HOSPITAL /ANCILLARY PROVIDER CREDENTIALING APPLICATION

INSTRUCTIONS: In order to be considered complete:

1. **All information must be legible. Please print or type all information**
2. **Application must be completed in its entirety, signed, and dated**
3. **If necessary, use a separate sheet of paper to provide additional information**
4. **The original application with attachments should be attached to your MHS Health Wisconsin Provider Participation Agreement**

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

- ❑ Copy of Wisconsin State Operational License
- ❑ Copy of Quality Improvement or Performance Management Plan
- ❑ Copy of other applicable State/Federal Licensures (ie. CLIA, DEA, Pharmacy, or Department of Health)
- ❑ 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 Medicaid/Medicare Certification (if not certified, provide proof of participation)
- ❑ Copy of Site Evaluation Results by a governmental agency (If not accredited by a governmental agency)
- ❑ Copy of W-9
- ❑ Copy of Original Provider Participation Agreement (if initial submission)

☐ **Initial Credentialing** ☐ **Re-Credentialing** ☐ **Addition of a new site to current Agreement**

Facility credentialing is required for the following facility types – Choose all that apply:

☐ **Hospital** ☐ **Skilled Nursing Facility** ☐ **Diagnostic Imaging Center**

☐ **Rehabilitation Center** ☐ **Clinic – FQHC, RHC, Other** ☐ **Long-Term Acute Care Facility**

☐ **Surgical Center(Free Standing)** ☐ **Home Health Agency/Hospice** ☐ **Durable Medical Equipment (DME)**

OWNERSHIP/MANAGEMENT

President/CEO Name:	**Phone:**
Vice President Name:	**Phone:**
CFO Name:	**Phone:**
Medical Director:	**Phone:**

LEGAL INFORMATION

Entity Legal Name:	**Fed. Tax ID Numbers:**	**Medicaid Numbers:**
Wisconsin State License No.	**National Provider ID# (NPI):**	**Medicare Numbers:**

FACILITY INFORMATION

Group or d/b/a Name		**Group Fed. Tax ID No.**
Medicaid Number:	**Title/Name of Group Signatory:**	**Location Code:**
Physical Address	**City/State/Zip**	**County**
Phone Number	**Email Address**	

Contact Information

Credentialing Contact:		
Street:	**City/State**	**Zip**
Phone:	**Fax:**	**E-Mail:**

BILLING ADDRESS

Pay To:		
Street:	**City/State/Zip**	**Phone:**
Contact Person:	**Fax:**	**E-Mail:**

Office Hours:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**

Is this facility open at least 5 days per week? ☐**Yes** ☐ **No** | **Handicap Access?** ☐**Yes** ☐ **No**

Are PAs, CNMs and/or Nurse Practitioners used? ☐**Yes** ☐ **No** | **Will you be accepting new patients?** ☐**Yes** ☐ **No**

Please list any Foreign Languages Spoken at this location:

Is your practice limited to certain ages? ☐**Yes** ☐ **No**

If Yes, specify age restrictions. Please Check One.

☐ **None**	☐ **0-2 years**	☐ **0-12 years**	☐ **0-17 years**	☐ **0-20 years**	☐ **13+ years**
☐ **13-17 years**	☐ **13-20 years**	☐ **21+ years**	☐ **3+ years**	☐ **17+ years**	

AFFILIATIONS

Is your facility affiliated with any other health care organization(s) through corporate linkage or other formal arrangement? If so, please provide the following information (*List additional affiliations on a separate page.*)	
Facility Name:	TIN:
Address:	
Services Provided (IP/OP):	

DIAGNOSTIC IMAGING

If the answer is NO to any of the following questions, please provide details on separate sheet.	
1. 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 ☐ N/A
2. Diagnostic Imaging machines are registered and inspected according to state law?	☐ Yes ☐ No ☐ N/A
3. Technicians, physicians, and other personnel who work with imaging machines comply with state law regarding monitoring?	☐ Yes ☐ No ☐ N/A
4. Screening and Diagnostic Mammography services are provided?	☐ Yes ☐ No

LABORATORY

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.	
1. Does the laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)?	☐ Yes ☐ No ☐ N/A

PHARMACY

If the answer is YES to the following question, please provide a copy of any DEA Registration Certificates. If the answer is No to the following question, please provide details on separate sheet.	
	☐ Yes ☐ No ☐ N/A

1. Does this Facility dispense medication?	
2. Can a patient fill a prescription at this Facility?	☐ Yes ☐ No ☐ N/A

INSURANCE COVERAGE

Please attach copy of declaration pages			
Current Professional Carrier:			
Amount per Occurrence: $		**Amount per Aggregate: $**	
Dates of Coverage	**From:**	**To:**	
Current Liability Carrier:			
Amount per Occurrence: $		**Amount per Aggregate: $**	
Dates of Coverage	**From:**	**To:**	
Current Worker's Compensation Carrier:			

ACCREDITATION / CERTIFICATION TYPE

Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective date of accreditation or certification, deficiencies and approved plan for corrective action.

Agency Name	Acronym	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	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		
Commission on Accreditation for Rehab Facilities	CARF		
Clinical Laboratory Improvement Act	CLIA		
Community Health Accreditation Program	CHAP		
Agency Name	**Acronym**	**Applied Date**	**Expiration Date**
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
Others (please list)			

SANCTIONS

If yes to any question below, please explain on a separate sheet	
Have there been or are there currently pending any malpractice claims, suits, settlements or proceedings involving your professional practice?	☐ **Yes** ☐ **No**
Have you 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 governmental health care plans or programs?	☐ **Yes** ☐ **No**
Have you 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 professional conduct?	☐ **Yes** ☐ **No**
Have you ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payor, or a Regulatory Agency (CLIA, OSHA, etc.)?	☐ **Yes** ☐ **No**
Has your DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason?	☐ **Yes** ☐ **No**
Has an officer 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 a board member ever been convicted of a felony?	☐ **Yes** ☐ **No**

RELEASE OF INFORMATION

I certify that the information in this document and any attached documents is true, correct, and complete. I understand and agree that any misrepresentation, misstatement, or omission from this application, if discovered after network participation has been awarded to me, may lead to suspension or termination of that participation.

I hereby consent to the inspection by MHS and its representatives of all records, documents or any other institutions that may be material to an evaluation of qualifications and competence, as well as moral and ethical qualifications for membership. I hereby release from liability all representatives of MHS and its agents and employees for their acts or omissions performed in good faith and without malice in connection with the evaluation of my application and my credentials and qualifications. I further authorize any party having information bearing upon my credentials and qualifications for membership in MHS to release such information to MHS and its representatives. I release from any liability all individuals and organizations who provide information to MHS in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for membership, including otherwise privileged or confidential information.

You have the right to correct any erroneous information.

MHS provides equal employment opportunities to, and is open and accessible to all qualified physicians without regard to race, color, national origin, sex or disability, with respect to all of its programs and activities.

Print Name_____ Date_____

Signature_____

(**Stamp signatures are not acceptable)**