



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

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.

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

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
- \_\_\_\_\_ W-9 Form
- \_\_\_\_\_ American College of Radiology (ACR) Certificate (s)
- \_\_\_\_\_ Most recent State or CMS Survey Inspection with any corrective actions taken for deficiencies
- \_\_\_\_\_ A list of all medical staff and technologists 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: \_\_\_\_\_

**Magnetic Resonance Imaging (MRI) – Open**

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Field Strength: \_\_\_\_\_ Table Weight: \_\_\_\_\_ Software: \_\_\_\_\_  
Coils: \_\_\_\_\_

**Computed Tomography (CT)**

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Table Weight: \_\_\_\_\_ Capabilities: \_\_\_\_\_  
CT Slice Available: \_\_\_\_\_

**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: \_\_\_\_\_

**Nuclear Medicine:**

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Capabilities: \_\_\_\_\_

**Radiography/Fluoroscopy:**

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Capabilities: \_\_\_\_\_

\_\_\_\_\_  
*Signature: Owner or Authorized Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Title*