# ORGANIZATIONAL PROVIDER CREDENTIALING APPLICATION

## TYPE OF ORGANIZATION

□ Ambulatory Surgery Center
□ Home Health Agency
□ Hospital
□ Skilled Nursing Facility/Nursing Home
□ Durable Medical Equipment
□ Rural Health Clinic
□ Home Infusion
□ Other Inpatient Facility

## DEMOGRAPHIC INFORMATION

Facility Name**:** _____

Address: _____

City, State, Zip: _____

Phone: _____ On-Call Phone: _____ Fax: _____

Contact Person: _____Email: _____

Tax ID number: _____

NPI number: _____ Taxonomy Code: _____

## CREDENTIALING CONTACT INFORMATION

Name**:** _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Email: _____

## LICENSURE (Please attach copies to this application)

| | **Certificate or License Number** | **Expiration Date** |
|---|---|---|
| State License | _____ | _____ |

**ACCREDITATION** **(Please attach copies to this application)**

| | Certificate or License Number | Expiration Date |
|---|---|---|
| Medicare Certification | _____ | _____ |
| Medicaid Provider Number | _____ | _____ |
| The Joint Commission | _____ | _____ |
| CHAP | _____ | _____ |
| AAAHC | _____ | _____ |
| AAAASF | _____ | _____ |
| CARF | _____ | _____ |
| ACHC | _____ | _____ |
| HFAP/AOA | _____ | _____ |
| DNV/NIAHO | _____ | _____ |

**RESTRICTIONS**

Please list any license sanctions or regulatory agency sanctions:

_____

_____

_____

I attest and certify that I have completed the above application truthfully and that information given in or attached to this application is accurate and completed to the best of my knowledge. I understand that, as a condition to signing this attestation, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with UNIVITA.

Signature: _____ Date: _____

Printed Name and Title: _____

**PROFESSIONAL LIABILITY INSURANCE "UNIVITA" LISTED AS CERTIFICATE HOLDER**
**(Minimum limits of $500,000 / $1,000,000)**

Carrier Name: _____ Policy Number: _____

Effective Date: _____ Expiration Date: _____

Claims Limits: Occurrence: _____ Aggregate: _____

**GENERAL LIABILITY INSURANCE**

Carrier Name: _____ Policy Number: _____

Effective Date: _____ Expiration Date: _____

Claims Limits: Occurrence: _____ Aggregate: _____

**ADDITIONAL INFORMATION**

Please answer the following questions by checking the appropriate box:

1. Does your Company perform illegal drug screening on all staff employees and/or per diem employees?
   Yes _____ No _____

QUESTIONAIRE – If the answer to any of the following questions is yes, please provide details on a separate sheet.

2. Have criminal proceedings ever been initiated against your Company or its authorized representative(s)
   Yes _____ No _____

3. Has your Company ever been the subject of an investigation, suspended, sanctioned, has had limitations of privileges, any disciplinary actions, and/or otherwise restricted from participating in any private, state or federal health insurance program (for example Medicare or Medicaid)?
   Yes _____ No _____

4. In the last five years, have there been any professional liability suits, or are there currently any pending or potential suits against your Company, or have any judgments been made or settlements paid on its behalf?
   Yes _____ No _____

5. Has there been any disclosure of complaints or adverse action reports files with a local, state or national professional society or licensing board?
   Yes _____ No _____

6. Has there been any disclosure of refusal or cancellation of professional liability insurance?
   Yes _____ No _____

I attest and certify that I have answered the above application questions truthfully and that the information given in or attached to this application is accurate and completed to the best of my knowledge. I authorize the Company to collect any information necessary to verify the information provided in this credentialing application. I understand that, as a condition to completing this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with UNIVITA. I have acknowledged that I have received a copy of my rights as a Provider during credentialing.

Signature: _____ Date: _____

Print Name: _____ Title: _____

For Univita use only: Credentialing date: _____

**Please attach a copy of the following required documents / credentials:**

- Credentialing Application for each location included under this contract.
- Current Professional Liability Insurance & General Liability Insurance Certificate per location with Univita listed as a Certificate Holder.
- State License per location and Medicare / Medicaid Certification.
- Business License (DME only) and Medicare / Medicaid Certification.
- Accreditation Certificate, if applicable.
- Copy of AHCA Survey / State Survey / Inspection Report if not Accredited.
- W-9
- Ownership Disclosure Form

**If you have any questions regarding this Credentialing Application or the required documents / credentials please call Christopher Rodriguez at 954-333-1085 or email Crodriguez2@atenda.com**

## PROVIDER'S RIGHTS DURING CREDENTIALING

- Right to review information submitted to support their credentialing application.
- Right to correct erroneous information.
- Right to be informed of the status of their credentialing / re-credentialing upon request.
- Right to be notified about these rights.
- Contact Credentialing Department to receive further information.
- To initiate these rights contact 954-333-1085