Organizational Provider Credentialing Application

PacificSource HEALTH PLANS

Before completing this application, please read and observe the following:

This form should be **typed or legibly printed in black or blue ink**. If more space is needed, attach additional sheets and reference the question being answered. If applicable, please use a separate application for each location.

- Modification to the wording or format of the Organizational Provider Credentialing Application will invalidate the application.
- Complete the application in its entirety. Please sign and date pages 6, 7, and 9. Submit this application via email attachment, USPS (mail), or fax:

Email
Credentialing@PacificSource.com

Fax
541-225-3644

Mail
PacificSource Health Plans
Credentialing Dept.
PO Box 7068
Springfield, OR 97475-0068

Important: Current copies of all applicable documentation requested in Section IX (Attachments) must accompany this application. Applications that are incomplete or fail to include the required documentation will be deemed incomplete and will not be processed.

I am applying to PacificSource for (please list credentialing, recredentialing, etc.):

_____

_____

_____

_____

PLEASE USE A SEPARATE APPLICATION FOR EACH LOCATION

I. Provider identification

A. Corporate identification information

All payments will be issued in the provider's legal business name in compliance with IRS regulations.

Legal business name as reported to the IRS (claims will be paid to this name):

_____

Doing business as (DBA) name (if applicable) _____

County where DBA name registered (if applicable) _____

Billing address _____

Tax identification number _____

B. Current practice location

Practice location name _____

Practice location address line 1 _____

Practice location address line 2 _____

City _____ State _____ Zip code _____ County _____

Phone _____ Fax _____ Email _____

Administrator (full name) _____

Medicare no. _____ Medicaid no. _____ NPI _____

C. Mailing and credentialing correspondence address

This must be an address where provider can be contacted directly.

☐ Check here if all correspondence can be directed to the practice location in Section B.

Practice location address line 1 _____

Practice location address line 2 _____

City _____ State _____ Zip code _____ County _____

D. Type of provider (check all that apply)

- ☐ Ambulatory/Freestanding Surgery Center
- ☐ Behavioral Health (see below)
- ☐ Birthing Center
- ☐ Clinical Laboratories
- ☐ Comprehensive Outpatient Rehab Facility
- ☐ Diabetes Prevention Program
- ☐ Durable Medical Equipment
- ☐ Eating Disorder Treatment Facility
- ☐ End-Stage Renal Disease Services
- ☐ Free Standing Laboratory
- ☐ Federally Qualified Health Center
- ☐ Home Infusion
- ☐ Hospice Agency
- ☐ Hospital
- ☐ Home Health Agency
- ☐ Independent Diagnostic Testing Facility
- ☐ Outpatient Diabetes Self-Management Training
- ☐ Outpatient Physical Therapy
- ☐ Portable X-Ray Suppliers
- ☐ Public Health Center
- ☐ Rural Health Clinics
- ☐ Skilled Nursing Facility
- ☐ Sleep Study Lab
- ☐ Speech Pathology
- ☐ Other (explain) _____

Behavioral Health Facility

Mental health:

- ☐ Inpatient
- ☐ Residential
- ☐ Ambulatory Setting

Substance use:

- ☐ Inpatient
- ☐ Residential
- ☐ Ambulatory Setting

E. Scope of services

List all services provided at this facility:

- ☐ Acute Care
- ☐ Emergency Department (Level I, II, III, IV, V)
- ☐ PT, OT, Speech Therapy
- ☐ Imaging Department
- ☐ Laboratory/Pathology Department
- ☐ Skilled Nursing
- ☐ Outpatient Surgery
- ☐ Hospice
- ☐ Infusion Therapy
- ☐ Home Health
- ☐ Other (explain) _____

II. Certification and accreditation

A. Certification

Is this provider participating in the Medicare program? ☐ Yes ☐ No ☐ Pending

If Yes, please provide the following:

Date of initial Medicare certification (MM/DD/YYYY) _____

Date of last full CMS survey* (MM/DD/YYYY) _____

If the provider is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accredited organization meets this requirement.

Were any deficiencies identified during the last full CMS/accreditation survey? ☐ Yes ☐ No

If Yes, have all deficiencies been corrected?

- ☐ Yes (please provide evidence, i.e., approval letter from the surveying body)
- ☐ No (please provide a complete copy of the most recent survey and any or all corrective action plans)

B. Accreditation

Is this provider accredited by a national accreditation organization? ☐ Yes ☐ No ☐ Pending

If Yes, please select one of the boxes below:

☐ AAAASF
☐ AAAHC
☐ AASM
☐ ABC
☐ ACHC
☐ ACR
☐ AOA
☐ BCAI
☐ CABC
☐ CAMTS
☐ CAP
☐ CARF
☐ CHAP
☐ CLIA
☐ COA
☐ COLA
☐ DNV/NIAHO
☐ EURAMI
☐ HFAP
☐ HQAA
☐ NABP
☐ NBAOS
☐ TCC
☐ TJC
☐ URAC
☐ Other (explain) _____

Date of initial accreditation (MM/DD/YYYY) _____

Has the accreditation organization been granted deeming authority by CMS for this provider type? ☐ Yes ☐ No

III. Healthcare licensure, registration, certificates, and ID numbers

	License No.	Issue Date	Expiration Date	Licensing Agency
State of Oregon				
State of Washington				
Other				

Medicare no. _____ Medicaid no. _____ NPI _____

DEA no. (if applicable) _____ Expiration date _____

CLIA no. (if applicable) _____ Expiration date _____

If the organizational provider does not have a Medicare number, please submit an explanation.

_____

IV. Liability insurance

This section is to be completed with information about the provider's professional liability and/or medical malpractice insurance including, but not limited to, General Liability, Excess Liability, Umbrella and/or Reinsurance policies. If there is more than one carrier, copy and complete this section for each.

A copy of all fact sheets showing current coverage amounts and expiration dates must be attached.

A. Current coverage

Current carrier name _____ Policy no. _____

Carrier address _____

Practice location address line _____

City _____ State _____ Zip code _____

Coverage type ☐ Occurrence based ☐ Claims based

Effective date _____ Expiration date _____

Aggregate amount _____ Per incident amount _____

V. Credentialing program

Contact name _____ Contact tiltle _____

Phone _____ Fax _____ Email _____

Is there a formal credentialing program in place for healthcare professionals employed or contracted at the facility?

☐ Yes ☐ No

☐ Credentialing procedures are performed internally

☐ Credentialing procedures are outsourced to _____

Include a description of how the facility conducts the credentialing process and clinical staff privileging program for each practitioner employed or contracted at your facility.

VI. Restraint and Seclusion

Attach a copy of your policy and procedure related to the use of seclusion and restraint as required under the Code of Federal Regulations (CFR), **438.100.**

Policy must include:

- Measures to ensure patients are free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. See addendum to application if no policy exists.

VII. Patient visitation – hospitals only

Attach a copy of your policy and procedure regarding the visitation rights of patients as required under the Code of Federal Regulations (CFR), **482.013.**

- The policy must include identifying all clinically necessary or reasonable restriction or limitation the hospital may need to place on such rights.

VIII. Exclusion Certification

I hereby certify the online exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and Systems for Awards Management (SAM) 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 healthcare 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 healthcare program.

Authorized signature for facility _____ Date _____

Print name _____ Title _____

IX. Attachments

These documents should, if applicable, be submitted with this completed enrollment application. Please indicate which documents are being included with this application.

- ☐ Copy(s) of all federal, state, and/or local professional licenses, certifications and/or registrations specifically required to operate as a healthcare facility.
- ☐ Copy(s) of all accreditation certificates and a copy of most recent survey results.
- ☐ Copy(s) of most recent CMS survey, including corrective action plan if deficiencies were cited, and evidence from CMS that all deficiencies are remedied, if no CMS exemption provision applies.
- ☐ IRS documents confirming the tax identification number and legal business name (e.g., CP 575).
- ☐ Description of credentialing and clinical staff privileging program for healthcare professionals (required, see addendum).
- ☐ Copy of your policy and procedure for Restraint and Seclusion (required, see addendum).
- ☐ Copy of your policy and procedure for Patient Visitation Rights at hospitals (applicable to hospitals).
- ☐ Copy of your Patient Safety/Evacuation Policy (required for hospitals with 50 or more beds).

X. Attestation questions

Please answer the following questions "**YES**" or "**NO.**" All "yes" responses require an explanation provided on a separate sheet (as appended information). Please sign and date each additional sheet. **Modification to the wording or format will invalidate the application.**

Has this provider, 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 a state healthcare program, or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions, 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 healthcare item or service?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, ever had any felony or misdemeanor convictions under federal or state law, relating to the interference with or obstruction of any investigation into any criminal offense described in 42 CFR Section 1001.101 or 1001.201?	☐ Yes ☐ No

X. Attestation questions *continued*

Please answer the following questions "**YES**" or "**NO.**" All "yes" responses require an explanation provided on a separate sheet (as appended information). Please sign and date each additional sheet. **Modification to the wording or format will invalidate the application.**

Has this provider, 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 a state healthcare program, or (b) the abuse or neglect of a patient in connection with the delivery of a healthcare item or service?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, ever had licensure to provide healthcare by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a state licensing authority.	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, ever had accreditation denied, revoked, or suspended?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, ever been suspended or excluded from participation in, or any sanction imposed by, a federal or state healthcare program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program?	☐ Yes ☐ No
Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	☐ Yes ☐ No

Printed name of authorized representative _____

Signature of authorized representative _____

Authorized representative's title _____ Date _____

Authorization and Release of Information Form

PacificSource HEALTH PLANS

By submitting this application, it is agreed and understood that:

1. As a representative of the healthcare provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history, and sanctions indicated in this application is upon the contracted provider or its representative.

2. I further understand and acknowledge that The Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the NPDB reporting and information as required by law as a part of the verification and credentialing process.

3. I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated, and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with The Healthcare Organization(s) or designated agent.

4. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of The Healthcare Organization(s) or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

5. I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to The Healthcare Organization(s) cycle of recredentialing, provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with The Healthcare Organization(s).

6. The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of The Healthcare Organization(s) or its respective agent(s) before initiating judicial action.

7. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

8. I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with The Healthcare Organization.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as The Healthcare Organization(s) Participating Provider or cause for summary dismissal from The Healthcare Organization(s), or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with The Healthcare Organization(s) and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by The Healthcare Organization(s).

I acknowledge that action on this application will be delayed until all required information is received and/or verified.

This provider complies with all federal, state, and local handicapped access requirements as well as the standards required by the Federal Americans with Disabilities Act (ADA).

Signature _____ Date _____

Title _____

Printed name _____

As the authorized representative for the following provider(s)/supplier(s), I grant permission for the release of information related to licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions for the following provider(s)/supplier(s):

Facility name _____ City _____ State _____

Facility name _____ City _____ State _____

Addendum to application

For facilities that have have not supplied a copy of a Restraint and Seclusion policy or a copy/description of a credentialing and clinical staff privileging program for healthcare professionals as attachments to this application, please supply descriptions of each on this addendum. If copies or descriptions of each of these policies are attached to this application, this page can be left blank.

Description of Restraint and Seclusion Action

If restraint/seclusion of any person(s) visiting our location were to become necessary, the healthcare professionals working for our organization would:

☐ Check here if plan is to contact local law enforcement authorities for intervention/assistance.

☐ Check here and provide description below if there is another plan of action for restraint/seclusion and no policy copy has been attached to this application:

Your facility's onboarding or hiring practices

Please use the space below to summarize how the facility conducts staff onboarding, or how the hiring program for each employee is conducted at your facility. Examples: Criminal background checks, Office of Inspector General (OIG) search, verification of licenses, certifications, and education.