Asuris Northwest Health Organizational Provider/Facility Credentialing/Recredentialing Application

Asuris contracts with facilities to form provider networks essential for the delivery of health care services to our members.

Asuris requires all organizational providers to meet criteria prior to contracting, and remain in compliance with criteria at all times. Please refer to the *Organizational Provider Credentialing Criteria for Participation and Termination* for details.

You will receive an email confirmation once you have passed successful credentialing. When your agreement documents are available online for viewing or signature you will receive another email. This email will contain instructions for accessing the online documents securely through the eContracting Center.

To begin the credentialing verification process, please:

1. Complete this application in its entirety using black or blue ink.
2. Provide the email address and name of the individual who is responsible for reviewing and electronically signing your agreement documents:

First Name:	
Last Name:	
Email:	

3. **Return all completed applications**
   Asuris Northwest Health
   Credentialing Department
   P.O. Box 21267
   Mail Stop S555
   Seattle, WA 98111-3267

   Fax: 1 (888) 335-3002

If you believe any information is erroneous, you may request a correction however; we have sole discretion over whether or not to make any changes.

To learn more about the credentialing process and eContracting, visit the Welcome Center at **www.asuris.com/provider/welcome.** If you have questions about the process or the status of your application, please contact our Credentialing Department at 1 (888) 258-3435.

Asuris Northwest Health
Credentialing Department M/S S555
PO Box 21267
Seattle, WA 98111-3267

Fax: 1 (888) 335-3002

Organizational Provider/Facility Credentialing/Recredentialing Application

General Information:

Corporate Name (as assigned on W9): ____________________

Federal Tax Identification (TIN) Number: ____________________

NPI# ____________________ Effective Date: ____________________

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

Hospital System ____________________

Organizational Provider Type:

☐ Ambulatory Surgery Center
☐ Ambulance
☐ Behavioral Health Care ☐ *Intensive Outpatient* ☐ *Partial Hospitalization* ☐ *Residential Treatment* ☐ *Inpatient*
☐ Birthing Center ☐ *Institution Affiliated* ☐ *Free Standing* ☐ *Home Based*
☐ Cardiac Rehabilitation
☐ Durable Medical/Home Medical Equipment
☐ Home Health
☐ Home Infusion Therapy
☐ Hospice
☐ Hospital ☐ *Acute Care* ☐ *Critical Access*
☐ Kidney Dialysis Center
☐ Laboratory
☐ Orthotics/Prosthetics
☐ Radiation Therapy
☐ Radiology/Medical Imaging Centers (Free Standing or Mobile)
☐ Skilled Nursing Facility
☐ Sleep Disorder Center
☐ 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# ______________________ Effective Date: ______________________

Street Address: ______________________

City: ______________________ State: ______ Zip code: ______________

Phone#: ______________________ Fax#: ______________________

Contact(s) at this address:

Contact Name: ______________________ Email Address: ______________________

Phone#: ______________________ Fax#: ______________________

Address #2 *(choose both, if applicable)* ☐ *Primary Office* ☐ *Mailing*

Facility/Organization Name (DBA): ______________________

NPI# ______________________ Effective Date: ______________________

Street Address: ______________________

City: ______________________ State: ______ Zip code: ______________

Phone#: ______________________ Fax#: ______________________

Contact(s) at this address:

Contact Name: ______________________ Email Address: ______________________

Phone#: ______________________ Fax#: ______________________

Address #3 *(choose both, if applicable)* ☐ *Primary Office* ☐ *Mailing*

Facility/Organization Name (DBA): ______________________

NPI# ______________________ Effective Date: ______________________

Street Address: ______________________

City: ______________________ State: ______ Zip code: ______________

Phone#: ______________________ Fax#: ______________________

Contact(s) at this address:

Contact Name: ______________________ Email Address: ______________________

Phone#: ______________________ Fax#: ______________________

Payment/Billing Information:

Reporting Name: ______________________________

Corporate Name: ______________________________

Tax ID Number: ______________________________

Street Address: ______________________________

City: ____________________ State: ______ Zip code: ____________

Billing Contact Name: ____________________ Phone#: ____________

Email Address: ____________________ Fax#: ____________

Please provide a copy of the W-9 IRS form

Licensure/Certification/Accreditation:

State License Number: ____________________ Expiration Date: ____________

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: ____________________ Expiration Date: ____________

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#: ____________

Policy#: ____________________ Dates of Coverage: ____________

$ Amount per Occurrence: ____________ $ Amount Aggregate: ____________

Please provide a copy of your current professional and general liability insurance.

Ownership/Management Information:

President/CEO:

Name: ______________________________

Title: ____________________ Phone#: ____________

Chief Financial Officer (CFO):

Name: ______________________________

Title: ____________________ Phone#: ____________

Medical Director:

Name: ______________________________

Title: ____________________ Phone#: ____________

Ownership/Management Information (continued):

Other Managing Employees[1] or Persons with Ownership or Control Interest[2]:

Name:____

Title: ______________________________ Phone: ______________________

Name:____

Title: ______________________________ Phone: ______________________

Name:____

Title: ______________________________ Phone: ______________________

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)?

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[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: ____________________

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____

Exclusion Certification:

I hereby certify that the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and Excluded Parties List System (EPLS) are checked for all new hires and annually 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.

____________________ ____________________

Authorized Signature for Facility Date

____________________ ____________________

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
Print Name	Title

TRICARE Conflict of Interest:

Federal law (5 U.S.C. 5536) prohibits medical personnel, who are active duty members or civilian employees of the government, compensation above their normal pay and allowances for medical care rendered. This prohibition applies to TRICARE benefits whether the claim for reimbursement is filed by the individual who provided the care, the facility in which the care was rendered, or by the sponsor/beneficiary. Claims for TRICARE benefits will be denied in any situation where either a uniform member or civilian employee of the uniform services has the opportunity to exert, directly or indirectly, any influence on the referral of TRICARE beneficiaries to one or more providers on a selective basis.

As part of the credentialing and contracting process, if the provider has included any information that they are an Active Duty Service Member (ADSM), they are not eligible to bill TRICARE for any services provided inside or outside of the Military Treatment Facility. These providers should not be contracted as a network provider. Provider agreements for ADSMs that are currently contracted as a network provider should be terminated.

Authorized Signature for Facility	Date
Print Name	Title

Hospital/Facility Services/Capability

Date:__________________________ Provider Name:________________________________

Physical Address:____

City, State, Zip code:____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

☐ Acute Care
☐ Air Ambulance
☐ Alcohol/Chem Dep Adol. Detox
☐ Alcohol/Chem Dep Adol Outpatient
☐ Alcohol/Chem Dep Adol PHP
☐ Alcohol/Chem Dep Adol Rehab
☐ Alcohol/Chem Dep Adult Detox
☐ Alcohol/Chem Dep Adult Outpatient
☐ Achohol/Chem Dep Adult PHP
☐ Alcohol/Chem Dep Adult Rehab
☐ Ambulance Services
☐ Audiology
☐ Behavioral Health
☐ Birthing Rooms
☐ Blood Bank
☐ Burn Unit
☐ Cancer
☐ Cardiac
☐ Cochlear Implant Surgery
☐ CT Scanner
☐ Diabetes Education
☐ Dialysis - Outpatient
☐ EEG Monitoring
☐ Emergency Room
☐ Gamma Knife
☐ Geriatric Services
☐ Home Health *
☐ Home Infusion *
☐ Hospice Care
☐ Hyperbaric Treatment
☐ ICU
☐ IOP
☐ Lab-Outpatient
☐ Lithotripsy
☐ Mammography
☐ Maternity
☐ MRA
☐ MRI
☐ Neonatal ICU Level 1
☐ Neonatal ICU Level 2
☐ Neonatal ICU Level 3
☐ Neurology
☐ Nuclear Medicine
☐ Nursery
☐ Obstetrics
☐ Occupational Therapy Inpatient
☐ Occupational Therapy IP/OP
☐ Occupational Therapy Outpatient
☐ Oncology
☐ Open Heart Surgery
☐ Orthopedics
☐ Outpatient Surgery
☐ Pain Management
☐ Partial Hospitalization
☐ Pediatric Emergency Care
☐ Pediatric Hematology Oncology
☐ Pediatric ICU
☐ Pediatric Physical Therapy
☐ Pediatric Rehabilitation
☐ Pediatrics
☐ PET Scan
☐ Physical Therapy Inpatient
☐ Physical Therapy IP/OP
☐ Physical Therapy Outpatient
☐ Psych Unit *
☐ Psych Svcs – Adol Eating Disorder
☐ Psych Svcs – Adol Inpatient
☐ Psych Svcs – Adol Outpatient
☐ Psych Svcs – Adol PHP
☐ Psych Svcs – Adult Inpatient
☐ Psych Svcs – Adult Outpatient
☐ Psych Svcs – Adult PHP
☐ Psych Svcs – Child Inpatient
☐ Radiation Center
☐ Radiation Oncology
☐ Rehab Unit *
☐ Skilled Nursing Unit *
☐ Sleep Studies
☐ Speech Therapy Inpatient
☐ Speech Therapy IP/OP
☐ Speech Therapy Outpatient
☐ Sports Medicine
☐ Swing Bed *
☐ Transplant-Bone Marrow
☐ Transplant-Cornea
☐ Transplant-Heart
☐ Transplant-Heart/Lung
☐ Transplant-Kidney
☐ Transplant-Liver
☐ Transplant-Liver-Kidney
☐ Transplant-Pancreas/Kidney
☐ Transplant-Small Intestine
☐ Transplant-Small Intestine/Liver
☐ Transplant-Tissue
☐ Trauma Level 1
☐ Trauma Level 2
☐ Trauma Level 3
☐ Trauma Level 4
☐ Trauma Level 5
☐ Traumatic Brain Injury
☐ Ultra Sound
☐ Urgent Care
☐ Ventilator Care

* If these services are separately Medicare Certified please identify.

Durable Medical Equipment Services/Capability

Date:_________________________ Provider Name:______________________________

Physical Address:____

City, State, Zip code:____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

- ☐ Air Mattress
- ☐ Augmentative Device
- ☐ Bath Chair
- ☐ Breast Pumps
- ☐ Chest Compression Apparatus/Cystic Fibrosis
- ☐ Commodes
- ☐ Computer Software
- ☐ CPM Machine
- ☐ Easy Stander
- ☐ Enteral
- ☐ EZ Lock Wheelchair
- ☐ Feeding Pumps
- ☐ Grab Bars
- ☐ Hand Control for Vehicle
- ☐ Hearing Aids
- ☐ Home Care
- ☐ Infusion Pumps
- ☐ Infusion Therapy – Adult
- ☐ Infusion Therapy – Pediatric
- ☐ Insulin Pump
- ☐ Jazzy Wheelchair
- ☐ Medical Equipment and Repairs
- ☐ Medical Supplies
- ☐ Orbital Prosthesis
- ☐ Orthotics
- ☐ Parenteral
- ☐ Prosthetics
- ☐ Pulse Oximeter
- ☐ Respiratory
- ☐ Respite Care
- ☐ Restrain System
- ☐ RT-300 Ergometer Cycle
- ☐ Specialized Beds
- ☐ Specialized Wheelchair Custom
- ☐ Specialized Wheelchair Manual
- ☐ TPN
- ☐ Van Lift
- ☐ Walker
- ☐ Wheelchair Lift Car

Skilled Nursing Facility Services/Capability

Date:___________________________ Provider Name:________________________________

Physical Address:____

City, State, Zip code:____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

- ☐ Behavioral Health Dual Diagnosis
- ☐ Cardiac Rehab
- ☐ Cardio Drips
- ☐ Hemo Dialysis
- ☐ Hyperbaric Treatment
- ☐ IV Administration
- ☐ Levels of Care
- ☐ Neurology Services
- ☐ Occupational Therapy Inpatient
- ☐ Occupational Therapy IP/OP
- ☐ Occupational Therapy Outpatient
- ☐ Orthopedic Services
- ☐ Ostomy Care
- ☐ Oxygen Therapy
- ☐ Pediatric Vents
- ☐ Pediatrics
- ☐ Physical Therapy Inpatient
- ☐ Physical Therapy IP/OP
- ☐ Physical Therapy Outpatient
- ☐ Post Hospitalization
- ☐ Post Transplant
- ☐ Residential Care
- ☐ Specialized/Complex Wound Care
- ☐ Specialty Beds (Types)
- ☐ Speech Therapy Inpatient
- ☐ Speech Therapy IP/OP
- ☐ Speech Therapy Outpatient
- ☐ Suction Therapy
- ☐ Trachs
- ☐ Transportation
- ☐ Traumatic Brain Injury
- ☐ Vents
- ☐ Wound Care
- ☐ Wound Vac

Radiology Center Services/Capability

Date:___________________________ Provider Name:_________________________________

Physical Address:____

City, State, Zip code:____

Please check the services that are available at your hospital/facility. These may or may not be a covered benefit.

☐ Bone Scan	☐ MRI
☐ CT Scan	☐ Nuclear Medicine
☐ DEXA Scan	☐ PET Scan
☐ Mammography	☐ Radiation Therapy
☐ MRA	☐ Ultrasound