ANCILLARY PROVIDER CREDENTIALING APPLICATION

Please complete each section thoroughly by typing or clear printing in blue or black ink.

Entity Legal Name:	Date
NPI	Tax ID

PLEASE INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION

☐ Copy of Business/Occupational License

☐ Copy of State Licensure/Certification

☐ Copy of other applicable State/Federal Licensures (e.g. CLIA,DEA, Pharmacy, or Department of Health)

☐ Copy of current general liability insurance policy face sheet, showing expiration dates, limits, and name

☐ Copy of accreditation/certification [e.g. joint Commission)

☐ Copy of Medicaid/Medicare Certification (if not accredited by an accrediting body)

☐ Copy of Site Evaluation Results by a governmental agency (If not accredited by a governmental agency)

☐ W9

☐ Signature requirement on pages 4

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment.

1. Entity Information

Entity Legal Name			DBA Name
Federal Tax ID#	**NPI#**	**State License#**	
Medicaid#	**Medicare#**	**States you are licensed to conduct business**	

Facility Type check all that apply

☐Hospital	☐Urgent Care Center	☐Home Health Agency	☐ DME:________________________
☐ Ambulatory Surgery Center	☐Skilled Nursing Facility	☐Home Infusion	☐Other:________________________

2. Administrative Information

Administrative Manager	Phone	Fax	Email
Billing Manager	**Phone**	**Fax**	**Email**
Credentialing Manager	**Phone**	**Fax**	**Email**

Misrepresentation of any statements and information provided by you in support of this application shall be considered fraudulent and may result in denial or revocation of appointment.

3. Location Information:

If you have more than one location please attach a listing and include all the information in this section.

Address (Building, Street, Suite #)		City
State	**Zip Code**	**County**
Phone	**Fax**	**Covered Counties**
Federal Tax ID#	**NPI#**	**State License#**
Medicaid#	**Medicare#**	**Handicap Access?**
		☐Yes ☐No

4. Billing Information:

Pay To Address (Street, Suite #, Building)		City
State	**Zip Code**	**County**
Phone	**Fax**	**Contact Name**

5. Sanctions:

If the answer to any of these questions is yes, please provide a full explanation of the details of each and every matter.

Question		
A. Have there been or are there currently pending and malpractice claims, suits, settlements or proceedings involving this organization?	☐ No	☐ Yes
B. Has this organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs?	☐ No	☐ Yes
C. Has this organization ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct?	☐ No	☐ Yes
D. Has this organization ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party, or a Regulatory Agency (CLIA, OSHA, OMIG, etc.)?	☐ No	☐ Yes
E. Has this organization's DEA Registration or State Controlled Substance Certificate ever been denied, suspended, or revoked for any reason?	☐ No	☐ Yes ☐ N/A
F. Has any officer of this organization ever been convicted of or plead guilty to any felony including an act of violence, child abuse or a sexual offense?	☐ No	☐ Yes
G. Has this organization, an officer or a board member ever been convicted of a felony?	☐ No	☐ Yes

ATTESTATION/AUTHORIZATION AND RELEASE OF INFORMATION

By submitting this attestation/authorization and release of information form in conjunction with the Ancillary Provider Credentialing Application (PCA) and the Attestation/Authorization, I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical/dental staff membership and/or participating status with the Health Care Entity indicated on the PCA for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and/or other qualifications.

2. I further understand and acknowledge that the Health Care Entity or designated Agent will investigate the information in this application. By submitting this application, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Health Care Entity as part of the verification and credentialing process.

3. I authorize all individuals, institutions, and entities or organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Health Care Entity (ies), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the requested clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the PCA Attestation/Authorization and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

6. I agree to exhaust all available procedures and remedies as outlined by in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Health Care Entity (ies) where I have membership and/or clinical privileges/participation.

7. I understand that completion and submission of the PCA Attestation/Authorization and Release of Information does not automatically grant me membership or clinical privileges/participating status with the Health Care Entity(ies) indicated on the PCA or Attestation/Authorization.

8. I further acknowledge that I have read and understand the foregoing Attestation/Authorization and Release of Information. A photocopy of this Attestation/Authorization and Release of Information shall be as effective as the original, and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation/authorization.

9. I release from liability any and all individuals and organizations who provide information to the credentialing entity in good faith and without malice concerning my professional qualifications and competence, and the credentialing entity, from liability for their acts performed and statements made relating but not limited to verifying, evaluating and acting upon my credentials and qualifications.

Print Name and Title: ____

Signature: ____ Date: __________________________

NOTE: Through above signature, I hereby affirm that contents are current, accurate, and complete as of the signature date.

Modification to the wording or format of the PCA/Attestation/Authorization and Release of Information may invalidate an application.

EZ Healthcare will treat this application and any information secured in connection therewith in strict confidence in accordance with the Entities' policies and/or Medical Staff Bylaws and preserves with all reasonable safeguards the privacy of the Applicant.