FACILITY CREDENTIALING APPLICATION

FACILITY INFORMATION

Please complete a separate application for each facility.

Facility Name: ____

Street Address:____

City: ________________ County: _______________ State: _______ Zip: __________

Phone: ___________________________________ Fax: ______________________________

Federal Tax I. D. No: ______________ Facility NPI # _______________ State License No: ______________

Group Medicare #:_________________________ Group Medicaid #:________________________________

Web Site Address: ____

Office Manager Name: __________________ Phone and Ext: ___________ Email: ______________________

Scheduling Mgr. Name: _________________ Phone and Ext: ___________ Email: ______________________

Claims Mgr. Name: ____________________ Phone and Ext: ___________ Email: ______________________

Type of Facility:
___ Free Standing Imaging Center ___ Radiology Services within a Private Med Group or Practice
___ Mobile Service ___ Hospital-Based Practice ___ Hospital Outpatient Facility
___ Hospital Affiliated Free-Standing Other (please list) ____

Mailing Address (if different than above)
Street Address: _______________________ City: ___________ State: __________ Zip: __________

Billing Address (if different than above)
Check Payable Name: ____

Street Address: ____

City: ______________________________ State: ___________________ Zip: _________________

Billing Business Phone: ____________________ Billing Business Fax: _______________________

Billing Manager: _____________________ Phone and Ext: __________ Email: ______________________

Do you have the capacity to bill electronically? Yes _____ No _____

MEDICAL STAFFING

Medical Director: *A specific physician Medical Director must clearly be identified as responsible for the oversight of medical management at the facility in accordance with established policies.*

Medical Director Name: _____________________________ Address: ________________________________

Phone: ______________________ Fax: ____________________ E-mail: ___________________________

Credentials (MD; DO; Specialty): ____

Physicians: *List all physicians who practice at this site. Please list Board Certification status of each physician and if Board eligible, date of initial board eligibility. * Attach a separate sheet if needed.*

Physician Name	State	License Number	NPI#	UPIN #	Board Certified Yes/No	If yes, name of Board/Sub-Specialty	If no, date eligible

Medical Staff: The facility must have an organized medical staff, established in accordance with policies and procedures developed by the facility, which will be responsible for maintaining proper standards of medical care.

Please indicate the composition and employment relationship of the facility's staff by indicating the number of positions in the appropriate column.

Staff Position	Facility Employee	Contract Services	Number Certified
Radiologists			
Radiology PAs			
Registered Nurses			
Radiology Technologists			
Other (please specify)			

FACILITY SERVICES

Modalities: *Please circle all those that apply:*

MRI Open MRI Breast MR CT CTA CCTA Ultrasound X-Ray Mammography Analog

Digital Mammography Nuclear Medicine PET Scan PET/CT Scan Bone Density Bone Scan

MRA Capability EMG/NCV Fluoroscopy Radiation Oncology Stereotactic Virtual Colonoscopy

ACR Accreditation:
Please list all modalities/equipment the facility is accredited for by the American College of Radiology. Please include a copy of the certificate and/or letter of accreditation.

____

____

ICAMRL/ ICACTL/ ICANL Accreditation:
Please list all modalities/ equipment the facility is accredited for by the Intersocietal Accreditation Commission. Please include a copy of the certificate and/or letter of accreditation.

____

____

Do you have a PACS system? Yes _____ No _____

Do you provide transportation for patients to your facility? ____Yes ____No

Is the facility wheelchair accessible? ____Yes ____No

Please list all languages spoken fluently at the site: ____

Hours of Operation

Facility Hours	From:	To:
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Workers Compensation:
Certification status as a Workers Compensation Provider:
Certified _______ Denied _______ Applied for: _______ NA _______
State Workers Compensation Number ____________________

INSURANCE INFORMATION

General Liability Carrier Name: ____

Street Address: ________________________ City: _________________ State: _______ Zip: __________

Policy Number: _______________________ Coverage Limits: ______________________________

Coverage Dates From: __________ To:__________

Type of Coverage: ________ Occurrence _______ Aggregate _______Property Damage

INFORMATION

1. Have you ever been denied participation in Medicare, Medicaid or any other governmental or quasi-governmental health related program? …………………………………………….. ___yes ___no
2. Have you ever been reprimanded, censured, excluded, suspended (even if the suspicion was stayed), barred or disqualified from participating in Medicare, Medicaid, or any other governmental or quasi- governmental health-related program? …………………………………………….. ___yes ___no
3. Have any complaints ever been filed against you by a licensing authority? ……. ___yes ___no
4. Have you ever been denied professional liability insurance coverage or had your professional liability insurance coverage canceled by your carrier? ………………………………………. ___yes ___no
5. Have you ever been refused participation in the network of managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization? ……………… ___yes ___no

If "yes" was answered to any of the above, please provide a full description and explanation on a separate sheet and attach to application.

ATTESTATION & CREDENTIALS VERIFICATION RELEASE

I hereby authorize all professional or allied health societies, insurance carriers, peer review organizations, foundations for medical care, hospitals, state or federal agencies or other agencies, and other organizations to release information about me in connection with the evaluation of my application to become a Participating Provider and during the term of the Provider Agreement.

I release and agree to hold harmless US Imaging and its designees to which this information is given, and the representatives, employees and agents of each of them, from any and all liability for any damages, costs and expenses which may result from gathering or use of such information, so long as such release or use of information is done in good faith and without malice.

I have read and understand the Provider Agreement. I warrant that all of the statements made in this Participating Provider Application, and in any certificates, documents and any other information submitted in connection with this application, are true and correct.

____   _________________________
Owner or Authorized Representative Signature   Date

____
Print Name

Please remember to include copies of the following documents with your completed application.

_______ Certificate of Facility Insurance (Occurrence, Aggregate, and Property Damage)
_______ Facility Operating License (If Applicable)
_______ W-9 Form
_______ American College of Radiology (ACR) Certificate (s)/ Intersocietal Accreditation Commission (ICAMRL, ICACTL, ICANL) Certificate
_______ Most recent State or CMS Survey Inspection with any corrective actions taken for deficiencies
_______ A list of all medical staff including: name, title, and copy of State Licensure and or applicable certifications
_______ New Facility Equipment Summary signed and dated

NEW FACILITY EQUIPMENT SUMMARY

Equipment Specifications: Please be specific regarding coils and capabilities you have in order for US Imaging to list the full range of services your facility provides for example, Breast MRI.

Magnetic Resonance Imaging (MRI) – Closed

Manufacturer/Model: ________________________________ Year Manufactured: _____________________

Field Strength: ______________ Table Weight: ______________ Software: ___________________

Coils: _____________________ ACR Accredited: □ ICAMRL Accredited: □

Magnetic Resonance Imaging (MRI) – Open

Manufacturer/Model: ________________________________ Year Manufactured: ____________________

Field Strength: ______________ Table Weight: ______________ Software: ___________________

Coils: _____________________ ACR Accredited: □ ICAMRL Accredited: □

Computed Tomography (CT)

Manufacturer/Model: ________________________________ Year Manufactured: ____________________

Table Weight: ___________________ Capabilities: ____

CT Slice Available: ______________ ACR Accredited: □ ICACTL Accredited: □

Mammography:

Manufacturer/Model: ________________________________ Year Manufactured: _____________________

Digital System: ____________ Analogue: ____________ CAD System: ______________

Capabilities: _______________________________________ FDA Certification # _____________________

Ultrasound:

Manufacturer/Model: ________________________________ Year Manufactured: ____________________

Capabilities: ____

PET Imaging:

Manufacturer/Model: ________________________________ Year Manufactured: _____________________

PET/CT (combined preferred technology): ____

Capabilities: ____________________ ACR Accredited: □ ICANL Accredited: □

Nuclear Medicine:

Manufacturer/Model: ________________________________ Year Manufactured: ____________________

Capabilities: ____________________ ACR Accredited: □ ICANL Accredited: □

Radiography/Fluoroscopy:

Manufacturer/Model: ________________________________ Year Manufactured: ____________________

____ ________________________________

Signature: Owner or Authorized Representative *Date*

____ ________________________________

Print Name *Title*