HOSPITAL CREDENTIALING APPLICATION

SECTION I: PRACTICE INFORMATION

Name of Hospital: ____

Chief Executive Officer: ____

Address____
Street City

____
County State Zip Code

Office Telephone ( )________________________ Fax# ( )____________________________________

Office Manager's Name: ____

Tax ID# ______________________________ (Attach a copy of W9 form)

Medicare Provider #_____________________ Medicaid Provider #________________________________

National Provider ID #____________________

Locations not listed above:

____
Street City County Zip Telephone

____
Street City County Zip Telephone

What counties are included in your service area?

SECTION II

Any responses which cannot be included in the space provided may be included on supplementary attachments.

HOSPITAL
CREDENTIALING APPLICATION
PAGE 2

Quality

Please attach your current Quality Improvement Plan.

1. What is your patient satisfaction level? How is it measured?

2. How frequently is it measured?

3. Are you Medicare certified? If so, please attach a copy of your certification.

SECTION III

If your answer is YES to any of the following questions, please furnish details on a separate sheet.

1. Has a judgement or settlement ever been made against your company in a professional liability case, or are there any currently pending?

   ❑ YES ❑ NO If yes, Please give details on the attached form.

2. Has your company been suspended, sanctioned, fined, or restricted from participation as a Medicare or Medicaid provider?

   ❑ YES ❑ NO If yes, Please explain on a separate sheet.

Completed by: ____
Please Print

____
Signature Title Date

Please attach copies of the following documents (if applicable):

1 Proof of Professional Liability Coverage
2. Medicare Certificate
3. Accreditation Certificate (if applicable)
4. Quality Improvement Plan
5. W9 Form
6. State License (if applicable)
7. Services Available

COMMUNITY HEALTH PLAN
STATEMENT OF APPLICATION
(Please read carefully before signing)

All information submitted by me on behalf of the organization noted below in this Application, and all documentation submitted by me in support of this Application, is true to the best of my knowledge and belief. I fully understand that any misleading statement or material omission in this Application may constitute cause for denial of eligibility.

By applying for membership in Community Health Plan, I hereby authorize Community Health Plan and its representatives to seek relevant information, whether written or oral, from health maintenance organizations, health plans (including employer-sponsored), institutions, state licensing and other regulatory boards, and professional organizations with which our organization has been associated, and with others, including past and present malpractice carriers (Health Care and Related Entities), who may have information bearing on the professional competence, character, and ethical qualifications. I hereby further consent to the inspection by Community Health Plan and its representatives of all documents that may be material to an evaluation of the organization's qualifications and competence as well as moral and ethical qualifications for eligibility. I hereby further authorize all Health Care and Related Entities to release to Community Health Plan and its authorized representatives any information, whether written or oral, with respect to the organization's, status with such Health Care and Related Entities pursuant to a written request from Community Health Plan, or its authorized representative, that such information be provided.

I hereby release from liability all representatives of Community Health Plan for their acts performed in good faith and without malice in connection with evaluating the Application.

I understand and agree that our organization, as an applicant for membership in Community Health Plan, have the burden of producing adequate information for proper evaluation of our professional competence, character, ethics, and other qualifications and for resolving any doubts about such qualifications. As such, I will before and after approval of my Application, notify Community Health Plan in writing of any changes, errors or omissions with respect to the information I have provided in this Application.

I authorize any State Licensing Board to release any and all information regarding the organization's licensure, including any and all information regarding past or present, proved or alleged violations, complaints, letters of concern issued, reprimands and any past or present disciplinary actions relating to the organization's license.

A photocopy of this Certification, Authorization and Release shall be as effective as the original when so presented.

Organization: ____

Name and Title:____
(Please print or type)

Signature:____ Date:____________________