ANCILLARY PROVIDER NAME: ______________________________

CREDENTIALING REQUIREMENTS FOR ANCILLARY PROVIDERS	
PLEASE CHECK AND SUBMIT COPIES OF THE FOLLOWING	
	Organizational Chart
	W9 Form
	Accreditation Certificate, if applicable
	Occupational License(s)
	Applicable License(s)
	DEA Certificate, if applicable
	On-Call Emergency Procedures / Disaster Recovery Plan
	Oxygen Permit(s) Applicable License(s)
	(HIPAA) Notice of Privacy Practices
	Professional & General Liability Insurance Coverage – Declaration Page
	Proof of Workers Compensation Insurance Coverage – Declaration Page
	Copy of current State Controlled Dangerous Substance (CDS) Certificate (if applicable)
	Copy of NPI Letter

NOTE: Each facility baring a Tax ID Number will require a credentialing application. If there are multiple facilities under one Tax ID Number, please include them all on this application.

PLEASE REQUEST A CREDENTIALING FORM TO BE COMPLETED BY EACH LICENSED MD OR DO THAT WILL PROVIDE SERVICES AT THE ANCILLARY FACILITY.

PLEASE SUBMIT COPIES OF THE INFORMATION BELOW AS IS APPLICABLE TO THE ANCILLARY SERVICES PROVIDED BY YOUR FACILITY (only if not accredited)	
• Admission Process • Client's Right and Responsibilities • Client Satisfaction Measurement Tool • Most Recent Regulatory (AHCA) Survey	• Informed Consent • Patient Handbook • Right to Refuse Care
PLEASE HAVE AVAILABLE FOR REVIEW AT TIME OF SITE VISIT	
• Complaint / Grievance Policy • Professional Personnel's Licenses • Personnel Policy and Procedures	• Policy & Procedure Manuals • Quality Improvement Plan • Utilization Review Plan

1. ANCILLARY PROVIDER CREDENTIALING APPLICATION

Name:

Primary Address: *(Please note that checks will be sent to this address.)*

City: State: Zip Code:

Telephone #: Fax #:

Toll Free Telephone #: Toll Free Fax #:

Multiple Facilities: _____ NO _____ YES *If YES, And Under Same Tax ID # Complete Attachment A*

If Yes, Do You Have Centralized Intake? ___ NO ___ YES Phone Number _______________ Fax Number ________________

E-mail Address:	Web Site:
Federal Tax I.D. #:	Date When Company Began Operations:
Administrator:	Facility Manager:

Hours of Operations: Posted ___ NO ___ YES 24 Hours Availability ______ NO _______ YES

Date: Are you a Minority Owned Business? _____ NO _____ YES
If Yes, are you Certified? _____ NO _____ YES Expiration ____________________

Medicare Provider: _____ NO _____ YES Number________________________ # of Years ____________

Medicaid Provider: _____ NO _____ YES Number________________________ # of Years ____________

NPI Number: ___________________________

If not participating, does your facility plan to participate? ____ NO ____ YES Date: ________________

State License #: Expiration Date:

If HME please provide Compressed Medical Gas Manufacturer Permit #: Expiration Date:

Please indicate your staff's multilingual and multicultural capabilities (e.g. languages spoken) other than English:

___ Spanish ___ Creole Other ____

2. LICENSED PERSONNEL

Please indicate licensed personnel employed by your company: *(use separate sheet of paper if necessary)*

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

Name: _____________________________________ Type: ______________ License #: _________________Exp. Date: ______________

3. SERVICES PROVIDED

_____ Ambulance
_____ Audiology Services
_____ Community Resources
_____ Day Activity / Health Services
_____ Dialysis
_____ Dialysis / Renal Care- Medicare Approved
_____ Dietitian / Nutritional Services
_____ Early Childhood Intervention
_____ Emergency Response Systems
_____ Family Planning Services
_____ Fetal Monitoring Services
_____ Genetic Services
_____ Hearing Aids
_____ Hemophilia Center
_____ Home Health Agency
_____ Home Infusion Therapy
_____ Home Medical Equipment
_____ Hospice Care – Outpatient
_____ Imaging Facility
_____ Interpreter Services
_____ Laboratory
_____ Lithotripsy Services
_____ Occupational Therapy Services
_____ Orthotics and Prosthetics
_____ Outpatient Rehab Center
_____ Personal Assistance Services (By Home Health Agency)
_____ Physical Therapy Services
_____ Radiology Facility
_____ Respite Care
_____ Sleep Disorder Clinic
_____ Speech Therapy Services
_____ Transportation – non emergency
_____ Transportation - emergency
_____ Women Health Services
_____ Ambulatory Surgical Center
_____ Birthing Center
_____ Freestanding Emergency Room
_____ Hospice Facility
_____ Hospital
_____ Inpatient Rehab Hospital
_____ Nursing Home / Skilled Nursing Facility
_____ Sub-acute / Intermediate Care Facility
_____ Trauma Center
_____ Other ______________________________________

4. SCOPE OF SERVICES/COUNTIES

In the space provided below, please delineate the Ancillary Services which you provide at your facility(s). Include any limitations. If you should require extra space please use a separate sheet.

____

____

____

____

____

____

PLEASE INDICATE THE COUNTIES IN WHICH YOUR ORGANIZATION WILL BE PROVIDING SERVICES

____

____

____

____

5. COMPLIANCE QUESTIONNAIRE	YES	NO
Does your organization have a formal quality assurance program?		
Does your organization have a formal infection control plan?		
Does your organization have a formal safety plan?		
Does your organization comply with all OSHA guidelines (as applicable)?		
Does your organization have policies and procedures for patient grievance and resolution?		
Are the credentials, certifications and/or licenses of personnel involved in the care and/or treatment of patients verified by your organization prior to employment or contract?		
Are the credentials, certifications and/or licenses of personnel involved in the care and/or treatment of patients re-verified by your organization at least every three years or at expiration?		
Does your organization have a formal emergency-preparedness plan designed to provide continuity of necessary operations in the event of disaster or emergency?		
Does your organization comply with current employment/labor laws?		
Does your organization have a formal program or process for the maintenance of a drug free working environment?		
Does your organization comply with all guidelines of the Americans with Disabilities Act?		
Do you question prospective employees/independent contractors as to any previous involvement in professional/malpractice litigation?		
Do you run background checks on all personnel (employed and/or contracted) who enter a patient's home (if applicable)?		
Are you able to provide / deliver same day urgent services, 24 hours a day / 7 days a week?		

6. PROVIDER DATA RECORD	YES	NO
Have you had any Medicare / Medicaid sanctions within the past 10 years?		
Has your organization or any member of your staff ever been expelled, excluded, or suspended from any federal program or from service reimbursement under Medicare or Medicaid?		
Are there any actions contemplated or pending against this organization by any government agency, professional group, institution, or other entity?		
Has your organization's professional liability coverage ever been restricted, limited, denied or cancelled?		
Has any insurance carrier ever made an out-of-court settlement or paid a judgment on a professional liability claim on your organization's behalf?		
At present or during the last five years, has this organization been part of any legal proceedings?		
Do you have any litigation pending?		
Have there ever been any actions against your organization's license, accreditation, certifications or permits or the license of any member of your staff, including restrictions, limitations, denial, suspension, revocation or cancellation?		
Has your organization or any member of your staff ever been convicted of or pleaded no contest to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?		
Has your organization ever lost its accreditation status?		
Does any staff member of your organization have a history of chemical dependency or substance abuse or currently abuses drugs and/or alcohol?		
If you have answered YES to any of the above questions, please provide details on a separate sheet of paper		

7. INSURANCE INFORMATION		
Professional Liability Carrier:	Coverage:	Exp Date: ______ / ______ / _____
General Liability Carrier:	Coverage:	Exp Date: ______ / ______ /
Worker's Compensation Carrier:	Coverage:	Exp Date: ______ / ______ / ____
Please submit a copy of each insurance policy declaration page indicating current status and coverage amount		

8. ACCREDITED ORGANIZATION	NUMBER OF YEARS OF ACCREDITATION	EXPIRATION DATE
		_____ / ______ / _____
Please submit copies of all certificates of accreditation, per location		

If not accredited, does the organization plan to achieve accreditation in the future? _____NO _____YES

If Yes, what is the expected date of review? ____

What accreditation will be sought? ____

9. PROFESSIONAL REFERENCES Please submit two professional references from managed care or insurance companies	
Company:	Company:
Address:	Address:
Telephone:	Telephone:
Contact Person:	Contact Person:

I hereby attest that all information provided in this or in connection with this application is complete and accurate to the best of my knowledge, and I shall immediately notify Renaissance Health Systems of Florida, Inc. (Renaissance) of any changes thereto. I understand that this application does not entitle me to participate in Renaissance's Health Systems in Florida. By applying for appointment as a Renaissance Participating Provider, I authorize its Medical Director, and appropriate representatives to consult with administrators and members of medical staffs of hospitals and/or other institutions where I currently have or have had admitting privileges and others with which I have been associated with, including past and present malpractice carriers who may have information bearing on my professional competence, character and ethical qualifications. I herby further consent to the inspection by Renaissance Health its medical director and appropriate representatives of all records and documents, excluding medical records of non-members of Renaissance at other hospitals, that may be material to an evaluation of any professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for Participating Provider status with Renaissance I hereby release Renaissance Health Systems of Florida, Inc. and its representatives from liability for their acts performed in good faith and without malice in connection with evaluating my application, credentials and qualifications. I hereby release any individual and organizations from any liability who provided information to Renaissance or its staff in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information By executing this application, I confirm that I am bound by the terms of the Primary Care Provider Agreement or Specialty Care Provider Agreement, as such terms may be applicable to me.

I understand that as an applicant for participation in Renaissance Health Systems of Florida, Inc., I have the right to review information obtained from primary verification sources during the credentialing process. I further understand that upon notification from Renaissance, I have their right to explain any information obtained that may vary substantially from that provided by me and correct any erroneous information submitted by another party. This shall be accomplished by my submission of a written explanation or y appearance before the Credentialing Committee, if they so request. I further understand that I may appeal the Committee's decision either in writing or by appearance before the Credentialing Committee, if they so request.

10. Practitioner Signature (REQUIRED)	Date (REQUIRED)

11. PLEASE LIST ALL LOCATIONS

If there are multiple locations, please copy and complete pages 3 & 4 of this application per location

Location 1.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
License # ________________	Medicare # _________________	Medicaid # ____________________
Location 2.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
License # ________________	Medicare # _________________	Medicaid # ____________________
Location 3.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
License # ________________	Medicare # _________________	Medicaid # ____________________
Location 4.		
Address:		
City:	State:	Zip Code:
Telephone #:	Fax #:	
Toll Free Telephone #:	Toll Free Fax #:	
License # ________________	Medicare # _________________	Medicaid # ____________________

12. RELEASE OF INFORMATION

In order for Renaissance Health Systems of Florida, Inc. (RHS) to access and verify our professional qualifications and suitability for contract, I hereby authorize RHS to make inquiries and consult with all persons, places of employment and education, malpractice carriers, State licensing Boards and all other agencies who may have information bearing on ethical and professional qualifications and competence to carry out the contracted duties we have requested. I authorize release of all such information and copies of related records and/or documents to RHS.

I authorize RHS to disclose to such persons, institutions, boards or other agencies any identifying information about our company to efficiently enable RHS to make such appropriate inquiries.

I release from liability all those who provide information to RHS in good faith and without malice in response to such inquiries.

______________________________	______________________________
Signature	Date
______________________________	______________________________
Printed Name	Title
______________________________	
Policy Number	

18. VERIFICATION OF PROFESSIONAL LIABILITY

By completing and signing this form, the undersigned provider agrees to authorize its current Professional Insurance Carrier to release verification and renewal of professional liability insurance to *Renaissance Health Systems*.

Renaissance Health Systems, is to hereinafter, as Certificate Holder, to be notified of the amount of my coverage and any future changes in our company's insurance status, to include all information regarding claims history (but not necessarily limited to judgments entered, claims settled, cases and lawsuits pending), and any restriction regarding specific privileges which may be excluded from our coverage.

We will notify *Renaissance Health Systems* of any changes in Professional Liability carriers so that another Verification of Professional Liability form can be completed.

____ ____________________
Administrator's Signature Date

____
Printed Name

____ ____________________
Enter Current Professional Liability Insurance Carrier Name Policy Number

____
Enter Street Address City State & Zip