Facility contracting questionnaire

Date: _____/_______/___________

Organization name: ____

Street address: ____

City: ____State:__________ ZIP code: ________________

Phone number: (_______)________-__________ Fax number: (_______)________-__________

Website: ____

E-mail address: ____

Primary contact name: ____

Phone number: (_______)________-__________ Fax number: (_______)________-__________

Street address: ____

City: ____State:__________ ZIP code: ________________

E-mail address: ____

Billing address: ____

City: ____State:__________ ZIP code: ________________

Phone number: (_______)________-__________ Fax number: (_______)________-__________

Credentialing contact name: ____

Phone number: (_______)________-__________ Fax number: (_______)________-__________

Street address: ____

City: ____State:__________ ZIP code: ________________

E-mail address: ____

Ownership/contract owned by: ____

Street address: ____

City: ____State:__________ ZIP code: ________________

NPI #:____

Tax ID number (TIN):____________________________________

Medicare certification number: ____

Check all that apply: ☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C (ambulatory surgery only)

Medicaid certification number: ____

DEA (federal) certificate number: ____________________________Expiration date: ______________________

Other applicable narcotic certificate (state CDS):

Certificate number: _______________________________ State: ___________ Expiration date _____________

Provide copies of the following documentation:

☐ W-9

☐ State license, business registration or certificate of occupancy (if applicable)

☐ Accreditation or certification certificates or letter (if applicable)

☐ If the facility is not accredited, provide the most recent CMS or State Survey/Inspection Report, including Corrective Action Plan and compliance letters.

☐ Clinical Lab Improvement Amendment (CLIA) (for laboratories only)

☐ Occupancy permit (urgent care and walk-in clinic only)

Note: If your facility has multiple locations, complete the Additional Locations Supplemental Form and include site-specific information and documentation for each location.

Professional/general liability insurance coverage (both are required)	
Do you have professional liability (malpractice) insurance coverage? ☐ Yes ☐ No Provide a copy of your current Professional Liability Insurance Certificate, including the carrier's name, effective date, expiration date, policy number and liability dollar limits. Or, provide the details below:	
Carrier's name:	
Policy effective date:	Policy expiration date:
Policy number:	
Amount of coverage per occurrence: $	Amount of coverage per aggregate: $
Do you have general liability insurance coverage? ☐ Yes ☐ No Provide a copy of your current General Liability Insurance Certificate, including the carrier's name, effective date and expiration date, policy number and liability dollar limits. Or, provide the details below:	

Carrier's name:	
Policy effective date:	Policy expiration date:
Policy number:	
Amount of coverage per occurrence: $	Amount of coverage per aggregate: $
Additional information or additional insurance coverage:	
☐ Additional professional liability (including patient comp. funds) ☐ Self-insured retention ☐ Excess coverage ☐ Umbrella	
Carrier's name:	
Policy effective date:	Policy expiration date:
Policy number:	
Amount of coverage per occurrence: $	Amount of coverage per aggregate: $

Check all the boxes that describe your facility. Then, circle the type of accreditation/certification your facility has. Provide copies of all certificates.

☐ Skilled nursing facility — TJC or CARF

☐ Home care agency — TJC or CHAP or ACHC

☐ Hospice agency — TJC or CHAP or ACHC

☐ Voluntary interruption of pregnancy center — TJC or AAAASF or AAAHC

☐ Urgent care facility — UCAOA

☐ Laboratory — CLIA

Facility is a draw site only? ☐Yes ☐No

☐ Comprehensive outpatient rehabilitation facility — TJC or CARF

☐ Outpatient physical/speech/occupational therapy facility — AAAASF or CARF

☐ Outpatient diabetic self-management training providers — ADA or IHS

☐ Portable X-ray suppliers — FDA

☐ Rural health clinics — AAAASF

☐ Diagnostic radiology center — ACR or AIUM or ICACTL or ICAML or ICANL

Services: ☐MRI ☐Mammography ☐Other: ____

☐ DME: — JCAHO

☐ Orthotics and prosthetics: — JCAHO, ABD or BOC

(For custom-made oral appliances (sleep apnea), Board of Dental Sleep is required)

☐ Birthing center: — JCAHO or CABC

☐ Sleep center: — AASM or ABSS

☐ Other: ____

You must answer all of the following questions. If you answer "yes" to any of them, you must provide an explanation on a separate page (attach it to this form).

1. In the past 5 years, has the facility had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed? Has the facility

voluntarily relinquished any item in anticipation of any of these actions? Are any of these actions pending for any of the following items?

A. State license — A. ☐Yes ☐No

B. Medicare, Medicaid, or other local, state, and/or federal government program participation — B. ☐Yes ☐No

C. HMO, PPO, or other health plan participation — C. ☐Yes ☐No

D. Other regulatory agency (e.g. Quality Improvement Organization, CLIA, OSHA, etc.) — D. ☐Yes ☐No

E. Accreditation organization (CLIA, TJC, etc.) — E. ☐Yes ☐No

2. In the past 5 years, has the facility been placed under temporary government-ordered management?

☐Yes ☐No

3. In the past 5 years, has the facility permitted the appointment of a receiver for its business or assets?

☐Yes ☐No

4. Is the facility affiliated with other health plans? ☐Yes ☐No If yes, which ones: ___________________

____

5. Total number of licensed beds: _________

6. Does the facility offer 24/7 emergency services? ☐Yes ☐No ☐ N/A

7. Is the facility wheelchair accessible? ☐Yes ☐No

8. Are there other services for the disabled? ☐Yes ☐No

9. Text telephony (TTY): ☐Yes ☐No

10. American Sign Language (ASL) ☐Yes ☐No

11. Mental/physical impairment services ☐Yes ☐No

12. Other disability services: ____

13. Foreign languages spoken at the facility: ____

14. Is the facility accepting new Medicaid patients? ☐Yes ☐No

15. Hours of operation:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
Hours (from-to)							

Additional location supplemental form

Complete this form if your facility has more than one location. Include a copy of shared documents (W9, professional/general liability, etc.) and state license for each location.

Additional location facility name: ____

Street address: ____

City: ____State:__________ ZIP code: ________________

Phone number: (_______)________-__________ Fax number: (_______)________-__________

E-mail: ____

Medicare certification number: ____

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C (ambulatory surgery only)

Additional location facility name: ____

Street address: ____

City: ____State:__________ ZIP code: ________________

Phone number: (_______)________-__________ Fax number: (_______)________-__________

E-mail: ____

Medicare certification number: ____

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C (ambulatory surgery only)

Additional location facility name: ____

Street address: ____

City: ____State:__________ ZIP code: ________________

Phone number: (_______)________-__________ Fax number: (_______)________-__________

E-mail: ____

Medicare certification number: ____

☐ Medicare Part A ☐ Medicare Part B ☐ Medicare Part C (ambulatory surgery only)