

# FACILITY CREDENTIALING APPLICATION



**Please indicate type of organization:**

- Hospital                       Nursing Home                       Skilled Nursing Facility  
 Home Health Care Agency     Ambulatory Surgical Center     Durable Medical Clinic Center  
 Other \_\_\_\_\_

## GENERAL INFORMATION

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

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Billing Address: (if different) \_\_\_\_\_

Contact Person Name/Title: \_\_\_\_\_

Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

## LICENSURE AND ACCREDITATION

Ownership: \_\_\_\_\_

Legal type:

- Nonprofit Corporation                       Professional Corporation                       Subsidiary  
 Wholly Owned Subsidiary                       Limited Liability Corporation

State License #: \_\_\_\_\_ Expires: \_\_\_\_\_ Tax ID #: \_\_\_\_\_

Medicare License #: \_\_\_\_\_ Medicaid License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ NPI #: \_\_\_\_\_ NPI #: \_\_\_\_\_

If the facility operates more than one patient site (inpatient or outpatient), please indicate additional Names, Tax ID numbers, NPI numbers, addresses and phone numbers on a separate piece of paper.

JCAHO Accreditation:  Yes     No    If yes, survey date: \_\_\_\_\_

(Please attach copy of accreditation letter)                      Accreditation date: \_\_\_\_\_

Are you accredited by any other agency?  Yes     No

If yes, survey date: \_\_\_\_\_ Accredited: \_\_\_\_\_

Name of accrediting agency? \_\_\_\_\_

**BEDS** Not Applicable

Type of Bed	Med./Surg.	Special Care	Obstetrical	Pediatric	Swing Bed	Other	Total
Licensed							

Average Admits per (choose one of the following): Day \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

**RADIOLOGY** Not Applicable

If the facility has a contractual relationship for Radiology, please list contracting party:

\_\_\_\_\_

**PATHOLOGY** Not Applicable

If the facility has a contractual relationship for Pathology, please list contracting party:

\_\_\_\_\_

**REFERRAL PATTERNS**

If physicians affiliated with the facility refer most of their tertiary care to one or more other institutions please indicate: \_\_\_\_\_

Is your facility a teaching facility?  Yes  No

Name of teaching affiliation: \_\_\_\_\_

**KEY PHYSICIANS**

List the name and title of key physicians (e.g. Medical Director, Department Chiefs) of the facility. If there are any specific physicians or physician committees with which Sanford Health Plan should interact, please indicate.

Name	Title	Phone

*Use additional attachments if necessary.*

**STAFFING**

Please indicate the number of each of the following providers at your facilities, *use N/A if not applicable*:

Full-Time Medical Doctors or Doctors of Osteopathy? \_\_\_\_\_

Outreach Medical Doctors? \_\_\_\_\_ Physical Therapists? \_\_\_\_\_

Occupational Therapists? \_\_\_\_\_ Speech Therapists? \_\_\_\_\_

**DISCLOSURE QUESTIONS**

Has your license ever been restricted, conditioned, suspended or terminated?  Yes  No

Does your organization have any current state or federal sanctions or limitations?  Yes  No

**ATTESTATION**

All information and documentation submitted here within is correct and complete to my best knowledge and belief. I acknowledge and understand that any material misstatements in or omissions from this application may constitute cause for denial of my application for participation in the health plan. A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

I authorize Sanford Health Plan the right to obtain documents, recommendations, reports and statements relating to the Credentialing process of this facility and the associated facilities that intend to contract with the Sanford Health Plan. In addition, I also authorize the right to verify my standing with state & federal regulatory bodies relating to the Credentialing process.

Name: (print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sanford Health Plan Representative: \_\_\_\_\_ Date: \_\_\_\_\_

**Please attach the following documents:**

1. Copy of State License
2. Copy of JCAHO Accreditation Letter and Accreditation Decision Grid, (or)
3. Copy of the most recent survey results from the State Department of Health if not currently accredited by JCAHO, AAAHC, or AAAASF.
4. Copy of Professional Liability and General Liability Insurance Certification, which list amounts and coverage dates.

**SERVICES**

Please indicate on Attachment (A), all programs or services provided by your institution. If these programs or services are billed for under a different name and address, please indicate. If these services have been accredited or licensed by an agency which is different from those above, please provide the name of the accrediting agency and the date of accreditation.

**Return to:**

Judy Winter, PhD • Sanford Health Plan • PO Box 91110 • Sioux Falls, SD 57109-1110  
605-328-6815 • 605-328-7224 (Fax)

