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COMMUNITY HEALTH PLAN

**FREE STANDING DIAGNOSTIC RADIOLOGY CENTER
CREDENTIALING APPLICATION**

Application Requirements:

1. Certification by The American College of Radiology
2. Baseline physician exam available on site (mammography only)
3. Ability to provide quarterly patient satisfaction data
4. Ability to provide quarterly patient outcome data by age group

SECTION I - PRACTICE INFORMATION

Name of Business: _____

Administrator: _____

Address: _____

Street City

County State Zip Code

Billing Address: _____

Street City

County State Zip Code

Office Telephone: () _____ Fax #: () _____

Office Manager's Name: _____

State License(s)#: _____

Tax ID# : _____

Medicare Provider #: _____ Medicaid Provider #: _____

Accreditation _____

Office Hours:

HOURS	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M.						
P.M.						

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Locations of all offices not listed on previous page:

Street	City	County	Zip	Telephone
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Street	City	County	Zip	Telephone
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Number of years of practice at current location: _____

List all languages spoken at office: _____

Do you have 24 hour call? Yes? No?

What radiology services do you provide?

MRI /MRA

Mammography

Nuclear Medicine

Ultrasound

Other:

SECTION II

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

Services

1. Do you provide pediatric services as well as adult? Yes? No?
2. Is a physician on duty at this facility during business hours?
3. What is your average time for obtaining an appointment after referral?

Quality

Please attach your current quality improvement plan.

1. Do you measure quality outcomes? Yes? No?

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**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 the Executive Vice-President of 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. This release authorizes any State Licensing Board to provide 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 my 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: _____