ConnectiCare

HEALTH DELIVERY ORGANIZATION INFORMATION FORM

INSTRUCTIONS

Please complete and submit this form with attachments as outlined below or send directly to your contracting representative. Contracts will not be completed until credentialing is completed. Credentialing approval, however, **does not** constitute finalization or approval of your contract and network participation.

- **Please make sure to answer every question. Incomplete forms will not be processed.**
- **Information listed below must accompany a completed application:**
    - Current organizational or facility licenses/certifications/registrations
    - Current professional liability insurance face sheet **(min. $1million/occurrence and $3 million/aggregate)**, or general liability if professional is unavailable.
    - W-9 form(s) showing all federal Tax Identification Numbers (TINs) used by the organization/facility.
- **Please submit a copy of one of the following documents if your organization is not accredited but is required to be certified by the Centers for Medicare & Medicaid Services (CMS) or the state.**
    - Most recent CMS or state on-site survey results
    - Letter verifying approval of CMS participation
- **Non-accredited Skilled Nursing Facilities, Home Health Agencies, or Ambulatory Surgical Centers** must submit their most recent annual state or Medicare survey in lieu of accreditation. *To avoid a delay in processing, include it with your completed application.*
- **Please e-mail this form and all attachments to CCICredentialing@connecticare.com; fax it to 866-561-9260; or mail to:**

ConnectiCare
Attn: Network Operations
175 Scott Swamp Road
Farmington, CT 06032-3124

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Organization name: _____

Organization specialty: (**Credentialing sign-off required)*

Ambulatory surgery center* ☐ Free standing ☐ Office based	☐ Other	☐ Radiology center a) ☐ Advanced radiology (AR) (*Also select if provider performs <u>both</u> advanced and non-advanced radiology)* b) ☐ Non-advanced radiology c) ☐ Both (a & b) d) ☐ Hospital outpatient radiology
☐ Birthing center*	☐ Hospice*	☐ Outpatient PT/ST/OT
☐ Dialysis center*	☐ IV infusion facility*	☐ Home health agency*
☐ Durable medical equipment	☐ Skilled nursing facility*	☐ Walk-in/urgent care

Service description:

Primary practice address:

Street Address:_____City: _____

State: _____ Zip:_____County: _____

Phone Number: (____) _____ Fax Number: (_) _____

Please list the hours of operation: o **24 hours/7 days**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Does your organization provide services at locations other than the primary address? ☐ Yes ☐ No ☐ N/A

If "Yes", then please complete the Addendum section of this form for **<u>each</u>** additional service location.

Languages spoken (other than English)?

☐ Yes _____ ☐ No

Does your organization provide translator or interpreter services?

☐ Yes ☐ No ☐ N/A

Does your organization have wheelchair access? ☐ Yes ☐ No ☐ N/A

If you answer "n/a or "no" to any of the above questions, please explain the process to assist clients with these needs:

Mailing address: (*if different from above)*	**Payment address:** (*if different from above)*

Federal tax ID#: _____ Medicare provider# _____

NPI#:_____Taxonomy#_____

Medicare legacy #_____ASC# (*For ambulatory surgical centers only)* _____

Name of administrator:_____E-mail address: _____

Phone number: (_ _) _____ Fax number: (____) _____

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Business contact:_____E-mail address: _____

Phone number: (_ _)_____Fax number: (_ _) _____

License information:

State	License type	License number/facility operating certificate	Issue date	Expiration date

Accreditation information:

Accrediting body	Accreditation status	Expiration date (mm/dd/yy)

Are all patient service locations/satellite sites accredited? ☐ Yes ☐ No ☐ N/A

- If the organization is not accredited, are there plans to apply for accreditation?

☐ Yes ☐ No ☐ N/A

If "No", then please explain:

Before submitting, please check the form for completeness and be sure to include the required attachments listed on page 1.

Contact Information

_____	_____
Authorized signature	Date
_____	_____
Print name/title	Phone
_____	
E-mail address	

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ADDENDUM

To be completed ONLY to list additional service locations.

Type of organization: (**Credentialing sign off required)*

Ambulatory surgery center* ☐ Free standing ☐ Office based	☐ Other	☐ Radiology center a) ☐ Advanced radiology (AR) b) ☐ Non-advanced radiology c) ☐ Both (a & b) d) ☐ Hospital outpatient radiology
☐ Birthing center*	☐ Hospice*	☐ Outpatient PT/ST/OT
☐ Dialysis center*	☐ IV infusion facility*	☐ Home health agency*
☐ Durable medical equipment	☐ Skilled nursing facility*	☐ Walk-in/urgent care

Organization name: _____

Medical director: _____

Name of administrator: _____

Phone number: (_____)_____ Fax number: (_____) _____

Federal tax ID#:_____ Medicare provider#: _____

NPI#:_____ Taxonomy#: _____

Practice Address:

Street _____

City _____ State_____ Zip_____

County_____

Phone number: (_____)_____ Fax number: _____

Please list hours of operations: ☐ **24 hours/7 days**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

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Does your organization have wheelchair access? ☐ Yes ☐ No ☐ N/A

If you answer "n/a or "no" to any of the above questions, please explain the process to assist clients with these needs:

Languages spoken (other than English)?

☐ Yes _____ ☐ No

Does your organization provide translator or interpreter services? ☐ Yes ☐ No ☐ N/A

Please complete the following sections <u>ONLY</u> if it differs from the information provided on pages 3 & 4.

State	License type	License number/facility operating certificate	Date of issue	Date of expiration

New York only: Permanent facility identifier number: _____
NY surcharge provider? ☐ Yes ☐ No

Accreditation information:

Accrediting body	**Accreditation status**	**Expiration date (mm/dd/yy)**

Are all patient service locations/satellite sites accredited? ☐ Yes ☐ No ☐ N/A

- If the organization is not accredited, are there plans to apply for accreditation?

☐ Yes ☐ No ☐ N/A

If "No", then please explain: