VANTAGE HEALTH PLAN
FACILITY CREDENTIALING APPLICATION

GENERAL INFORMATION

Primary Practice Facility Location

The type of application being submitted: ☐ **Initial Credentialing** ☐ **Re-Credentialing**

Please choose facility type (check all that apply):

- ☐ **Hospital (Acute, Critical, or Rural)**
- ☐ **Rehabilitation Center**
- ☐ **Laboratory**
- ☐ **Diagnostic Imaging Center**
- ☐ **Rural Health Clinic (RHC)**
- ☐ **Federally Qualified Health Center (FQHC)**
- ☐ **Skilled Nursing Facility**
- ☐ **Hospice**
- ☐ **Home Health Agency**
- ☐ **Long Term Acute Care (LTAC)**
- ☐ **Dialysis Center**
- ☐ **Durable Medical Equipment (DME)**
- ☐ **Ambulatory Surgical Center**
- ☐ **Sleep Center**
- ☐ **Therapy Center**
- ☐ **Other** _____

Legal Business Name (as reported to the IRS): _____

Doing Business As (DBA) Name , if applicable: _____

Tax Identification Number (TIN): _____ National Provider Identifier (NPI): _____

CMS Certification Number (Medicare Number): _____

Facility Address, Suite #: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

Facility Phone Number: _____ Fax Number: _____ Office email: _____

Remittance Address (payments will be made to this address), Suite #: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

SERVICES / STAFFING

Indicate which of the skilled services the facility provides (check all that apply):
Services that are in **BOLD**, *please provide an accurate certified bed count.*

- ☐ **Critical Care Services – Intensive Care Units (ICU)** **Bed Count:** _____
- ☐ **Acute Inpatient Hospitals** **Bed Count:** _____
- ☐ **Inpatient Psychiatric Facility Services** **Bed Count:** _____
- ☐ **Skilled Nursing Facilities** **Bed Count:** _____
- ☐ Inpatient Substance Abuse
- ☐ Orthotics and Prosthetics
- ☐ Home Health
- ☐ Durable Medical Equipment
- ☐ Outpatient Infusion / Chemotherapy
- ☐ Laboratory Services
- ☐ Outpatient Mental Health
- ☐ Outpatient Substance Abuse
- ☐ Cardiac Surgery Program
- ☐ Cardiac Catheterization Services
- ☐ Outpatient Dialysis
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Heart Transplant Program
- ☐ Heart / Lung Transplant Program
- ☐ Intestinal Transplant Program
- ☐ Kidney Transplant Program
- ☐ Liver Transplant Program
- ☐ Lung Transplant Program
- ☐ Pancreas Transplant Program
- ☐ Diagnostic Radiology
- ☐ Mammography
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy

For hospitals with fifty (50) beds or more: Does the hospital participate with a patient safety organization? ☐ Yes ☐ No
If yes, please fill out the attached Hospital Patient Safety Attestation Statement or provide proof of participation.

Does the facility currently accept new or existing Medicaid patients? ☐ Yes ☐ No

***Attach a copy of a current staff roster.

Secondary Practice Facility Location

Please choose facility type (check all that apply):

- ☐ **Hospital (Acute, Critical, or Rural)**
- ☐ **Rehabilitation Center**
- ☐ **Laboratory**
- ☐ **Diagnostic Imaging Center**
- ☐ **Rural Health Clinic (RHC)**
- ☐ **Federally Qualified Health Center (FQHC)**
- ☐ **Skilled Nursing Facility**
- ☐ **Hospice**
- ☐ **Home Health Agency**
- ☐ **Long Term Acute Care (LTAC)**
- ☐ **Dialysis Center**
- ☐ **Durable Medical Equipment (DME)**
- ☐ **Ambulatory Surgical Center**
- ☐ **Sleep Center**
- ☐ **Therapy Center**
- ☐ **Other** _____

Legal Business Name (as reported to the IRS): _____

Doing Business As (DBA) Name , if applicable: _____

Tax Identification Number (TIN): _____ National Provider Identifier (NPI): _____

CMS Certification Number (Medicare Number): _____

Facility Address, Suite #: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

Facility Phone Number: _____ Fax Number: _____ Office email: _____

Remittance Address (payments will be made to this address), Suite #: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

SERVICES / STAFFING

Indicate which of the skilled services the facility provides (check all that apply):
Services that are in **BOLD***, please provide an accurate certified bed count.*

- ☐ **Critical Care Services – Intensive Care Units (ICU)** **Bed Count:** _____
- ☐ **Acute Inpatient Hospitals** **Bed Count:** _____
- ☐ **Inpatient Psychiatric Facility Services** **Bed Count:** _____
- ☐ **Skilled Nursing Facilities** **Bed Count:** _____
- ☐ Inpatient Substance Abuse
- ☐ Orthotics and Prosthetics
- ☐ Home Health
- ☐ Durable Medical Equipment
- ☐ Outpatient Infusion / Chemotherapy
- ☐ Laboratory Services
- ☐ Outpatient Mental Health
- ☐ Outpatient Substance Abuse
- ☐ Cardiac Surgery Program
- ☐ Cardiac Catheterization Services
- ☐ Outpatient Dialysis
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Heart Transplant Program
- ☐ Heart / Lung Transplant Program
- ☐ Intestinal Transplant Program
- ☐ Kidney Transplant Program
- ☐ Liver Transplant Program
- ☐ Lung Transplant Program
- ☐ Pancreas Transplant Program
- ☐ Diagnostic Radiology
- ☐ Mammography
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy

For hospitals with fifty (50) beds or more: Does the hospital participate with a patient safety organization? ☐ Yes ☐ No
If yes, please fill out the attached Hospital Patient Safety Attestation Statement or provide proof of participation.

Third Practice Facility Location

Please choose facility type (check all that apply):

- ☐ **Hospital (Acute, Critical, or Rural)**
- ☐ **Rehabilitation Center**
- ☐ **Laboratory**
- ☐ **Diagnostic Imaging Center**
- ☐ **Rural Health Clinic (RHC)**
- ☐ **Federally Qualified Health Center (FQHC)**
- ☐ **Skilled Nursing Facility**
- ☐ **Hospice**
- ☐ **Home Health Agency**
- ☐ **Long Term Acute Care (LTAC)**
- ☐ **Dialysis Center**
- ☐ **Durable Medical Equipment (DME)**
- ☐ **Ambulatory Surgical Center**
- ☐ **Sleep Center**
- ☐ **Therapy Center**
- ☐ **Other** _____

Legal Business Name (as reported to the IRS): _____

Doing Business As (DBA) Name , if applicable: _____

Tax Identification Number (TIN): _____ National Provider Identifier (NPI): _____

CMS Certification Number (Medicare Number): _____

Facility Address, Suite #: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

Facility Phone Number: _____ Fax Number: _____ Office email: _____

Remittance Address (payments will be made to this address), Suite #: _____

City: _____ State: _____ Zip: _____ County/Parish: _____

SERVICES / STAFFING

Indicate which of the skilled services the facility provides (check all that apply):
Services that are in **BOLD***, please provide an accurate certified bed count.*

- ☐ **Critical Care Services – Intensive Care Units (ICU)** **Bed Count:** _____
- ☐ **Acute Inpatient Hospitals** **Bed Count:** _____
- ☐ **Inpatient Psychiatric Facility Services** **Bed Count:** _____
- ☐ **Skilled Nursing Facilities** **Bed Count:** _____
- ☐ Inpatient Substance Abuse
- ☐ Orthotics and Prosthetics
- ☐ Home Health
- ☐ Durable Medical Equipment
- ☐ Outpatient Infusion / Chemotherapy
- ☐ Laboratory Services
- ☐ Outpatient Mental Health
- ☐ Outpatient Substance Abuse
- ☐ Cardiac Surgery Program
- ☐ Cardiac Catheterization Services
- ☐ Outpatient Dialysis
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Heart Transplant Program
- ☐ Heart / Lung Transplant Program
- ☐ Intestinal Transplant Program
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- ☐ Lung Transplant Program
- ☐ Pancreas Transplant Program
- ☐ Diagnostic Radiology
- ☐ Mammography
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy

For hospitals with fifty (50) beds or more: Does the hospital participate with a patient safety organization? ☐ Yes ☐ No
If yes, please fill out the attached Hospital Patient Safety Attestation Statement or provide proof of participation.

ATTESTATION

Answer every question "YES" or "NO". Provide a detailed explanation on a separate sheet for any question(s) answered "YES". Sign and date this sheet after completion.

1. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service? ☐ Yes ☐ No

2. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service? ☐ Yes ☐ No

3. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 – Code of Federal Regulations Section 1001.1001 or 1001.201? ☐ Yes ☐ No

4. Has this facility, under any current or former name or business identity, ever had any felony or misdemeanor convictions under Federal or State law relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance? ☐ Yes ☐ No

5. Has this facility, under any current or former name or business identity, ever had its licensure by any state licensing authority revoked or suspended, or ever been issued a conditional or restricted license? This includes revocation of such a license while under appeal or while a formal disciplinary proceeding was pending before a State licensing authority. ☐ Yes ☐ No

6. Has this facility, under any current or former name or business identity, ever had its accreditation revoked or suspended? ☐ Yes ☐ No

7. Has this facility, under any current or former name or business identity, ever been suspended or excluded from participation in or had any sanction imposed by a Federal or State health care program or had any disbarment from participation in any Federal Executive Branch procurement or non-procurement program? ☐ Yes ☐ No

I, the undersigned authorized agent, hereby attest and certify that all information and documentation submitted by me in this credentialing application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for continued network participation.

I consent to the release of all information that may be relevant to an evaluation of any credentials, including information about disciplinary actions or other confidential or privileged information, to Vantage Health Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which the facility is a Vantage Health Plan provider. The facility and its affiliates and successors release Vantage Health Plan, its affiliates, successors, and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating the facility's credentials.

Printed Name	Signature
Title	Attestation Date

REQUIRED ATTACHMENTS

Included: For ALL applicants:

- ☐ A roster of facilities if more than three.
- ☐ Completed facility application. All sections and questions of the application should be answered. If the question is not applicable, please indicate that with "N/A". Explanations of answers as requested, and a governing board member list should be included as applicable.
- ☐ Copy of all Federal, State, and/or local licenses required to operate the facility.
- ☐ Documentation of an appropriate Medicare certification as required by State or Federal regulations if applying to participate in Vantage's Medicare Advantage network. A copy of the Medicare certificate or provision of the Medicare number will be acceptable proof of participation certification.
- ☐ Current copy of facility's Medical Malpractice Liability declaration page showing coverage limits.
- ☐ Copy of current W-9
- ☐ Copy of the most recent accreditation certificate, if applicable, for the institution.
    - If the institution is not accredited, a copy of the most recent State (DHH certificate) or Medicare site survey results.
    - If the institution has never had a site survey performed by Medicare or the State (DHH), Vantage must complete a site survey before the facility can be credentialed. *(This is only required for Hospitals, Home Health Agencies, Skilled Nursing Facilities, Ambulatory Surgical Centers, Behavioral Healthcare Facilities, and others as Vantage deems necessary).*

Included: Additional attachments required for SPECIFIC facility types:

- ☐ Hospital Patient Safety Attestation Statement (attached) or proof of participation (for hospitals with fifty (50) beds or more)
- ☐ Surety Bond (for DME's only).
- ☐ Copy of CLIA Certificate (CLIA requires all facilities that perform even one test, including waived tests, on "materials derived from the human body for the purpose of providing information for the diagnosis, prevention, or treatment of any disease or impairment of, or the assessment of the health of human beings to meet certain Federal requirements. If a facility performs tests for these purposes, it is considered a laboratory under CLIA.).
- ☐ Copy of Bureau of Radiation Control Certificate (for Diagnostic Imaging Centers).
- ☐ Copy of Louisiana Mental Health and Mental Retardation Certificate (for Community Mental Health Centers).
- ☐ Roster of Therapists (for Therapy Centers)

Hospital Patient Safety Attestation Statement

(This form only applies to hospitals with fifty (50) beds or more.)

Hospital Name: _____

Address: _____

City: _____ State: _____ Zip: _____

I do hereby attest that the hospital described above implements an evidence-based initiative to improve health care quality through the collection, management, and analysis of patient safety events, that reduces all cause preventable harm, prevents hospital readmissions, or improves care coordination; raising awareness and informing health professionals, providers, and employees to improve patient safety and a comprehensive hospital discharge program.

* I certify that the information in this attestation is accurate and current as of this date. I acknowledge that the regulations must be continually adhered to, and any change, such as ownership, different management or participation in any patient safety evaluation system will be reported and disseminated to Vantage Health Plan, Inc.

Signed: _____ Date: _____

(Signature of authorized person acting on behalf of the hospital)

Printed Name: _____

(Printed name of signature above)

Title: _____

(Title of authorized person acting on behalf of the hospital)