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INSTRUCTIONS

Complete all sections and attach all required documentation noted in the application. All documentation must be valid for a minimum of 60 days after the date the application is submitted.

Return the completed application via email to facility.credentialing@hsc.utah.edu or if necessary, fax to 801-281-6121.

Our team will notify you if more information is needed. Please attach the following items for each location where members will be treated:

- ☐ Copy of current licenses
- ☐ Copy of DEA certificates, if applicable
- ☐ Copy of CLIA certificates, if applicable
- ☐ Malpractice Insurance Certificate
- ☐ Accreditation Information or CMS Certification as applicable
- ☐ For Behavioral Health Facilities and Skilled Nursing Facilities include your most recent survey or certification from your State or Federal governing agency
- ☐ Explanations for any affirmative disclosure questions numbers 3-9 on page 6

If your organization is not accredited, not certified by CMS, or has not had a state survey, a site visit will be scheduled prior to completing credentialing.

Name of contact to schedule site visit:

Phone:

Email:

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Organizational Provider Credentialing Application

ORGANIZATION INFORMATION	
Legal name of organization/parent company (legal name listed with IRS)	
DBA Name of organization (if applicable)	
Organization Medicare # *(primary)*	**Organization Medicaid #** *(primary)*
Organization TIN *(primary)*	**Organization NPI** *(primary)*
Credentialing address Street address: _____ Address line 2: _____ City:_____State:_____Zip: _____ Contact:_____ Email:_____ Phone: _____	**Billing address** *(if different than Credentialing address)* Street address: _____ Address line 2: _____ City:_____State:_____Zip: _____ Contact:_____ Email:_____ Phone: _____

LOCATION #1		
Address: (choose both, if applicable) ☐ Primary address ☐ Mailing		
Organization name (DBA):		
Group NPI number:	**Medicare number:**	
Street address:		
City:	**State:**	**Zip code:**
Location phone number:	**Location fax number:**	
Location contact name:	**Email address:**	
Office hours:	**Virtual visits:** ☐ Yes ☐ No	
Languages spoken by office personnel:		
Service area: ***(States, Counties, Cities, etc.)***		

Is the location handicap accessible?	☐ Yes	☐ No	
Is this location ADA compliant? If not please explain	☐ Yes	☐ No	
Does the location provide any of the following?			
Language translation/interpretation services	☐ Yes	☐ No	
Visual impairment accommodations	☐ Yes	☐ No	
Hearing impairment accommodations	☐ Yes	☐ No	
Does the location have age restrictions?	☐ Yes	☐ No	**Please explain:** _____
Does the location have gender restrictions?	☐ Yes	☐ No	**Please explain:** _____
Does the location have any other restrictions?	☐ Yes	☐ No	

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LOCATION #2		
Address: (choose both, if applicable) ☐ Primary address ☐ Mailing		
Organization name (DBA):		
Group NPI number:	**Medicare number:**	
Street Address:		
City:	**State:**	**Zip code:**
Location phone number:	**Location fax number:**	
Location contact name:	**Email address:**	
Office hours:	**Virtual visits:** ☐ Yes ☐ No	
Languages spoken by office personnel:		
Service area: ***(States, Counties, Cities, etc.)***		

Is the location handicap accessible?	☐ Yes	☐ No	
Is this location ADA compliant? If not please explain	☐ Yes	☐ No	
Does the location provide any of the following?			
Language translation/interpretation services	☐ Yes	☐ No	
Visual impairment accommodations	☐ Yes	☐ No	
Hearing impairment accommodations	☐ Yes	☐ No	
Does the location have age restrictions?	☐ Yes	☐ No	**Please explain:** _____
Does the location have gender restrictions?	☐ Yes	☐ No	**Please explain:** _____
Does the location have any other restrictions?	☐ Yes	☐ No	

LOCATION #3		
Address: (choose both, if applicable) ☐ Primary address ☐ Mailing		
Organization name (DBA):		
Group NPI number:	**Medicare number:**	
Street address:		
City:	**State:**	**Zip code:**
Location phone number:	**Location fax number:**	
Location contact name:	**Email address:**	
Office hours:	**Virtual visits:** ☐ Yes ☐ No	
Languages spoken by office personnel:		
Service area: ***(States, Counties, Cities, etc.)***		

Is the location handicap accessible?	☐ Yes	☐ No	
Is this location ADA compliant? If not please explain	☐ Yes	☐ No	
Does the location provide any of the following?			
Language translation/interpretation services	☐ Yes	☐ No	
Visual impairment accommodations	☐ Yes	☐ No	
Hearing impairment accommodations	☐ Yes	☐ No	
Does the location have age restrictions?	☐ Yes	☐ No	**Please explain:** _____
Does the location have gender restrictions?	☐ Yes	☐ No	**Please explain:** _____
Does the location have any other restrictions?	☐ Yes	☐ No	

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STATE LICENSE(S) AND/OR STATE REGISTRATION(S) – *Attach a copy of all*				
Type of credential	**State**	**Number**	**Issue date**	**Expiration date**
State License				
DEA registration				
CLIA#				
PHARMACY DME				

ACCREDITATION / CERTIFICATION (*check all that apply*)

Attach a copy of your most recent accreditation, state survey, or Centers of Medicare and Medicaid (CMS) survey, with any site visit corrections showing that your facility is in compliance. If your survey is older than 3 years, please include date of next scheduled site visit, if applicable. Next Survey Date:_____

☐ Medicare (CMS) Certification
☐ State Survey (including Dept. of Health and Human Services, State Medicaid, etc.)
☐ Accreditation (indicate accrediting body(bodies) below)
☐ Please mark here if your organization is NOT accredited, not certified by CMS, or has not had a state survey. If you check this box, a site visit will be scheduled prior to completing credentialing.

Name of contact to schedule site visit:_____ Phone: _____
Has your organization ever been put on a Plan of Correction (POC) by CMS, State or Accrediting Body? ☐ Yes ☐ No
If Yes, please provide a written explanation or attach the POC Acceptance Letter or other documentation showing compliance.

Accreditation Organization	
☐ (AAAHC)	Accreditation Association for Ambulatory Health Care
☐ (ACHC)	Accreditation Commission for Health Care
☐ (AAAASF)	American Association for Accreditation of Ambulatory Surgery Facilities
☐ (ABCOP)	American Board for Certification in Orthotics/Prosthetics
☐ (ACR)	American College of Radiology
☐ (ASHI)	American Society for Histocompatibility and Immunogenetics
☐ (BOC)	Board of Certification / Accreditation, International (O&P or DMEPOS)
☐ (CAP)	College of American Pathologists
☐ (CARF)	Commission on Accreditation of Rehabilitation Facilities
☐ (COLA)	Committee of Laboratory Accreditation
☐ (CHAP)	Community Health Accreditation Program
☐ (CT)	The Compliance Team
☐ (COA)	Council on Accreditation
☐ (DNV)	Det Norske Veritas
☐ (HFAP)	Healthcare Facilities Accreditation Program - AOA
☐ (HQAA)	Healthcare Quality Association on Accreditation
☐ (IAC)	The Intersocietal Accreditation Commission
☐ (NABP)	National Association of Boards of Pharmacy
☐ (NBAOS)	National Board of Accreditation for Orthotics Suppliers
☐ (NCQA)	National Commission for Quality Assurance
☐ (NDAC)	National Dialysis Accreditation Commission
☐ (TJC)	The Joint Commission
☐ (URAC)	Utilization Review Accreditation Commission
☐ (CABC)	Commission for the Accreditation of Birth Centers
☐ (PPFA)	Planned Parenthood Federation of America

LIABILITY INSURANCE

Insurance carrier:	**Phone number:**
Policy number:	**Dates of coverage:**
Dollar amount:	**Dollar amount aggregate:**

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

ORGANIZATIONAL PROVIDER TYPE

☐ Hospital Number of Beds _____ Number of ICU Beds _____ Number of Swing Beds _____
☐ Acute Care ☐ Physical Rehabilitation ☐ Pediatric/Children ☐ Indian Health
☐ Long Term Acute Care ☐ Critical Access
Do you offer mammography or chemo infusion on site? ☐ Yes ☐ No If yes, list services here _____

☐ Behavioral Health Organizations
Please check how many patients your license allows for? ☐ 16 beds or less ☐ 17 beds or more
☐ Residential Treatment Facility for Chemical Dependency/Substance Abuse
☐ Psychiatric Hospital Inpatient for Behavioral Health
☐ Ambulatory Outpatient Behavioral Health for Counseling Only (please include a roster of all providers)
☐ Partial Hospitalization/Day Treatment ☐ Intensive Outpatient Program (IOP)
☐ Medical Detox ☐ Social Detox
☐ Residency Recovery Location ☐ Residential Support Location
☐ Receiving Center
☐ Medicaid Essential Provider and/or Prepaid Mental Health Plan (please include roster of all providers)

☐ Agencies
☐ Home Health
☐ Home Infusion Therapy
☐ Personal Care

☐ Skilled Nursing Facility ☐16 beds or less ☐17 beds or more
☐ Current Medicare STAR Rating = _____
For STAR ratings < = 3 please attach plan of correction

☐ Laboratory

☐ Sleep Study Center/Lab

☐ Ambulatory Specialties
☐ Ambulatory Surgical Center
☐ Birthing Center
○ Institution-affiliated
○ Free Standing
○ Home Based
☐ Endoscopy
☐ End-Stage Renal Disease (ESRD)/Dialysis Center
☐ Ophthalmologic Surgery
☐ Public Health – Federal
☐ Public Health – State or Local
☐ Radiology / Medical Imaging Center
○ Mobile
○ Free Standing

☐ Suppliers
☐ Diabetes Supply Center
☐ Durable Medical Equipment (DME)
☐ Eyewear
☐ Hearing Aid Equipment
☐ Prosthetics

☐ Independent Diagnostic Testing Facility
☐ Specify services or tests that you offer

☐ Other facility type not listed above (specify)

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ATTESTATION AND RELEASE OF INFORMATION

SITE REVIEW AUTHORIZATION

I hereby grant permission for University of Utah Health Plans to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support quality improvement and utilization review programs conducted by University of Utah Health Plans.

ATTESTATION QUESTIONNAIRE

1. ☐ Yes ☐ No This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.
2. ☐ Yes ☐ No This facility maintains a process for credentialing and recredentialing its practitioners upon initial appointment, at least every 2 years and removes providers from the organization who do not meet minimum criteria as established by the facilities' policies.
3. ☐ Yes ☐ No Has the facility ever had or currently have pending any legal actions excluding medical malpractice?
4. ☐ Yes ☐ No Has the facility ever been convicted of a crime, excluding misdemeanors?
5. ☐ Yes ☐ No Has any government agency ever investigated, suspended, revoked, or taken other actions against this facility's license to conduct business?
6. ☐ 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 underway?
7. ☐ 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?
8. ☐ Yes ☐ No At any time, have the third party payers ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality-of-care issues?
9. ☐ Yes ☐ No Has any managing employee or person with an ownership or controlling interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?

EXCLUSION CERTIFICATION

I hereby certify that the online exclusions lists for the Health and Human Services, Office of Inspector General (OIG), and General Services Administration (GSA) are checked for all new hires, and monthly 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. The OIG exclusion list can be found at **exclusions.oig.hhs.gov**. The GSA exclusion list can be found at **sam.gov**.

Authorized signature ▶	**Date**
Print name (Must Include First Name, Middle & Last Name)	**Title**

RELEASE OF INFORMATION AND AUTHORIZATION

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant University of Utah Health Plans permission to contact any individual, institution, facility, or agency identified on, or relative to, this application. Further, I hereby consent and authorize University of Utah Health Plans to request, receive, and inspect any and all records pertinent to consideration of this application. I, the undersigned authorized agent of the applicant facility/organization, agrees University of Utah Health Plans may share this provider application and related credentialing information with any group or entity that has delegated or contracted with University of Utah Health Plans to provide such activities on their behalf. Information cannot be shared for any reason other than for provider directory/demographic and credentialing activities.

As a University of Utah Health Plans facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply University of Utah Health Plans with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. 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 ▶	**Date**
Print name (Must Include First Name, Middle & Last Name)	**Title**