PREMERA | BLUE CROSS

ORGANIZATION/FACILITY CREDENTIALING/RECREDENTIALING APPLICATION

CURRENT COPIES OF DOCUMENTS TO BE SUPPLIED WITH COMPLETED APPLICATION INCLUDES:

- **Current accreditation certificates**
- **Current State license (issued by a State Department of Health or Human Services Division)**
- **Current Drug Enforcement Administration (DEA) certificate (as applicable)**
- **Current Liability Insurance face sheet/certificate or a letter if coverage is self-insured or copy of surety bond**

ORGANIZATION/FACILITY 1:

Name_____ Facility Type: _____

Complete Address_____

City _____ State _____ Zip Code _____

Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ NPI Number: _____

Contact Person _____ Phone _____ Fax _____

Contact Address _____

City _____ State _____ Zip Code _____

Email Address: _____ Does your facility provide language translation/interpreter services? □ Yes □ No

Licensure: Number _____ Is your license in good standing with the State? □ Yes □ No

Medicare: Number _____ Is your Medicare certification in good standing? □ Yes □ No Not Medicare certified □

DEA: Number _____ (If applicable to your organization/facility.)

Liability Insurance: Please provide a current copy of your liability insurance face sheet/certificate/surety bond which includes the Carriers Name, Name of Organization/Facility covered, Dates of Coverage and Amount of Coverage. For self-insured organizations/facilities, please provide a letter.

Accredited Facilities: ***Please provide a current copy of your accreditation certificate(s) and mark those that apply:***

- ❑ The Joint Commission (TJC)
- ❑ National Integrated Accreditation for Healthcare Organizations (NIAHO or DNV – Det Norske Veritas)
- ❑ American Osteopathic Association (AOA)
- ❑ Commission on Accreditation of Rehabilitation Facilities (CARF)
- ❑ Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
- ❑ Community Health Accreditation Program (CHAP)
- ❑ American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
- ❑ Accreditation Commission for Health Care, Inc. (ACHC)
- ❑ Oregon Hospice Association (OHA)
- ❑ Council on Accreditation (COA
- ❑ Healthcare Quality Association on Accreditation (HQAA)
- ❑ Other _____

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, Behavioral Health Facilities, Home Health Agencies/Home IV/Hospice, Ambulatory Surgical Centers, Birthing Centers.

Survey/audit documents must include:

- ❑ Any identified deficiencies
- ❑ Correction action plan(s)

Please Respond To The Following Questions:

Do you have a procedure/process in place to deal proactively with preventable patient errors or known potential errors? □ Yes □ No

Has the organization ever been convicted of a criminal offense related to healthcare? □ Yes □ No

Is the organization currently debarred, excluded, or otherwise ineligible for participation in Federal healthcare programs? □ Yes □ No

Does the facility have any current sanctions from any government agency? If yes, provide a detailed explanation and corrective actions. □ Yes □ No

ORGANIZATION/FACILITY 2:

Name_____ Facility Type: _____

Complete Address_____

City _____ State _____ Zip Code _____

Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ NPI Number: _____

Contact Person _____ Phone _____ Fax _____

Contact Address _____

City _____ State _____ Zip Code _____

Email Address: _____ Does your facility provide language translation/interpreter services? □ Yes □ No

Licensure: Number _____ Is your license in good standing with the State? □ Yes □ No

Medicare: Number _____ Is your Medicare certification in good standing? □ Yes □ No Not Medicare certified □

DEA: Number _____ (If applicable to your organization/facility.)

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- ❑ Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
- ❑ Community Health Accreditation Program (CHAP)
- ❑ American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
- ❑ Accreditation Commission for Health Care, Inc. (ACHC)
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ORGANIZATION/FACILITY 3:

Name_____ Facility Type: _____

Complete Address_____

City _____ State _____ Zip Code _____

Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ NPI Number: _____

Contact Person _____ Phone _____ Fax _____

Contact Address _____

City _____ State _____ Zip Code _____

Email Address: _____ Does your facility provide language translation/interpreter services? □ Yes □ No

Licensure: Number _____ Is your license in good standing with the State? □ Yes □ No

Medicare: Number _____ Is your Medicare certification in good standing? □ Yes □ No Not Medicare certified □

DEA: Number _____ (If applicable to your organization/facility.)

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ORGANIZATION/FACILITY 4:

Name_____ Facility Type: _____

Complete Address_____

City _____ State _____ Zip Code _____

Phone Number: _____ Fax Number: _____

Federal Tax ID Number: _____ NPI Number: _____

Contact Person _____ Phone _____ Fax _____

Contact Address _____

City _____ State _____ Zip Code _____

Email Address: _____ Does your facility provide language translation/interpreter services? □ Yes □ No

Licensure: Number _____ Is your license in good standing with the State? □ Yes □ No

Medicare: Number _____ Is your Medicare certification in good standing? □ Yes □ No Not Medicare certified □

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Does the facility have any current sanctions from any government agency? If yes, provide a detailed explanation and corrective actions. □ Yes □ No

For any other organizations/facilities that are part of your contract, including those listed below, please complete additional copies of the above form.

AUTHORIZATION/ATTESTATION:

I authorize and consent to the release of information necessary for evaluation of this application. I release from liability and hold harmless any person or organization furnishing such information.

I understand and agree that discovery of false or intentionally omitted material in this application may result in rejection of the application or termination of any contract awarded in consideration of this application.

I understand this submitted application will be considered in evaluating contracting or continued contracting status in networks sponsored by Premera Blue Cross.

I understand that medical records will be subject to inspection by representatives of Premera Blue Cross.

I understand that completion and submission of this application does not automatically grant me a contracted status in any Premera Blue Cross provider network, but that such status is dependent, in part, on evaluation and approval of this application. This application is not a contract.

I understand that until I am notified that this application is approved, and a written contract is in effect with Premera Blue Cross, I may not represent myself as a contracted provider in any Premera Blue Cross provider network. However, if I am already a contracted provider with Premera Blue Cross, I may continue in that status while evaluation of this application is pending.

I grant Premera Blue Cross staff or agent permission to conduct an on-site review with prior notification.

I certify that the information contained in this application is complete, accurate and true.

Authorized Signature	Date
Print Name	Title