



Organizational Credentialing Application

Type of Provider:

- Hospital
- Hospice
- Radiology Centers
- Dialysis
- Behavioral Health Facilities
- Skilled Nursing Facilities (SNF)
- Home Health
- Ambulatory Surgical Center (ASC)
- Outpatient Rehabilitation Centers
- Other: _____

ORGANIZATION/FACILITY: Contact Person: _____ Phone: _____

Name: _____

Tax ID Number: _____ NPI #: _____ AHCCCS ID #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

(Please list additional location/facilities on a separate sheet of paper)

LICENSURE: PLEASE PROVIDE A CURRENT COPY OF STATE LICENSE

Is your license in good standing with the State? YES NO

Are you Medicare certified? YES NO

MEDICARE NUMBER: _____

Is your Medicare Certification in good standing with Medicare? YES NO

ACCREDITED FACILITIES: PLEASE PROVIDE A CURRENT COPY OF YOUR ACCREDITATION CERTIFICATE (S)

Please mark those that apply:

- Joint Commission on Accreditation of Health Care Organization (JCAHO)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Accreditation Association for Ambulatory Health Care, Inc (AAAHC)
- American Association for Accreditation of Ambulatory Surgery Facilities, Inc (AAAASF)
- Other _____

Do you have a procedure/process in place to deal proactively with preventable patient errors or known potential errors?

YES NO

Is the organization currently excluded or otherwise ineligible for participation in Federal health care programs?

YES NO

NON-ACCREDITED FACILITIES: PLEASE PROVIDE THE MOST RECENT COPY OF YOUR STATE AND/OR MEDICARE SURVEY/AUDIT.

REQUIRED FOR THE FOLLOWING NON-ACCREDITED FACILITIES:

- Hospitals
- Skilled Nursing/Rehab Facilities
- Home Health Agencies/Home IV/Hospice
- Ambulatory Surgical Centers
- Birthing Centers

Survey/Audit documents must include:

- Any identified deficiencies
- Corrective action plan (s)

LIABILITY INSURANCE: PLEASE PROVIDE CURRENT COPY OF YOUR LIABILITY INSURANCE FACE SHEET/CERTIFICATE

Please Note: The face sheet/certificate must include Carrier's Name. Name of Organization/Facility Covered. Dates of coverage And amount of coverage. For self-insured organizations/facilities, please provide a letter.

AUTHORIZATION/ATTESTATION

RELEASE OF LIABILITY, INFORMATION STATEMENT, AND ATTESTATION

I release from liability all representatives of Care1st Health Plan of Arizona / ONECARE by Care1st Health Plan (their Directors, employees and agents) for their acts performed in good faith and without malice in connection with evaluation of our credentials. I release from any liability any and all individuals and organizations that provide information to Care1st Health Plan of Arizona in good faith and without malice concerning professional competence, character, and ethical qualifications. I authorize and give my consent for release of information necessary for processing this credentialing form.

I certify that the answers to all questions are complete, true and correct to the best of my knowledge.

I understand that falsification of any part of this application and/or documentation included with this application may be grounds for denial of credentialing.

Authorized Signature

Date

Printed Name

Title

FAX TO: Care1st Provider Network Operations 602.778.1875

QUESTIONS: 602.778.1800 (Options in order 5. 7)