# FACILITY CREDENTIALING APPLICATION

NORTHEAST LOUISIANA PHYSICIAN HOSPITAL ORGANIZATION

PRIMARY PRACTICE LOCATION - please choose facility type (*check all that apply*):

- ☐ Hospital
- ☐ Home Health Agency
- ☐ Laboratory
- ☐ Rehabilitation Center
- ☐ Behavioral Healthcare Facility
- ☐ Durable Medical Equipment
- ☐ Surgical Center
- ☐ Long Term Acute Care
- ☐ Other: _____

Legal Business Name (*as reported to IRS*): _____

Doing Business As (dba): _____

Tax Identification # (TIN): _____ National Provider Identifier (NPI): _____

CMS Certification # (Medicare #): _____ Does facility accept new patients? ☐ Yes ☐ No

Days of Operation / Business Hours: _____

Contact Name: _____ Title: _____ Email: _____

Facility Administrator: _____ Title: _____

Physical Address: _____

City: _____ State: _____ Zip: _____ Parish: _____

Phone: _____ Fax: _____ Email: _____

Payment Address: _____

City: _____ State: _____ Zip: _____ Parish: _____

Phone: _____ Fax: _____ Email: _____

SECONDARY PRACTICE LOCATION - please choose facility type (*check all that apply*):

- ☐ Hospital
- ☐ Home Health Agency
- ☐ Laboratory
- ☐ Rehabilitation Center
- ☐ Behavioral Healthcare Facility
- ☐ Durable Medical Equipment
- ☐ Surgical Center
- ☐ Long Term Acute Care
- ☐ Other: _____

Legal Business Name (*as reported to IRS*): _____

Doing Business As (dba): _____

Tax Identification # (TIN): _____ National Provider Identifier (NPI): _____

CMS Certification # (Medicare #): _____ Does facility accept new patients? ☐ Yes ☐ No

Physical Address: _____

City: _____ State: _____ Zip: _____ Parish: _____

Phone: _____ Fax: _____ Email: _____

Payment Address: _____

City: _____ State: _____ Zip: _____ Parish: _____

Phone: _____ Fax: _____ Email: _____

## MEDICARE STATUS

Is the facility participating in the Medicare program? ☐ Yes ☐ No Certification Date: _____

Has the facility's Medicare # ever been revoked, suspended, or terminated? ☐ Yes ☐ No

If yes, please explain: _____

## ACCREDITATION

Are you accredited? (*If yes, please attach a copy of current certificate or letter*)

Accredited by: _____ Effective Dates: ____ / ____ / ____ through ____ / ____ / ____

## NON-ACCREDITED FACILITIES

Has the facility had an onsite survey by a government agency such as the Department of Health & Hospitals or Medicare within the past 36 months?

☐ Yes Date of most recent onsite survey: ____ / ____ / ____ (*please attach copy of survey results or letter from agency*)

☐ No You will be contacted by NLPHO representative(s) to schedule an onsite review.

Has the facility or any of its owners ever been excluded from state or federal programs? ☐ Yes ☐ No

If yes, please explain: _____

## BILLING INFORMATION

Does the facility use a third party billing department or agency? ☐ Yes ☐ No

If yes, please provide information below for the company responsible for submitting claims for services provided at the facility.

Contact Name: _____ Company: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

## PROFESSIONAL LIABILITY INSURANCE COVERAGE

Carrier: _____ Policy #: _____

Amounts per occurrence / aggregate: _____ Coverage Dates: _____

# of settlements in past ten (10) years: _____ # of claims pending: _____

Is the facility self-insured? ☐ Yes ☐ No

Has current liability insurance carrier excluded any procedures from coverage? ☐ Yes ☐ No

If yes, please explain: _____

## ATTESTATION: *Please provide a detailed explanation to all "yes" answers on a separate sheet.*

1. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? ☐ Yes ☐ No

2. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor conviction under Federal or State law related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? ☐ Yes ☐ No

3. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor conviction under Federal or State law related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 – Code of Federal Regulations Section 1001.1001 or 1001.201? ☐ Yes ☐ No

4. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor conviction under Federal or State law relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? ☐ Yes ☐ No

5. Has this facility, under any current or former name or business identity, ever had its licensure by any state licensing authority revoked or suspended, or ever been issued a conditional or restricted license? This includes revocation of such a license while under appeal or while a formal disciplinary proceeding was pending before a State licensing authority? ☐ Yes ☐ No

6. Has this facility, under any current or former name or business identity, ever had its accreditation revoked or suspended? ☐ Yes ☐ No

7. Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in or had any sanction imposed by a Federal or State health care program or had any disbarment from participation in any Federal Executive Branch procurement or non-procurement program? ☐ Yes ☐ No

I, the undersigned authorized agent, hereby attest and certify that all information and documentation submitted by me in this credentialing application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for continued network participation.

I consent to the release of all information that may be relevant to an evaluation of any credentials, including information about disciplinary actions or other confidential or privileged information, to the Northeast Louisiana Physician Hospital Organization or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which the facility is a NLPHO provider. The facility and its affiliates and successors release NLPHO, its affiliates, successors, and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating the facility's credentials.

Print Name _____ Signature _____

Title _____ Date _____

REQUIRED ATTACHMENTS

- ☐ Copy of all Federal, State, and/or local licenses required to operate the facility.
- ☐ Current copy of facility's medical malpractice liability declaration page showing coverage limits.
- ☐ Copy of most recent accreditation certificate. *If not accredited*, a copy of the most recent DHH certificate or Medicare site survey results.
- ☐ Documentation of Medicare certification.
- ☐ Copy of W-9 form.
- ☐ Copy of CLIA certificate.
- ☐ Surety Bond (for DMEs only).
- ☐ Copy of LA Mental Health & Mental Retardation Certificate (*for community mental health centers*).