imaging Center; NPI:	☐ Personal Care Assistant Facilities (PCAs); NPI:
☐ Ambulatory Surgical Center; NPI:	☐ Dialysis; NPI:	☐ Residential Treatment Center; NPI:
☐ Autism Facility; NPI:	☐ Durable Medical Equipment; NPI:	☐ Rehabilitation Facility (Outside of Hospitals); NPI:
☐ Behavioral Health Agency/Child Placing Agency; NPI:	☐ Family Planning Clinics; NPI:	☐ Skilled Nursing Facility; NPI:
☐ Board of Health ; NPI:	☐ Home & Community Based Services (HCBS); NPI:	☐ Urgent Care (Attached to Hospital); NPI:
☐ Chemical Dependency /Substance Abuse; NPI:	☐ Home Health Agency; NPI:	☐ Urgent Care (Free Standing); NPI:
	☐ Hospice; NPI:	☐ Other; NPI:

Contact Information:

If questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**

Tax ID Number:_____

Credentialing Contact Information: ☐ **Same as Contact Information**

If questions about this application, contact:	**Phone Number:**
Email:	**Fax Number:**

Legal Entity Information (Name on Income Tax Return)

Tax ID Holder Name:	**Federal Tax ID Number:**
Legal/Tax Address (where you want the 1099 sent):	

Insurance Information

Carrier:	**Amount of Coverage:**	**Coverage Dates:**

Billing Information

Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to:	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

HCBS/Home Health Agencies Servicing Counties: (if needed attach an additional sheet)

Servicing County 1:	**Servicing County 2:**	**Servicing County 3:**	**Servicing County 4:**
Servicing County 5:	**Servicing County 6:**	**Servicing County 7:**	**Servicing County 8:**
Servicing County 9:	**Servicing County 10:**	**Servicing County 11:**	**Servicing County 12:**

Note: Each Provider Type/NPI listed on in the Provider Type Grid on Page 1, must have one service location.

Complete for each Service Location that is part of this application. .

Service Location 1 of ____		
Group or Facility Name (to be displayed in the Directory)		
Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID #:**
State License Number:	**Medicaid Number:**	**Medicare Number:**
Service Location Address: ☐**Same as Legal Entity**		
Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8 – 5**

Handicap Accessible? (Check all that apply). ☐ **Building** ☐ **Bathroom(s)** ☐ **Parking** ☐ **Therapy Room(s)**	**Service Location Accepting New Patients?** ☐**Yes** ☐ **No**	**ADA Compliant?** ☐**Yes** ☐ **No**

Crisis Intervention/ Emergency Services Offered? ☐**Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐**Yes** ☐ **No**	**In No, explain:**

Please list any Foreign Languages spoken at this location:

Do you provide services to any of the following special needs population? (Check all that apply):
☐ **Deaf/Hearing Impaired** ☐ **Physical Disability** ☐ **Blind/Vision Impaired** ☐ **Developmental Disability**
☐ **Other (Please specify: _____)**

Is your practice limited to certain ages? ☐**Yes** ☐ **No**
If Yes, specify age restrictions:
☐**None** ☐ **0-2 years** ☐ **0-6 years** ☐**0-12 years** ☐**0-17 years** ☐ **0-20 years** ☐ **6-12 years** ☐**13+ years**
☐**13-17 years** ☐**13-20 years** ☐**3+ years** ☐**17+ years** ☐**21+ years** ☐**65+ years** ☐**Other _____**

Behavioral Health Services Provided for Service Location 1 of _____: (check all that apply)	
☐ **Inpatient Mental Health** ☐ **Inpatient Substance Abuse** ☐ **Day Treatment – Mental Health** ☐ **Day Treatment – Substance Abuse** ☐ **Intensive Outpatient Program (IOP) – Mental Health** ☐ **Intensive Outpatient Program – Substance Abuse** ☐ **Observation** ☐ **Residential Treatment – Mental Health (PRTF)** ☐ **OP Treatment Services – Mental Health** ☐ **OP Treatment Services – Substance Abuse**	☐ **Inpatient – Eating Disorder** ☐ **Electroconvulsive Therapy (ECT) – Inpatient** ☐ **Electroconvulsive Therapy (ECT) - Outpatient** ☐ **Partial Hospitalization Program (PHP) – Mental Health** ☐ **Partial Hospitalization Program (PHP) – Substance Abuse** ☐ **Residential Treatment – Chemical Dependency** ☐ **Community Based Services** ☐ **Targeted Case Management** ☐ **Crisis Stabilization** ☐ **Detox; Ages Served: _____** ☐ **Other (please specify): _____**

Billing Information for Service Location 1 of _____ : ☐ **Same as indicated on Page 2 (If different, complete below)**		
Pay To Name (Issue check to): Note: May be different than name on the 1099.		
Pay To Address (Send remittance to:	**City, State, Zip:**	**Phone Number:**
Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Insurance Information for Service Location 1 of _____: ☐ **Same as indicated on Page 3 (If different, complete below)**		
Professional Carrier:	**Amount of Coverage:** **Per Occurrence:** **Per Aggregate**	**Coverage Dates:**
Worker's Compensation Carrier:	**Coverage Dates:**	

Service Location 1 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

Agency Name	Level Status	Applied Date	Expiration Date
Accreditation Commission for Health Care (ACHC)			
American Association of Ambulatory Health Centers (AAAHC)			
American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)			
American College of Radiology (ACR)			
American Osteopathic Hospital Association (AOHA)			
Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Tax ID Number:_____

Service Location 1 of _____ – Sanctions ☐ **Same as Legal Entity** *If yes, to any question below, please explain on a separate sheet of paper.*	
Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐**Yes** ☐**No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐**No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐**Yes** ☐**No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐**Yes** ☐**No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐**Yes** ☐**No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐**No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐**Yes** ☐**No**

Complete for each Service Location that is part of this application. .

Service Location 1 of ____		
Group or Facility Name (to be displayed in the Directory)		
Tax ID Number: ☐ **Same as Legal Entity**	**Provider Type:**	**National Provider ID #:**
State License Number:	**Medicaid Number:**	**Medicare Number:**
Service Location Address: ☐**Same as Legal Entity**		
Physical Street Address:	**City, State, Zip:**	**County:**
Main Switchboard Phone Number:	**Service Location Fax Number**	**Email:**

Service Location Hours:

Office Hours	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

☐ **24 Hours** ☐ **8 – 5**

Handicap Accessible? (Check all that apply). ☐ **Building** ☐ **Bathroom(s)** ☐ **Parking** ☐ **Therapy Room(s)**	**Service Location Accepting New Patients?** ☐**Yes** ☐ **No**	**ADA Compliant?** ☐**Yes** ☐ **No**

Crisis Intervention/ Emergency Services Offered? ☐**Yes** ☐ **No**	**If Yes, explain:**	**Do you provide services to both Males & Females?** ☐**Yes** ☐ **No**	**In No, explain:**

Please list any Foreign Languages spoken at this location:

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☐**13-17 years** ☐**13-20 years** ☐**3+ years** ☐**17+ years** ☐**21+ years** ☐**65+ years** ☐**Other _____**

Behavioral Health Services Provided for Service Location 2 of _____: (check all that apply)	
☐ **Inpatient Mental Health** ☐ **Inpatient Substance Abuse** ☐ **Day Treatment – Mental Health** ☐ **Day Treatment – Substance Abuse** ☐ **Intensive Outpatient Program (IOP) – Mental Health** ☐ **Intensive Outpatient Program – Substance Abuse** ☐ **Observation** ☐ **Residential Treatment – Mental Health (PRTF)** ☐ **OP Treatment Services – Mental Health** ☐ **OP Treatment Services – Substance Abuse**	☐ **Inpatient – Eating Disorder** ☐ **Electroconvulsive Therapy (ECT) – Inpatient** ☐ **Electroconvulsive Therapy (ECT) - Outpatient** ☐ **Partial Hospitalization Program (PHP) – Mental Health** ☐ **Partial Hospitalization Program (PHP) – Substance Abuse** ☐ **Residential Treatment – Chemical Dependency** ☐ **Community Based Services** ☐ **Targeted Case Management** ☐ **Crisis Stabilization** ☐ **Detox; Ages Served: _____** ☐ **Other (please specify): _____**

Billing Information for Service Location 2 of _____ : ☐ **Same as indicated on Page 2 (If different, complete below)**		
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Billing Contact Name:	**Billing Contact Email:**	**Fax Number:**

Insurance Information for Service Location 2 of _____: ☐ **Same as indicated on Page 3 (If different, complete below)**		
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Worker's Compensation Carrier:	**Coverage Dates:**	

Service Location 2 of _____ - Accreditation/Certification Type

☐ **Same as Legal Entity**

Please provide a copy of these documents; including the Survey Results and a report that shows the effective date of accreditation or certification, deficiencies and approved corrective action plan.

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Accreditation Commission for Health Care (ACHC)			
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American College of Radiology (ACR)			
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Board of Orthotist / Prosthetist Certification (BOCUSA)			
Clinical Laboratory Improvement Act (CLIA)			
Commission on Accreditation for Rehab Facilities (CARF)			
Community Health Accreditation Program (CHAP)			
Council on Accreditation (COA)			
DEA Certificate			
Healthcare Quality Association on Accreditation (HQAA)			
The Joint Commission (TJC (aka JCAHO))			
Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)			
National Association of Boards of Pharmacy (NABP			
National Committee for Quality Assurance (NCQA)			
Pharmacy			
State Facility Operating License			
The National Board of Accreditation for Orthotic Suppliers (NBAOS)			
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)			
Others (please list):			

Service Location 2 of _____ – Sanctions ☐ **Same as Legal Entity** *If yes, to any question below, please explain on a separate sheet of paper.*	
Have there been or are there any currently pending malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?	☐**Yes** ☐**No**
Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?	☐**Yes** ☐**No**
Has the facility ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to personal conduct?	☐**Yes** ☐**No**
Has the facility ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payer or a Regulatory Agency (CLIA, OSHA, etc.)?	☐**Yes** ☐**No**
Has the facility's DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended or revoked for any reason?	☐**Yes** ☐**No**
Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?	☐**Yes** ☐**No**
Has the corporation, an officer or board member ever been convicted of a felony?	☐**Yes** ☐**No**

PROVIDER RESPONSIBILITY STATEMENT

I hereby understand that as a prospective/current **Louisiana Healthcare Connections** provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to **Louisiana Healthcare Connections** Credentials Committee for their review and approval, and, absent such affirmative approval, **Louisiana Healthcare Connections** members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from **Louisiana Healthcare Connections**. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying **Louisiana Healthcare Connections** in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy **Louisiana Healthcare Connections** credentials/re-credentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, DOM, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

STATEMENT OF APPLICATION/AUTHORIZATION FOR RELEASE OF INFORMATION

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: _____ Date: _____

Print or type name

_____

Signature of Provider or Authorizing Representative **Title**

A stamp signature is not acceptable

Tax ID Number:_____