HEALTH PLANS
UNIVERSITY OF UTAH

Organizational Provider Credentialing Application

ORGANIZATION INFORMATION	
Legal name of Organization/Parent Company (Legal name listed with IRS)	
DBA Name of Organization (if applicable)	
Organization Medicare # *(primary)*	**Organization Medicaid #** *(primary)*
Organization TIN *(primary)*	**Organization NPI** *(primary)*
Ownership Type: ◯ Sole Proprietorship ◯ City / County / State Owned ◯ Corporate/LLC/Partnership ◯ Federally Owned	
Credentialing Address *(Enter Mailing Address if not Credentialing Address)* Street Address: _____ Address Line 2: _____ City: _____ State: _____ Zip: _____ Contact: _____ Email: _____ Phone: _____	**Billing Address** *(If different than Credentialing Address)* Street Address: _____ Address Line 2: _____ City: _____ State: _____ Zip: _____ Contact: _____ Email: _____ Phone: _____

LOCATION #1		
Address: (choose both, if applicable) ◯ Primary Address ◯ Mailing		
Organization Name (DBA):		
Group NPI Number:		
Street Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Contact Name:	**Email Address:**	
Phone Number:	**Fax number:**	
Location is handicap accessible? ◯ Yes ◯ No	**Location offers pediatric services?** ◯ Yes ◯ No	
Describe your service area: *(States, Counties, Cities, etc.)*		
Describe your office hours at this location:		
List any languages spoken by office personnel:		
Does the location provide language translation/interpretation services? ◯ Yes ◯ No		
Practice limitations: *(e.g., age, gender, etc.)*		

HEALTH PLANS
UNIVERSITY OF UTAH

LOCATION #2		
Address: (choose both, if applicable) ◯ Mailing ◯ Additional Location	***If Organization has more than 3 locations, please make additional copies of page 2.***	
Facility/Organization Name (DBA):		
NPI Number:	**Effective Date:**	
Street Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Contact Name:	**Email Address:**	
Phone Number:	**Fax number:**	
Location is handicap accessible? ◯ Yes ◯ No	**Location offers pediatric services?** ◯ Yes ◯ No	
Describe your service area: *(States, Counties, Cities, etc.)*		
Describe your office hours at this location:		
List any languages spoken by office personnel:		
Does the location provide language translation/interpretation services? ◯ Yes ◯ No		
Practice limitations: *(e.g., age, gender, etc.)*		

LOCATION #3		
Address: (choose both, if applicable) ◯ Mailing ◯ Additional Location		
Facility/Organization Name (DBA):		
NPI Number:	**Effective Date:**	
Street Address:		
City:	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**	
Contact Name:	**Email Address:**	
Phone Number:	**Fax number:**	
Location is handicap accessible? ◯ Yes ◯ No	**Location offers pediatric services?** ◯ Yes ◯ No	
Describe your service area: *(States, Counties, Cities, etc.)*		
Describe your office hours at this location:		
List any languages spoken by office personnel:		
Does the location provide language translation/interpretation services? ◯ Yes ◯ No		
Practice limitations: *(e.g., age, gender, etc.)*		

HEALTH PLANS
UNIVERSITY OF UTAH

STATE LICENSE(S) AND/OR STATE REGISTRATION(S) – *Attach a copy of all*					
Type of Credential	**State**	**Number**	**Issue Date**	**Expiration Date**	**Most Recent Survey Date**
State License					
State Registration					
CLIA#					
Other:					

ACCREDITATION / CERTIFICATION (*check all that apply*)

Please provide a copy of your most recent accreditation or Centers of Medicare and Medicaid (CMS) survey with any site visit corrections showing that your facility is in compliance.

*Please check here if your organization **IS** or **IS NOT** accredited or certified by CMS.*

◉ *Yes, our organization is accreditted.* ○ *No, our organization is NOT accreditted. If you check this box, a site visit will be scheduled prior to completing credentialing.*

Accreditation Organization	**Date of Last Survey**
○ (CMS) Medicare Certification (attach most recent survey and acceptance letter)	
○ (AAAHC) Accreditation Association for Ambulatory Health Care	
○ (ACHC) Accreditation Commission for Health Care	
○ (AAAASF) American Association for Accreditation of Ambulatory Surgery Facilities	
○ (ABCOP) American Board for Certification in Orthotics/Prosthetics	
○ (ACR) American College of Radiology	
○ (ASHI) American Society for Histocompatibility and Immunogenetics	
○ (BOC) Board of Certification / Accreditation, International (O&P or DMEPOS)	
○ (CAP) College of American Pathologists	
○ (CARF) Commission on Accreditation of Rehabilitation Facilities	
○ (COLA) Committee of Laboratory Accreditation	
○ (CHAP) Community Health Accreditation Program	
○ (CT) The Compliance Team	
○ (COA) Council on Accreditation	
○ (DNV) Det Norske Veritas	
○ (HFAP) Healthcare Facilities Accreditation Program - AOA	
○ (HQAA) Healthcare Quality Association on Accreditation	
○ (IAC) The Intersocietal Accreditation Commission	
○ (NABP) National Association of Boards of Pharmacy	
○ (NBAOS) National Board of Accreditation for Orthotics Suppliers	
○ (NCQA) National Commission for Quality Assurance	
○ (TJC) The Joint Commission	
○ (URAC) URAC, (aka, American Accreditation Healthcare Commission)	
○ (CABC) Commission for the Accreditation of Birth Centers	
○ (PPFA) Planned Parenthood Federation of America	

HEALTH PLANS
UNIVERSITY OF UTAH

LIABILITY INSURANCE	
Insurance Carrier:	**Phone Number:**
Policy Number:	**Dates of Coverage:**
Dollar Amount:	**Dollar Amount Aggregate:**
Please provide a copy of your current professional and general liability insurance.	

ORGANIZATIONAL PROVIDER TYPE	
○ Sleep Study Center/Lab	○ Hospital ☐ Acute Care ☐ Critical Access
○ Residential Treatment Facility ☐ Chemical Dependency/Substance Abuse: Indicate level of care provided: ☐ Mental Health: Indicate level of care provided: ☐ Other	
○ Agencies ☐ Home Health ☐ Hospice ☐ Home Infusion Therapy	○ Laboratory
○ Kidney Dialysis Center	○ Skilled Nursing Facility
○ Ambulatory Care Clinics/Center ☐ Ambulatory Surgical Center ☐ Urgent Care ☐ Speech Therapy ☐ Rural Health Clinic ☐ Oral and Maxillofacial Surgery ☐ Oncology-Radiation ☐ Ophthalmologic Surgery ☐ Occupational Therapy ☐ Endoscopy ☐ Mental Health - Outpatient ☐ Lithotripsy ☐ End-Stage Renal Disease (ESRD)/Dialysis ☐ Federally Qualified Health Center (FQHC) ☐ Physical Therapy ☐ Radiology / Medical Imaging Center (Free Standing/Mobile) ☐ Birthing Center ○ Institutional Affiliated ○ Free Standing ○ Home Based ☐ Public Health – Federal ☐ Public Health – State or Local	○ Supplier ☐ DME ☐ Hearing Aid Equipment ☐ Eyewear ○ Other:_____

HEALTH PLANS
UNIVERSITY OF UTAH

ATTESTATION AND RELEASE OF INFORMATION

RELEASE OF INFORMATION

As part of the application process and for the purpose of verifying any information provided on this application. I, the undersigned authorized agent of the applicant facility/organization, grant University of Utah Health Plans permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize University of Utah Health Plans to request, receive and inspect any and all records pertinent to consideration of this application.

As a University of Utah Health Plans facility/organization applicant, I the undersigned authorized agent, acknowledged that I am required to supply University of Utah Health Plans with verification if current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION

I hereby grant permission for University of Utah Health Plans to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support University of Utah Health Plans quality improvement and utilization review programs.

ATTESTATION QUESTIONNAIRE

1. ☐ Yes ☐ No Has the facility ever had or currently have pending, any legal actions excluding medical malpractice?
2. ☐ Yes ☐ No Has the facility ever been convicted of a crime, excluding misdemeanors?
3. ☐ Yes ☐ No Has any government agency ever investigated, suspended, revoked, or taken other actions against your license to conduct business?
4. ☐ Yes ☐ No At any time, has any license or certification ever been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now under way?
5. ☐ Yes ☐ No At any time, has the facility been assessed a penalty, conviction or suspension or is the facility currently under investigation by the Medicaid or Medicare programs?
6. ☐ Yes ☐ No At any time, have the third party payers ever revoked, reduced, denied, or suspended your facility's participation due to inappropriate utilization management or any quality of care issues?
7. ☐ Yes ☐ No Has any managing employee or person with an ownership or control interest been excluded from participation in a government program (e.g., Medicare, Medicaid)?
8. ☐ Yes ☐ No This facility complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

EXCLUSION CERTIFICATION

I hereby certify that the online exclusions lists for the Health and Human Services, Office of Inspector General (OIG) and General Services Administration (GSA) are checked for all new hires and monthly for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above-referenced lists from any work related to a Federal health care program. The OIG exclusion list can be found at http://exclusions.oig.hhs.gov/. The GSA exclusion list can be found at https://www.sam.gov/.

Authorized Signature or Facility ▶	**Date**
Print Name	**Title**

RELEASE OF INFORMATION AND AUTHORIZATION

I hereby certify that all responses and information provided pursuant to the above questions and requests are complete, accurate and current to the best of my knowledge and belief. I acknowledge that any misstatements in or omissions from this application constitute cause for denial or summary dismissal. Further, I give permission to verify the organizational providers' credentials and by doing do hereby authorize release of the requested information concerning the organizational provider's licensing, certification and accreditation. I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Authorized Signature or Facility ▶	**Date**
Print Name	**Title**