



## **ANCILLARY CREDENTIALING APPLICATION**

The ancillary credentialing application applies to the following organization types:

- Urgent Care Centers (UCCs)
- Walk-In Clinics
- Hospice Care Facilities
- Physical & Occupational Therapy Centers
- Durable Medical Equipment (DMEs)
- MLTSS
- Other \_\_\_\_\_

To expedite the review process, please make sure the following documents are included, and up to date.

- Copy of state license/certification of registration and facility credentialing application (for each location)
- Copy of license for all subcontracted employees (if applicable)
- Copy of accreditation/certificate or letter with date of accreditation term (if applicable)
- Provide Medicare provider number
- Provide PROMISe/ Medicaid provider number with effective date (Be sure to revalidate with the State)
- Copy of face sheets for professional general liability Insurance (if applicable)
- Provide summary of liability judgments (if applicable)
- Copy of W-9\*\* (Must include the remittance/billing address)
- Roster (if applicable)

\* W9 Address must match what is listed in section B of this application, if the W9 billing/remittance address is different please use the last page of this application to provide an explanation.

# JEFFERSON HEALTH PLANS ANCILLARY CREDENTIALING APPLICATION

All providers making application to become a Jefferson Health Plans network ancillary provider are required to furnish information which fully describes their credentials and their program of medical services. Please note that acceptance of your application and subsequent contract execution may result in your being listed as a network provider in one or more of our provider directories. This application shall apply to the following companies:

## *JEFFERSON HEALTH PLANS*

PLEASE NOTE: JEFFERSON HEALTH PLANS RESERVES THE RIGHT TO DIRECT SERVICES TO SELECTED NETWORK PROVIDERS AND DOES NOT GUARANTEE A MINIMAL VOLUME OF SERVICES WILL BE DIRECTED TO ANY PROVIDER.

**DO NOT BIND APPLICATION OR APPLICATION MATERIALS OR REFORMAT THIS APPLICATION.**

### A. Corporate Office Information

Provider Name: \_\_\_\_\_

Physical Location of Provider/Facility (If more than one location, please include all branch locations/ facilities. You may attach additional pages if needed)

For Directory:

\_\_\_\_\_

(Street)

\_\_\_\_\_

(City)

(State)

(Zip)

\_\_\_\_\_

(County)

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

Fax  
Number: \_\_\_\_\_

**Corporate  
Office  
Address:**

\_\_\_\_\_

(Street)

\_\_\_\_\_

(City)

(State)

(Zip)

\_\_\_\_\_

(County)

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Facility Web Page:** \_\_\_\_\_

**B. BILLING INFORMATION/REMITTANCE ADDRESS:**

\_\_\_\_\_

(W-9) (Name)

\_\_\_\_\_

(Street)

\_\_\_\_\_

(City)

(State)

(Zip Code)

\_\_\_\_\_

(County)

**Phone Number:** \_\_\_\_\_ **Fax Number:** \_\_\_\_\_

**Categorize your Provider Type: (Check only those applicable.)**

PROVIDER TYPE	PEDIATRICS (0-18 Y/O) YES/NO	ADULT (19+) YES/NO
<input type="checkbox"/> Hospice Care <input type="checkbox"/> Other _____		
<input type="checkbox"/> Durable Medical Equipment (complete pages 7-8)		
<input type="checkbox"/> Ambulance/Medical Transportation (complete page 9)		
<input type="checkbox"/> IV/Infusion Therapy (complete page 10)		
<input type="checkbox"/> Freestanding Radiology/MRI (complete page 11)		

Name of facility credentialing contact:

Contact Person/title: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_ email address: \_\_\_\_\_

**C. CERTIFICATION/ACCREDITATION**

Please respond to the following and include as **ATTACHMENT 2**, the following items as applicable to your organization.

1. Submit a copy of your state licensure from the appropriate Department of Institutions and Agencies for all jurisdictions in which you provide services (i.e., the Department of Health or the Department of Public Welfare).

Have there been any restrictions on your licensure in the past five years?

Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain details of restrictions

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2. Are you accredited by an independent accreditation agency such as The Joint Commission on Accreditation of Healthcare Organizations (TJC), the Accreditation Association for Ambulatory Health Care (AAAHC), or the Community Health Accreditation Program (CHAP)?

Yes \_\_\_\_ No \_\_\_\_

If yes, type of Accreditation Achieved \_\_\_\_\_

If yes, please submit copy of the accreditation certificate or letter with the certifying date of accreditation. If any deficiencies, attach copy of the survey grid form.

Has your organization lost its accreditation, been denied accreditation, or otherwise been sanctioned by the accrediting body within the past five (5) years? (If so, please explain circumstances and remedies.) Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**NOTE: It is a requirement of Jefferson Health Plans and affiliates that providers be fully accredited by an accrediting body recognized by the company in order to qualify for participation in our networks.**

2. Please advise if you are certified as a provider in Medicare and Medical Assistance Programs.

Medicare Yes \_\_\_\_\_ No \_\_\_\_\_

Medical Assistance Yes \_\_\_\_\_ No \_\_\_\_\_

(a) If yes (certified) for Medicare, please provide the following:

(1) Effective date of Medicare participation \_\_\_\_\_

(2) Medicare provider number \_\_\_\_\_

(If Medicare certified for more than one service, e.g., home health and hospice, please list all Medicare numbers.)

(NOTE: Please respond to the following even if you are not currently Medicare participating.)

(3) Have there been any actions or sanctions by Medicare within the past five

(5) years? Yes \_\_\_\_ No \_\_\_\_

If yes, please furnish documentation concerning the dates of such sanctions and a description of any action taken against your organization and the outcome (i.e., suspension and your reinstatement under the program).

(b) If yes (certified) for Medical Assistance, please provide the following:

(1) PROMISe/Medicaid Provider Number \_\_\_\_\_

(2) Effective date of PROMISe/Medicaid participation \_\_\_\_\_

(Note: Please respond to the following even if you are not currently Medical Assistance participating.)

(3) Have there been any actions or sanctions by Medical Assistance within the past five (5) years?

If yes, please furnish documentation concerning the dates of such sanctions and a description of any action taken against your organization and the outcome (i.e., suspension and your reinstatement under the program).

(c) Please provide the following regarding your National Provider Identification Number (NPI):

(1) NPI Number for the physical location listed on page 1:  
\_\_\_\_\_

(2) Effective date of the NPI number:  
\_\_\_\_\_

(3) Is this NPI number used for more than one site location? Yes \_\_\_\_\_ No \_\_\_\_\_ (if yes, please provide all physical locations that use the NPI number listed as a separate attachment)

(4) Will the providing NPI Number and the Pay to NPI Number be the same? Yes \_\_\_\_\_ or No \_\_\_\_\_  
If yes, please provide the Pay to NPI Number \_\_\_\_\_

4. Submit a copy of the most current face sheets for your professional liability and general liability insurance policies.

5. Please submit as ATTACHMENT 3, a summary of claims filed against your organization over the past five (5) years which resulted in either a settlement or court disposition adverse to you and which settlement or disposition resulted in a payment of \$25,000 or more. Include claim type (professional or general liability), description, status/resolution, and amount of award.



9. Language(s) spoken by Patient-Care Staff: \_\_\_\_\_

**10. ADDITIONAL INFORMATION**

You may include any other information that you believe would assist us in reviewing your application. (Please take this opportunity to help us to understand the nature and scope of services you are offering, if need be.)

**ON BEHALF OF THE PROVIDER**, I hereby certify that:

- All the information included in this application and the accompanying documents are correct and complete to the best of my knowledge and belief.
- If this application contains either (i) any material omissions, or (ii) false or misleading information, participation with the Jefferson Health Plans network may be terminated.
- In the event that there are any changes to any of the information provided in this application, the Provider will notify Jefferson Health Plans immediately.

**ON BEHALF OF THE PROVIDER**, I hereby authorize Jefferson Health Plans to verify the information provided on this application and accompanying documentation. I also authorize the release of any relevant information pertaining to organizational status, licensure, accreditation or operations to Jefferson Health Plans.

I hereby authorize and agree that Jefferson Health Plans their respective agents, employees, and representatives may provide its affiliates with any information concerning the organization's qualifications for the purpose of credentialing, recredentialing or peer review. I release Jefferson Health Plans, their respective agents, employees, and representatives of any liability for furnishing any such information, which is provided in good faith and without malice.

I hereby authorize Jefferson Health Plans and affiliates to use the information provided in their selection, credentialing and recredentialing process, and to verify such information as appropriate. I further understand that Jefferson Health Plans and affiliates have its own criteria for acceptance, and that I may be accepted or rejected by each independently.

\_\_\_\_\_  
(Authorized Signature for Provider)

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Title)

\_\_\_\_\_  
(Date)

**DURABLE MEDICAL EQUIPMENT / ORTHOTIC & PROSTHETIC PROVIDER**

**SERVICES PROVIDED: Please check all boxes that apply to services provide by your organization.**

- |                             |                              |
|-----------------------------|------------------------------|
| Medical/Surgical Supplies   | Enteral/Parenteral Nutrition |
| Walkers / Wheelchairs       | Hospital Beds                |
| Oxygen Equipment / Supplies | Orthotics / Prosthetics      |
| Hearing Aids                |                              |

**Please list any special services you provide (i.e. only provider of item in area)**

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**AMBULANCE PROVIDER**

**SERVICES PROVIDED: Please check all boxes that apply to services provide by your organization.**

- |                    |                    |            |     |
|--------------------|--------------------|------------|-----|
| ALS Transportation | BLS Transportation | Wheelchair | Van |
|--------------------|--------------------|------------|-----|

**NUMBER OF VEHICLES: Please list the number of vehicles for each type of transportation.**

**Number of ALS Transport Vehicles** \_\_\_\_\_

**Number of BLS Transport Vehicles** \_\_\_\_\_

**Number of Wheelchair Vans** \_\_\_\_\_

**TRANSFER AGREEMENT:**

1. Does your facility have a transfer agreement with an acute care hospital?  
Yes                      No

If yes, provide name(s) of hospital(s)

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2. Does your facility have a transfer agreement with a skilled nursing facility?

Yes No

If yes, provide name(s) of skilled nursing facility(ies)

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**HOME INFUSION PROVIDER**

**SERVICES PROVIDED: Please check all boxes that apply to services provide by your organization.**

Anti-Infective Therapies  
 Chemotherapy  
 (TPN) Enteral Nutrition  
 Hydration Therapy  
 Factor Products

Pain Management  
 Total Parenteral Nutrition  
 IVIG  
 Catheter Care  
 Other: \_\_\_\_\_

**STAFFING**

	# EMPLOYED		**# SUBCONTRACTED	
	Adult	Pediatric	Adult	Pediatric
RN				
LPN				
Registered Dietitian				
Certified Diabetes Educator				
Other (Please list)				

**\*\*Please list any agencies with which you currently subcontract to provide patient care services and the types of services provided to you by this subcontractor. Submit current copy of license for each.**

<b>Name</b>	<b>Name</b>
<b>Address</b>	<b>Address</b>
<b>City/State/Zip</b>	<b>City/State/Zip</b>
<b>Contact Person/Phone</b>	<b>Contact Person/Phone</b>

**FREE STANDING RADIOLOGY CENTER**

**SERVICES PROVIDED: Please check all boxes that apply to services provide by your organization.**

- |                |                              |
|----------------|------------------------------|
| MRI – closed   | Mammography                  |
| MRI – open     | X-ray / Diagnostic Radiology |
| MRI – standing | Ultrasound                   |
| CT Scan        | Other: _____                 |

**STAFFING**

**Number of radiologists on staff or contracted: \_\_\_\_\_**

**Please list each staff or contracted radiologist along with each radiologist’s admitting hospital(s)**

<b>Last Name</b>	<b>First Name</b>	<b>Admitting Hospital</b>	<b>Staff (Y/N)</b>

