



Assessment for Facility and Non-Credentialed Providers

Facilities and non-credentialed providers are reassessed every three years. All facilities and non-credentialed providers must complete this assessment application. Each section of this form must be filled out to be considered complete. If a section does not apply, please indicate with N/A. Once you attach additional documentation with this signed and dated attestation form, your attestation can begin. Failure to submit a completed application and all necessary documents will result in a delay in the assessment process.

Documentation Checklist:

- Copy of current and valid facility/group license
- Copy of current and valid certificate of insurance for both general and professional liability displaying occurrence and aggregate limits, policy numbers, and expirations (minimum limit amounts-1 million occurrence and 3 million aggregate)
- Current copy of the facility's/group's Accreditation
- Roster of all providers (use CHO excel roster)
- The completed Assessment and Reassessment Form

Attached, please find additional details on the required items for documentation and additional information to complete. If you have any questions, please email credentialing@healthoptions.org.

Please complete each section leaving no blank spaces. Clearly state if the information requested is not applicable. Attach additional documents as needed.

TYPE OF FACILITY OR GROUP (AS LISTED ON LICENSE OR ACCREDITATION)

- | | | |
|---|---|---|
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Behavioral Health Facilities |
| <input type="checkbox"/> Home Health Agencies | <input type="checkbox"/> Hospice Agencies | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Hospital | <input type="checkbox"/> Urgent Care Facilities | |
| <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Medical Air Transport | |

FACILITY OR GROUP INFORMATION

Legal business name (as reported to IRS): _____

Federal tax identification number (TIN): _____

Facility/Group NPI number: _____

Facility/Group name (to be listed in our directory): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

ASSESSMENT CONTACT

Assessment contact name: _____

Assessment contact email address: _____

Phone number: _____

BILLING ADDRESS INFORMATION (for mailing checks and remittances) Please include a W9

- Check if this address is the same as location address above

Address (if different than location address): _____

City: _____ State: _____ Zip code: _____

STATE LICENSURE

Attach a copy of license. (If you are licensed in multiple locations, attach copies of each location's license)

License number: _____ Initial issue date: _____ Expiration date: _____

License number: _____ Initial issue date: _____ Expiration date: _____

License number: _____ Initial issue date: _____ Expiration date: _____

ACCREDITATION INFORMATION

Please complete this section and attach copies of current accreditation certificates or letters. Your certificates and/or letters should list this facility/group location as being included in the accreditation.

- | | |
|--|--|
| <input type="checkbox"/> The Joint Commission (TJC) | <input type="checkbox"/> Healthcare Facilities Accreditation Program (HF AP) |
| <input type="checkbox"/> Center for Medicare and Medicaid Services Survey (CMS) | <input type="checkbox"/> American College of Radiology Accreditation (ACR) |
| <input type="checkbox"/> Ambulatory Healthcare Accreditation (AAHHC) | <input type="checkbox"/> Commission on Accreditation of Rehabilitation Facilities (CARF) |
| <input type="checkbox"/> Community Health Accreditation Partner (CHAP) | <input type="checkbox"/> College of American Pathologists Accreditation (CAP) |
| <input type="checkbox"/> Home Health & Hospice Accreditation (ACHC) | <input type="checkbox"/> Durable Medical Equipment, Prosthetics, Orthotics and Supplies Accreditation I (DMEPOS) |
| <input type="checkbox"/> Clinical Laboratory Improvement Amendments (CLIA) | <input type="checkbox"/> The American Association of Birth Centers (AABC) |
| <input type="checkbox"/> National Committee for Quality Assurance (NCQA) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Intersocietal Accreditation Commission (IAC) | |
| <input type="checkbox"/> American Association for Accreditation of Ambulatory Surgical Facilities (AAAASF) | |

Date of last accreditation/certification: _____

Expiration date of accreditation/certification: _____

LIABILITY INSURANCE INFORMATION

Complete this section and attach a copy of the facility's/group's insurance certificate(s):

Name of carrier: _____

Carrier address, city, state, zip: _____

Carrier telephone number: _____

Policy number: _____ Policy expiration date: _____

Amount of liability coverage (occurrence/ aggregate): _____

PRACTITIONERS

Does the facility/group validate, for each licensed practitioner employed or contracted at the facility/group, the credentials necessary to perform health care services?

If yes, indicate how the facility/group conducts the credentialing process for each practitioner. Health Options reserves the right to request copies of practitioner's licensure, certification, and malpractice insurance certificate): _____

If no, please explain: _____

ATTESTATION

Please answer the following questions by checking the appropriate boxes. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.

1. Has the facility/group license to do business ever been denied, restricted, suspended, reduced or been voluntarily given up by the facility/group? Yes No
2. Has this facility/group ever had or currently have pending any legal actions against it excluding medical malpractice? Yes No
3. Has this facility/group ever had its accreditation revoked or suspended? Yes No
4. Were any deficiencies cited during the last survey? Yes No
5. If yes, have all the deficiencies been corrected? Yes No
 - If yes, provide and attach copy of Corrective Action Plan (CAP)
 - If no, provide explanation and your plan to correct all deficiencies.
6. Has this facility's/group's liability insurance ever, for any reason, been denied, cancelled, non-renewed, or reduced? Yes No

Explanation, including dates and outcomes, for questions answered "Yes."

FACILITY AND NON-CREDENTIALLED PROVIDERS ATTESTATION/CONSENT & RELEASE FORM

By signing below, I attest that I am the duly authorized representative of the facility, and/or group, that all information on the application pertains to the above-named facility, and/or group, and that such information is current, complete and correct.

Facility/Group name: _____

Printed name of authorized representative: _____

Title of authorized representative: _____

Signature of authorized representative: _____

Date signed: _____