US FAMILY HEALTH PLAN

ANCILLARY PROVIDER APPLICATION

GENERAL INFORMATION

Ancillary Name:_____ **Network/Health System:**_____
Service Type:_____
NPI:_____ **CCN:**_____

Service Locations:
Address: _____
City: _____ **State:**_____ **Zip:** _____ **County:**_____
Phone: _____ **Fax:** _____ **Email:** _____

Please attach additional service locations separately

BILLING INFORMATION – W9

Corporate Name: _____ **Doing Business As:**_____
Phone:_____ **TIN:**_____
Billing Address: _____
City: _____ **State:**_____ **Zip:** _____ **County:**_____
Contact Name:_____
Phone: _____ **Fax:** _____ **Email:** _____

Must include official W9

SERVICE AREA/SPECIAL CAPACITY

Please indicate the county (counties) your organization services:

_____

Special Capacity, Bed Types, etc.:

_____

BUSINESS STAFF

Contact Name:_____
Phone:_____ **Email:**_____

ACCREDITATION (required for Hospitals, LTCH, IRF, ASC)

Accrediting Organization: _____
Status:_____ **Effective Date:** _____ **Expiration Date:** _____
Medicare Certified: Yes _____ **No** _____ **TRICARE Authorized Provider: Yes** _____ **No** _____

LICENSURE/OPERATING CERTIFICATE

Attach copy of each license/operating certificate:
Licensure Type: _____ **Licensing State:** _____
License Number: _____ **Expiration Date:** _____

PROFESSIONAL LIABILITY INFORMATION

Attach copy of current liability face sheet:
Carrier:_____
Policy Number:_____ **Effective/Expiration Dates:** _____
Include list of claims history: _____

PROFESSIONAL INFORMATION

If any of the following questions are answered yes, attach a detailed explanation.	YES	NO
1. Has your facility/program had any professional liability actions? (pending, settled, arbitrated, mediated or litigated) *If yes, provide information separately.*	____	____
2. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your liability history?	____	____
3. Has any government agency ever investigated, suspended, revoked or taken any other action against the facility/program's license to practice?	____	____
4. At any time, has any license or certification ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted; or are there any actions which could possibly lead to such conclusions now underway?	____	____
5. Has there been any challenge to the facility/ program licensure, registration or certification?	____	____
6. At any time, have any memberships in a professional organization ever been revoked, reduced, denied or suspended by others or voluntarily given up by the facility or are any actions that may lead to such conclusions now under way?	____	____
7. Has the facility/program ever been suspended, excluded from, disciplined, excluded from receiving payment under Medicare, Medicaid or TRICARE programs?	____	____
8. Has the facility/program ever been removed, sanctioned or suspended from membership in professional association for violation(s) of ethical code of practice?	____	____
9. Have deficiencies been cited on Standard and/or Complaint Inspections, during the last 3 years?	____	____
10. Have Federal fines/Federal payment denials incurred during the last 3 years?	____	____

CONSENT TO RELEASE INFORMATION/ATTESTATION

I hereby understand and agree that, as part of the credentialing application process for participation with US Family Health Plan (hereinafter, referred to as "USFHP") at Saint Vincent Catholic Medical Centers (hereinafter, referred to as "SVCMC"), this organization is required to provide sufficient and accurate information for a proper evaluation of its current licensure, clinical competence, character, ethics, and any other criteria used by USFHP for determining initial and ongoing eligibility for Participation. USFHP and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that USFHP has its own criteria for acceptance, and this organization may be accepted or rejected. I further acknowledge and understand that this organization's cooperation in obtaining information and this organization's consent to the release of information do not guarantee that USFHP participation.

I hereby authorize USFHP at SVCMC including, without limitation, their representatives and/or designated agents to investigate information, which includes both oral and written statements, records, and documents, concerning this organizations application for Participation. This organization agrees to allow USFHP to inspect and copy all records and documents relating to such an investigation.

I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, past or present malpractice insurance carriers and other verification and review sources with which this organization has been associated with, to release to USFHP information, including otherwise privileged or confidential information, concerning this organization's professional qualifications, credentials, clinical competence, quality assurance and utilization data, ethical character, or any other matter reasonably having a bearing on this organization's qualifications for Participation in, or with, USFHP. This organization authorizes its current and past professional liability carrier(s) to release its history of claims that have been made and/or are currently pending against it. This organization specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

I release from all liability and hold harmless all individuals, hospitals and other organizations which provides information to USFHP for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of USFHP in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. This organization further agrees not to sue USFHP for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such USFHP in connection with the credentialing process. In this Authorization, Attestation and Release USFHP retains the right to allow access to the application information for purposes of a credentialing audit their auditors to the extent required in connection with an audit of the credentialing processes and provided that their auditor executes an appropriate confidentiality agreement. This organization understands and agrees that this Authorization, Attestation and Release is irrevocable for any period during which this organization is an applicant for Participation at USFHP. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I hereby attest that information provided by this organization in its application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. This organization will notify USFHP within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, etc.) this organization has provided in its application or authorized to be released pursuant to the credentialing process. This organization understands that corrections to the application are permitted at any time prior to a determination of Participation by USFHP, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that USFHP will not process an application until they deem it to be a complete application and that this organization is responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to USFHP. This organization further acknowledges that it has read and understands the foregoing Authorization, Attestation and Release. This organization understands and agrees that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

I hereby attest that the information documented on this application is accurate and true to the best of my knowledge.

Signature: _____

Print Name: _____ **Date:** _____

2023