Asuris Northwest Health
Fax: 1 (888) 335-3002

Organizational Provider/Facility Credentialing/Recredentialing Application

GENERAL INFORMATION

Corporate Name (as assigned on CP 575 or 147C)

Federal Tax Identification (TIN) Number

NPI Number	Effective Date (mm/dd/yyyy)

Is the facility owned in whole or in part by a hospital system? ☐ Yes ☐ No

Hospital System

ORGANIZATIONAL PROVIDER TYPE

- ☐ Ambulatory Surgery Center
- ☐ Ambulance
- ☐ Residential Treatment Facility
  - ☐ Substance Use Disorder: Indicate levels of care provided _____
  - ☐ Mental Health: Indicate levels of care provided _____
- ☐ Behavioral Health Facility
  - ☐ Mental Health – Intensive Outpatient Program
  - ☐ Mental Health – Partial Hospitalization Program
  - ☐ Substance Use Disorder – Intensive Outpatient Program
  - ☐ Substance Use Disorder - Partial Hospitalization Program
- ☐ Behavioral Health Agency/Facility – Crisis Services
- ☐ Substance Abuse, Alcohol, Drug Treatment Facility
- ☐ Applied Behavioral Analysis (ABA) Agency
- ☐ Birthing Center: ☐ Institution Affiliated ☐ Free Standing ☐ Home Based
- ☐ Durable Medical/Home Medical Equipment
- ☐ Home Health
- ☐ Home Infusion Therapy
- ☐ Hospice
- ☐ Hospital: ☐ Acute Care ☐ Critical Access
- ☐ Independent Diagnostic Testing Facility
- ☐ Kidney Dialysis Center
- ☐ Laboratory
- ☐ Orthotics/Prosthetics
- ☐ Radiology/Medical Imaging Centers (Free Standing or Mobile)
- ☐ Skilled Nursing Facility
- ☐ Sleep Disorder Center
- ☐ Mass Immunization Provider
- ☐ Other _____

Copy this page, prior to completing, for additional offices.

DEMOGRAPHIC/LOCATION INFORMATION

Please indicate the facility's main office, mailing, payment and contact information by completing the appropriate information and checking one or more address type.

ADDRESS #1 (choose both, if applicable): ☐ Primary Office ☐ Mailing

Facility/Organization Name (DBA)		
NPI Number		Effective Date (mm/dd/yyyy)
Street Address		
City	State: State	ZIP Code: xxxxx-xxxx
Phone Number: (xxx) xxx-xxxx	Fax Number: (xxx) xxx-xxxx	
Contact(s) at this address:		
Contact Name	E-mail Address: Email address	
Phone Number: (xxx) xxx-xxxx	Fax Number: (xxx) xxx-xxxx	

ADDRESS #2 (choose both, if applicable): ☐ Primary Office ☐ Mailing

Facility/Organization Name (DBA)		
NPI Number		Effective Date (mm/dd/yyyy)
Street Address		
City	State: State	ZIP Code: xxxxx-xxxx
Phone Number: (xxx) xxx-xxxx	Fax Number: (xxx) xxx-xxxx	
Contact(s) at this address:		
Contact Name	E-mail Address: Email address	
Phone Number: (xxx) xxx-xxxx	Fax Number: (xxx) xxx-xxxx	

ADDRESS #3 (choose both, if applicable): ☐ Primary Office ☐ Mailing

Facility/Organization Name (DBA)		
NPI Number		Effective Date (mm/dd/yyyy)
Street Address		
City	State: State	ZIP Code: xxxxx-xxxx
Phone Number: (xxx) xxx-xxxx	Fax Number: (xxx) xxx-xxxx	
Contact(s) at this address:		
Contact Name	E-mail Address: Email address	
Phone Number: (xxx) xxx-xxxx	Fax Number: (xxx) xxx-xxxx	

PAYMENT/BILLING INFORMATION		
Reporting Name		
Corporate Name		
Tax ID Number		
Street Address		
City	State State	ZIP Code xxxxx-xxxx
Billing Contact Name	Phone Number (xxx) xxx-xxxx	
E-mail Address Email address	Fax Number (xxx) xxx-xxxx	
Please provide a copy of the W-9 IRS form		

LICENSURE/CERTIFICATION/ACCREDITATION:	
State License Number	Expiration Date (mm/dd/yyyy)
Is the facility a participating Medicare provider? ☐ Yes ☐ No	Medicare Number:
Is the facility a participating Medicaid provider? ☐ Yes ☐ No	Medicaid Number:
Accrediting Organization	
Effective Date (mm/dd/yyyy)	Expiration Date (mm/dd/yyyy)
Please provide a copy of all licenses and certificates and your most recent Centers of Medicare and Medicaid (CMS) survey with any site visit corrections showing that your facility is in compliance.	

LIABILITY INSURANCE:	
Insurance Carrier	Phone Number (xxx) xxx-xxxx
Policy Number	Dates of Coverage (mm/dd/yyyy)
Dollar Amount per Occurrence	Dollar Amount Aggregate
Please provide a copy of your current professional and general liability insurance.	

OWNERSHIP/MANAGEMENT INFORMATION:	
President/CEO:	
Name	
Title	Phone Number (xxx) xxx-xxxx
Chief Financial Officer (CFO):	
Name	
Title	Phone Number (xxx) xxx-xxxx
Medical Director:	
Name	
Title	Phone Number (xxx) xxx-xxxx

OWNERSHIP/MANAGEMENT INFORMATION (continued):	
Other Managing Employees[1] or Persons with Ownership or Control Interest[2]:	
Name	
Title	Phone Number (xxx) xxx-xxxx
Name	
Title	Phone Number (xxx) xxx-xxxx
Name	
Title	Phone Number (xxx) xxx-xxxx

ATTESTATION QUESTIONNAIRE:

If any of the following questions are answered "Yes", please provide details on a separate sheet.

1. ☐ Yes ☐ No Has the facility ever had or currently have pending, any legal actions excluding medical malpractice?
2. ☐ Yes ☐ No Has the facility ever been convicted of a crime, excluding misdemeanors?
3. ☐ Yes ☐ No Has any government agency ever investigated, suspended, revoked, or taken other action against your license to conduct business?
4. ☐ 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 under way?
5. ☐ 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?
6. ☐ Yes ☐ No At any time, has any third party payors ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality of care issues?
7. ☐ Yes ☐ No Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?

1. "Managing employee" means "a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization, or agency.

2. "A Person with an ownership or control interest" means "a person or corporation that:

   (a) Has an ownership interest totaling 5 percent or more in a disclosing entity;

   (b) Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

   (c) Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

   (d) Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by a disclosing entity if that interest equals at least 5 percent of the value of the property or assets of a disclosing entity;

   (e) Is an officer or director of a disclosing entity that is organized as a corporation; or

   (f) Is a partner in a disclosing entity that is organized as a partnership."

STAFFING:

Does the facility validate the credentials for licensed practitioner employed or contracted at the facility? ☐ Yes ☐ No

If Yes, indicate how the facility conducts the credentialing process for each practitioner employed or contracted at the facility:

- ☐ Credentialing procedures are performed internally.
- ☐ Credentialing procedures are outsourced to _____
- ☐ Other, specify _____

If No, please explain: _____

_____

EXCLUSION CERTIFICATION:

I hereby certify that the on-line exclusion 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 health care 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 health care program. The OIG exclusion list can be found at **http://exclusions.oig.hhs.gov/**. The GSA exclusion list can be found at **https://www.sam.gov/**.

Authorized Signature for Facility ▸	Date (mm/dd/yyyy)
Print Name	Title

RELEASE OF INFORMATION AND AUTHORIZATION:

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. Further, I give permission to verify the organizational providers credentials and by doing so hereby authorize release of the requested information concerning the organizational providers licensing, certification and accreditation. 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 for Facility ▸	Date (mm/dd/yyyy)
Print Name	Title