HEALTHCARE ORGANIZATIONAL FACILITY CREDENTIALING FORM

Send completed forms by:
Fax: (260) 969-2421
E-Mail: providerservices@phpni.com

Mail to: Physicians Health Plan
Attn.: Provider Services
8101 W. Jefferson Blvd.
Ft. Wayne, IN 46804-4163

Phone: (260) 432-6690
Toll Free: 1-800-982-6257

Please complete all sections of this form. Please indicate if a question is not applicable to your organization, or if the answer is *none*. If additional space is needed to complete a question, a separate sheet of paper may be attached indicating the question being answered.

Please attach a copy of the following documents:

- Current applicable certifications and letters of accreditation, including the certifying/ accrediting agency's recommendations
- Current Professional Malpractice Liability Insurance Policy face sheet
- Quality Improvement Program description, including structure, quality monitoring activities, and summary of most recent quality improvement analyses
- Current copy of State License
- Copy of CCN (CMS' Certification Number) certificate

IDENTIFICATION

Facility Name:	**Email Address:**
Facility Physical Address (if more than one, attach a list)**:**	**Facility Phone Number:** / **Facility Fax Number:**
Years in business: **National** _____ **Local** _____ **Years in business:** **National**_____ **Local**_____	**Are any of the organization's owners physicians (M.D./D.O.)?** ☐ Yes ☐ No ☐ Unknown List:_____
Specialty:	**NPI:** / **Tax I.D.#:**
W-9 – Name and D/B/A (Attach Copy of W-9)	**Payment Address: (include Zip+4)**
Address to Obtain Medical Records:	
National Corporate Owner or Affiliate, if applicable:	
Corporate Address:	**Corporate Phone Number:**

Please list the name(s) and telephone number(s) of the contact person for the following functions, as applicable:

Function	Name	Phone Number
Business Manager		
Billing		
Medical Records		
Credentialing		
Quality Management		
Utilization Review/Discharge Planning		

CONTRACTING CONTACT

Contracting Representative Name:		**Contracting Mailing Address:**
Contracting Phone Number:	**Contracting Fax Number:**	**Contracting Email Address:**

ACCESS INFORMATION

Do you provide 24 hours/day, 365 days/year service? ☐ Yes ☐ No

If no, please fill in the table below with regular operational hours, and with the procedure for clients to access emergency or informational assistance outside of operational hours.

Day	Hours	After-Hours Access Procedure
Sunday	to	
Monday	to	
Tuesday	to	
Wednesday	to	
Thursday	to	
Friday	to	
Saturday	to	

LICENSURE

Is this organization licensed or certified by any of the following agencies? ☐ Yes ☐ No

	Yes	No	Date of Survey
a) State of Indiana:			
b) Medicare:			
c) Medicaid:			
d) Other: (State or Agency) _____			

Has your license to do business in any jurisdiction ever been denied, restricted, suspended, reduced, or not renewed?

☐ Yes ☐ No **If yes, please attach explanation.**

INSURANCE

The number of client beds this organization maintains:

☐ Less than 50 beds ☐ 50-99 beds ☐ 100+ beds ☐ Not Applicable

Current Malpractice Liability Insurance Carrier ***(Please attach a copy of the policy face sheet, stating coverage amounts.)***

ACCREDITATION

Have you been reviewed by an accrediting organization? ☐ Yes ☐ No

If yes, fill in the appropriate boxes below. ***Please attach a copy of the accrediting agency's post survey letter or current accreditation certificate.*** **The letter or certificate should provide the name of the accrediting organization along with effective date and expiration dates.**

Accrediting Agency	Approved	Denied	Other (See attached explanation)
JCAHO (Joint Commission on Accreditation of Healthcare Organizations)			
CARF (Commission on Accreditation of Rehabilitation Facilities)			
AAAHC (Accreditation Association for Ambulatory Health Care)			
CCAC (Continuing Care Accreditation Commission)			
HFAP (Healthcare Facilities Accreditation Program)			
Other_____			
Other_____			

PHP USE ONLY

Contract Sign-off:_____ **Date:** _____

Credentialing Approval / Insurance Date: _____ **Contract Effective Date:** _____

Provider I.D.:_____ **Pay To I.D.:** _____ **Directory:** ☐

Contract ID: _____

CONTRACT DEMOGRAPHICS

Date Completed: _____

☐ LTR ☐ EDUC ☐ ATTH

Add Provider To: ☐ New Contract

☐ FWPG ☐ PG ☐ H.S.A.

☐ IND ☐ PHO ☐ LOU

☐ HMO ☐ SF ☐ SELECT

☐ OTHER _____

Provider Change Form:

☐ CHANGE NAME

☐ ADD Pay-To

☐ CHANGE Pay-To

☐ ADD Location(s)

☐ CHANGE Address _____

Input Stamp

☐ In-Credentialing

☐ Approved

Audit Stamp

☐ In-Credentialing

☐ Approved

FACILITY AUTHORIZATION AND RELEASE

Facility represents and certifies that all information given in or attached to this application is true, accurate, and complete. Facility will promptly provide Physicians Health Plan of Northern Indiana, Inc. (PHP) with notice of any changes in the submitted information, which may occur from time to time, and to provide PHP with updated current information regarding all questions on this application as such information becomes available. Facility will also promptly provide PHP with additional information as is requested by PHP in its review of this application.

Facility acknowledges and agrees that any significant misstatement in, or omission from, this application, as determined by PHP, will constitute cause for denial of this application or termination of participation with PHP. Failure to provide all information requested or to assist PHP staff as requested may also result in denial of the application.

Further, Facility acknowledges that this application is not a guarantee of network participation and that participation in the PHP network is not a right of every applicant who makes application for the same.

Facility accepts the following conditions during the processing and consideration of its application, regardless of whether approved or not, and, if approved, for the duration of its participation with PHP:

a) Facility authorizes PHP and its authorized representatives to consult with any third party, including but not limited to members of Facility's medical staff, other health care providers, affiliated hospitals, government agencies, professional liability carriers, and any other person, entity, institution or organization that has or may have information, including otherwise privileged or confidential information, bearing on Facility's qualifications, satisfaction of the criteria considered by PHP concerning this application, or otherwise for credentialing and recredentialing purposes. Facility authorizes PHP and its authorized representatives to inspect and obtain any and all communications, reports, records, statements, documents and recommendations from such third parties. Facility authorizes said third parties to release and disclose such information to PHP and its authorized representatives upon request.

b) Facility extends absolute immunity to, and releases from any and all liability, PHP, its employees, authorized representatives and any third party for any acts, communications, reports, records, statements, documents, recommendations, or disclosures involving Facility that are performed, made, requested or received by PHP and/or its authorized representatives to, from, or by third party, including otherwise confidential or privileged information, relating but not limited to Facility's qualifications, this application, or otherwise for credentialing or recredentialing purposes.

Facility agrees that a facsimile or photocopy of my signature will serve the same as the original.

Facility and the individual executing the application and Authorization and Release on behalf of Facility hereby expressly represent that such individual has the power and authority to execute the documents on behalf of Facility.

Facility, _____ by its duly authorized representative:
[Facility name]

_____ _____
Printed Name Title

_____ _____
Signature Date Date