



Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Provider type _____ Internal Record No. _____

Name _____ Physical address _____

City _____ State _____ Zip _____ County _____

Phone number _____ Fax _____

Primary Contact at Center _____ Email address _____

Phone number _____ Fax _____

Contractor name/title _____ Email address _____

Address (include city and state) _____

Ancillary Credentialing Notification Contact name/title _____

Address _____ City _____ State _____ Zip _____

Payment address _____ City _____ State _____ Zip _____

Federal Tax I.D. No. _____ National Provider Identifier _____

(Copy of W9 and 147C is required for all new applications) (Copy of NPI Enumerator letter or email required)

TPIN# (Medicaid- Star/CHIP) _____ Medicare Provider No. _____

Accredited by (list all accreditations and certification that apply)

Accreditation/Certification? Yes No CMS* Certification? Yes No

Accrediting body _____ Last CMS Site Survey date _____

Expiration date _____ Expiration date _____

Has your facility license or certification ever been revoked, reduced, denied, or suspended by others or voluntarily surrendered by the facility, or are any actions now under way, which could possibly lead to such conclusions? Yes No

If yes, please explain _____

Is any regulatory agency in the process of investigating your facility? Yes No

If yes, state the reason? _____

Insurance Information:

Liability Insurance? Yes No

If yes, please attach evidence of liability insurance, including effective date and monetary limits.

Carrier _____ Expiration date _____

Coverage amount _____ Each occurrence _____ Aggregate _____

Has your malpractice insurance ever been cancelled, non-renewed, restricted or special rated? Yes No

If yes, please explain _____

* Centers for Medicare & Medicaid Services

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

General Profile Information

Does this facility lease/timeshare their equipment or Operating Room? Yes No

If Yes, please list your current lease or timeshare client. (If additional space needed, please attach a listing.)

1. _____

2. _____

What physician or physician group does your facility use for the following services?

Radiology: Name _____ TIN _____ Phone _____

Anesthesiology: Name _____ TIN _____ Phone _____

Pathology/Laboratory: Name _____ TIN _____ Phone _____

Emergency Room Physicians: Name _____ TIN _____ Phone _____

Is this a Minority Business Enterprise?..... Yes No

Is this a Women's Business Enterprise?..... Yes No

Is this a Disadvantaged Business Enterprise? Yes No

Is your business a solely owned proprietorship? Yes No

If not, please describe your ownership/investment structure. Please indicate which party has majority ownership, majority financial responsibility and liability for the facility. Define vested interest percentage for each party:

(If additional space is needed, please attach a listing.)

Majority Owner Name		Percentage of interest	
Additional Investors	%	Additional Investors	%

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

The following pages are by specialty. Select the specialty below to go directly to that page.

[Ambulance Providers](#)

[Freestanding Imaging](#)

[Radiation Therapy Center Providers](#)

[Freestanding Independent Laboratories](#)

[Durable Medical Equipment Suppliers](#)

[Infusion Therapy Providers](#)

[Mental Health Services Providers](#)

[Hospital Providers](#)

[Signature Page](#)

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Ambulance Providers

Service area (counties or states) _____

Where are your bases located (city/state)? _____

Total number of transports in most recent fiscal year? _____ Total number of bases? _____

What types of medical transports does your company provide?

Ground **(G)** Yes No

Fixed-Wing Air **(F)** Yes No

Rotary Wing Air **(R)** Yes No

Condition Scenario	Basic Life Support	Advance Life Support	Critical Care	Specialty Care
Burns				
Dialysis/Renal Failure				
High Risk OB				
Infection Control				
Intra-aortic Balloon Pump				
Neonatal				
Pediatric				
Trauma				
Transplants				
Tracheotomy				
Ventilator				
Ventricular Assist Device				

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Freestanding Imaging

Does your Radiologist perform Interventional Procedures at this location?.....Yes No

This facility bills global _____ technical only _____ component.

Which Modalities do you currently offer? Please mark with an "X"

PET Scan		CT Scan		X-ray		Myelogram	
MRI-Open		Ultrasound		Bone Density		Nuclear Medicine	
MRI-Closed		Carotid Us		Mammography		Digital Mammography	
IVP		OB Ultrasound		Non-Invasive Vascular		Cardiac Nuclear Medicine	
MRA		MRM		Invasive Vascular		GI Studies	
IMRT		Brachytherapy		Accelerator		Simulator	

Radiation Therapy Center Providers

Is the patient imaged daily before treatment begins? Yes No

Do you have a physicist on staff?Yes No

Do you hold multi-disciplinary conferences with referring or other treating physicians?.....Yes No

Do you follow-up with the patient after they finish a course of treatment?Yes No

If yes, how many months before follow-up contact is made? _____

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Freestanding Independent Laboratories

Which services do you currently offer? Please mark with an "X"

Clinical Laboratory	Genetics	Clinical Pathology	Anatomical Pathology
Toxicology	Molecular Pathology	Histopathology	Cytopathology

Durable Medical Equipment Suppliers

Is the patient imaged daily before treatment begins? Yes No

Do you provide medical equipment intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease, in man or other animals? Yes No

Do you provide medical oxygen cylinders to home health care agencies, welding supplies, or home bound patients? Yes No

Do you supply hearing aid instruments? Yes No

Do you distribute drugs to anyone other than a consumer or patient? Yes No

Do you manufacture, prepare, propagate, compound, process package, repackage, or change the container, wrapper, or labeling of any drug product? Yes No

Are you categorized as a pharmacy? Yes No

Do you supply CPAP, IPPB, nebulizers, RADs, oxygen related services and devices, ventilator or respirator services? Yes No

Infusion Therapy Providers

Are you licensed to provide Home Health Services? Yes No
 (Do not respond if you subcontract services.)

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Mental Health Services Providers

1. Is the Supervising Physician a Board Certified Psychiatrist? Yes No
2. Is the Supervising Physician a certified Addictionologist? Yes No
3. Intake phone number _____

Which services do you currently offer? Please mark with an "X"

Services Provided			
Level of Care	Age	Service	"X"
Inpatient	Child	Mental health	
		Substance misuse	
		Detox.	
	Adolescent	Eating disorder	
		Mental health	
		Substance misuse	
	Adult	Detox.	
		Eating disorder	
		Mental health	
	Geriatric	Substance misuse	
		Detox.	
		Eating disorder	
Residential	Child	Mental health	
		Substance misuse	
		Eating disorder	
	Adolescent	Mental health	
		Substance misuse	
		Eating disorder	
	Adult	Mental health	
		Substance misuse	
		Eating disorder	
	Geriatric	Mental health	
		Substance misuse	
		Eating disorder	

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Mental Health Services Providers (cont)

Which services do you currently offer? Please mark with an "X"

Services Provided			
Level of Care	Age	Service	"X"
Partial Hospitalization	Child	Mental health	
		Substance misuse	
		Eating disorder	
	Adolescent	Mental health	
		Substance misuse	
		Eating disorder	
	Adult	Mental health	
		Substance misuse	
		Eating disorder	
	Geriatric	Mental health	
		Substance misuse	
		Eating disorder	
Intensive Outpatient	Child	Mental health	
		Substance misuse	
		Eating disorder	
	Adolescent	Mental health	
		Substance misuse	
		Eating disorder	
	Adult	Mental health	
		Substance misuse	
		Eating disorder	
	Geriatric	Mental health	
		Substance misuse	
		Eating disorder	
Outpatient	Child	Mental health	
		Substance misuse	
		Eating disorder	
	Adolescent	Mental health	
		Substance misuse	
		Eating disorder	
	Adult	Mental health	
		Substance misuse	
		Eating disorder	
	Geriatric	Mental health	
		Substance misuse	
		Eating disorder	

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Mental Health Services Providers (cont)

Which services do you currently offer? Please mark with an "X"

Services Provided			
Level of Care	Age	Service	"X"
ECT	Inpatient	Adult	
		Geriatric	
	Outpatient	Adult	
		Geriatric	

Which of the following services do you currently offer?

- Public Transportation Access Yes No
- TDD Capacity..... Yes No
- Wheelchair Accessibility Yes No

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

Hospital Providers

Do you own freestanding imaging centers?.....Yes No Quantity: _____

Do you own freestanding ambulatory surgery centers?.....Yes No Quantity: _____

Do you own freestanding emergency room centers?Yes No Quantity: _____

Service Description	Service Provided (Yes or No?)	Level of Care (i.e., Trauma Level 1,2,3, or 4)	Number of Beds or Operating Rooms	License or Certification
Medical				
Surgical				
Intensive Care				
Intermediate ICU				
Cardiac Care Unit				
Obstetrics				
Neonatal				
Orthopedics				
Trauma				
Psychiatric				
Detoxification				
Burn Care				
Oncology				
Rehabilitation (Inpatient)				
Hospice (Inpatient)				
Skilled Nursing				
Obesity (Bariatric Surgery)				
Gastrointestinal				
Emergency Room				

Please list any other services provided:

Credentialing/Recredentialing Ancillary/Hospital Provider Questionnaire

The aforementioned information is true and correct to the best of my knowledge. (Note: signature is valid for 120 days.)

Name and title of person completing this form _____

Signature _____

Phone number _____ Date _____

Email address _____

Completion of this form in no way guarantees our acceptance into any of our Managed Care, Medicaid, Medicare Advantage or Veterans Affairs networks. Providers will be notified by letter when credentialing is approved. In order to participate in or maintain your participation in one of these network(s) all supporting documents must be current and be submitted with this application to the applicable email address for the provider's specialty.

Refer to the **Credentialing and Contracting Process for Ancillary Providers** section of the **How to Join** page on the provider website and use the **Ancillary Specialty Checklists** to assist with gathering supporting documents.