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# Health One Alliance

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## **Facility/Ancillary/Durable Medical Equipment Application**

Please provide completed typed or printed information for all sections of this application  
(Include month, day and year for all dates.)

Facility/Ancillary/DME Corporate Name: \_\_\_\_\_

d/b/a (if applicable): \_\_\_\_\_

Type of Facility: (circle one)	Hospital	Home Health Agency
	Free-standing Surgical Center	Intensive Outpatient Facility
	Skilled Nursing Facility	Nursing Home
	PT/OT/SP Office	Specialty DME
	Laboratory	Behavioral Health Facility

Other (please specify): \_\_\_\_\_

Date opened for operation: \_\_\_\_\_ State of incorporation: \_\_\_\_\_

- Tax Id number: \_\_\_\_\_
- Name tied to Tax ID: \_\_\_\_\_
- Office Telephone: \_\_\_\_\_ Office Fax: \_\_\_\_\_
- Contact Person (Name/Title/Phone): \_\_\_\_\_
- Chief Administrator (Name/Title/Phone): \_\_\_\_\_
- Medical Director (Name/Specialty/Phone): \_\_\_\_\_
- Primary Service Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate Service Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Alternate Service Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- Billing Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

- Email address of main contact: \_\_\_\_\_

- Medicare Number \_\_\_\_\_
- Medicaid Number \_\_\_\_\_

- Number of beds for which your facility is currently licensed? \_\_\_\_\_
- Do you file claims electronically? \_\_\_ If yes, clearinghouse name? \_\_\_\_\_

**Professional Liability Insurance**

Please attach a copy of current Certificate of Insurance and return with completed application. (Include month, day and year of all dates.)

- Current Insurance Carrier: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Policy effective date: \_\_\_\_\_

Policy renewal date: \_\_\_\_\_

Policy retro Date: \_\_\_\_\_

Limits of Professional Liability:

Aggregate: \_\_\_\_\_ Occurrence: \_\_\_\_\_

Please provide a copy of the Certificate of Insurance for the past five years if there have been any changes in coverage.

**General Information**

1. Is the facility in good standing with the State Board of Health and State Licensing Bureau? \_\_\_ If no, please explain in an attachment.
2. Is facility in good standing with federal regulatory bodies (if applicable)? \_\_\_ If no, please explain in an attachment.
3. Is facility currently accredited? \_\_\_ If yes, what type? \_\_\_\_\_

**Confidential Information**

1. Is this facility now or has it ever been involved in any malpractice suit, including arbitration? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Has any malpractice claim settlement, not involving litigation or arbitration, ever been paid by the facility or on behalf of the facility? Yes \_\_\_\_\_ No \_\_\_\_\_

Note: If the answer to either of the above questions is “yes”, please attach the following information for each suit or settlement whether open or closed, and regardless of whether or not payment was made:

- Date and details of the incident(s) leading to the suit and/or settlement;
- Date of filing and settlement award;
- Professional liability insurer involved;
- Applying facility’s role in the incident(s);
- Applying facility’s status in any suit or other legal action (primary, co-defendant, other);
- Subsequent events, including outcome;
- Current status of suit or other legal action;
- Amount paid as an out-of court settlement or amount of jury award or court award.

**Has this facility had any of the following?**

(Please attach explanations if any of the following questions are answered “Yes”)

1. Revocations or suspensions as a Medicare or Medicaid provider? \_\_\_\_\_
2. Malpractice liability insurance cancellation in the past 5 years? \_\_\_\_\_
3. General liability insurance cancellation in the past 5 years? \_\_\_\_\_
4. State licensing investigations or actions? \_\_\_\_\_

**Quality/Utilization Review**

1. Are the credentials and/or certifications of professional staff members and admitting physicians verified? \_\_\_\_\_
2. Is continuing education and/or recertification required of your staff? \_\_\_\_\_
3. Is there a formal patient grievance/resolution procedure? \_\_\_\_\_
4. Is there a formal patient satisfaction or advocacy program? \_\_\_\_\_
5. Does this facility have written policies and procedures? \_\_\_\_\_

**Please submit with application copies of the following documents:**

1. Current license(s)-business (city and county), professional, DHR, permits, etc.;
2. letter or certificate from any/all accrediting organizations (explanation if not accredited)
3. copy current of Certificate(s) of Insurance- commercial and professional liability;
4. copy of W9 form;
5. list of all service locations with specific billing address for each;
6. list of all clinical staff and location(s) of practice for each (if applicable);
7. detailed list of services provided at facility and indicate whether performed in house or by contract;
8. any/all information applicable to Confidential Information section of this application.

All information that is provided in the application is correct and complete to the best of my knowledge. I understand that I have the burden of providing adequate information to Health One Alliance or the appropriate affiliates or successors in order to complete the initial credentialing process and any future recredentialing processes. I authorize Health One Alliance, its affiliates and/or successors to consult with necessary persons or entities to obtain and/or verify the

qualifications as listed in the application. I release Health One Alliance, its affiliates and/or successors and their employees and agents from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating the application. I understand and accept that Health One Alliance may conduct a site review of this facility. I authorize Health One Alliance to perform any such site review, upon reasonable request.  
See above attestation

\_\_\_\_\_  
Signature of Chief Administrator or Authorized Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Chief Administrator or Authorized Designee

\_\_\_\_\_  
Date

\_\_\_\_\_  
Facility Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip code

**Any information stated in this application which is subsequently found to be false may result in the immediate termination of the facility contract between facility and Health One Alliance.**

November 19, 2007