Community Health Direct

ENROLLMENT & CREDENTIALING APPLICATION FOR FACILITY / ANCILLARY PROVIDERS

Submit completed form via email to: CHDProviderRelations@eCommunity.com

What type of application is being submitted?

☐ Initial Credentialing

☐ Re-credentialing Update

APPLICATION INSTRUCTIONS

For the application to be considered complete please provide the following:

Completed Application, signed, dated and attach a list of any additional locations to be included.

Current Copies of all documents (if applicable) to your organization including:

☐ *State License*
☐ *CMS Site Evaluation*
☐ *Current W9 Form*
☐ *Medicare Certification Information*
☐ *Current Liability Insurance Coverage*
☐ *Indiana Dept of Health Accreditation Certificate*
☐ *Copy of Sample Claim (UB or CMS 1500) Form*
☐ *Medicaid Certification Information*

DEMOGRAPHIC INFORMATION

Legal Business Name (LBN): _____ **d/b/a (if applicable):** _____

Tax ID (TIN): _____ **Organizational NPI #:** _____
State License #: _____ **License Expiration Date:** _____
Medicare #: _____ **Medicaid #** _____
Address: _____ **Phone:** _____
City, ST, Zip: _____ **Fax:** _____
County: _____ **Taxonomy Code:** _____

Accreditation Type:

☐ **Health Care Finance Administration (HCFA)**
☐ **National Commission of Quality Assurance (NCQA)**
☐ **The Joint Commission (TJC)**
☐ **Indiana State Department of Health (ISDH)**
☐ **Other**

BILLING INFORMATION

Billing/Pay-To Name: _____
Billing/Pay-to Address: _____
City, State, Zip: _____
Phone: _____ **Fax:** _____ **Contact Name:** _____

COMPREHENSIVE / GENERAL / PROFESSIONAL LIABILITY INFORMATION

Liability Carrier: _____
Policy #: _____ **Expiration Date:** _____
Coverage Limits: _____

Community Health Direct

DISCLOSURE QUESTIONS

Please answer the following questions YES or NO.

A. Has your organization's malpractice insurance ever been terminated or revoked except with your consent or request?

☐ YES ☐ NO

B. Is your organization currently under investigation by any government entity or peer review or has your organization been under such review during the last ten years?

☐ YES ☐ NO

C. Has your organization ever been sanctioned by Medicare or any State's Medicaid programs?

☐ YES ☐ NO

D. Has your state license ever been restricted, revoked, surrendered, stipulated, or voluntarily relinquished?

☐ YES ☐ NO

E. Has your facility ever lost accreditation, certification, licensure, been placed on probation, or been sanctioned in any way?

☐ YES ☐ NO

Please provide a separate sheet with full details about any YES answer above.

IMPORTANT CONTACTS

Who should we reach out to within your organization regarding credentialing & contracting?

Credentialing Contact Information:

Name: _____
Phone: _____
E-mail: _____

Contracting Contact Information:

Name: _____
Phone: _____
E-mail: _____

Authorized Official / Legal Contract Signer Information

Name: _____
Address: _____ *Title:* _____

Phone: _____
E-mail: _____

NAME & TITLE OF PERSON COMPLETING THIS FORM: _____

DATE SUBMITTED: _____

SEE NEXT PAGE TO SIGN ATTESTATION & RELEASE OF INFORMATION

Statement of Attestation, Authorization and Release of Information Form

By applying or reapplying for membership in Community Health Direct., I hereby affirm and attest that all statements, answers, and information contained in this application are true and complete to the best of my knowledge, information, and belief. I understand that falsification, misrepresentations, or omission of any fact(s) requested would be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

I understand and agree that acceptance of this application does not constitute approval or acceptance of participating status in Community Health Direct., and grants me no rights or privileges of participation until such time as I receive written notice of participating status.

I understand that the information contained in this application will be used to evaluate my credentials according to the quality assessment standards of Community Health Direct. As part of the evaluation process and for the purpose of verifying any information provided on or relative to this application, I also grant Community Health Direct. permission to perform an on-site review. I further grant Community Health Direct., the right to release any materials it may gather in its credentialing process, including this application and its attachments, to the Community Health Direct. payers and other third parties as may be necessary or desirable to permit my participation in provider networks.

In the event that I subsequently receive notice of participating status, I authorize Community Health Direct. to use this information, excluding the "CONFIDENTIAL" sections, to answer questions that covered persons may have about my practice. I further agree that if I receive notice of participating status, I will assume the duty of informing Community Health Direct. in a timely manner of subsequent changes in any of the information provided in or related to this application.

I release from loss claim damage and liability, Community Health Direct. and their respective directors, employees, or agents for acts in good faith and without malice in connection with the evaluation of my competence and qualifications.

I authorize Community Health Direct. or its representatives to consult with and/or request information from administrators, current or former members of medical staff committees at hospitals or institutions with which I have been associated. As well as, past or present malpractice carriers, or others whom the Community Health Direct. or its representatives have reasonably determined may have credible material or information regarding my credentials.

I consent to inspection by, and release to Community Health Direct. of all records and documents, that may be material to an evaluation of my professional competence and other qualification for membership.

I release from liability all representatives of Community Health Direct., and its affiliated hospitals, who are acting in good faith and without malice concerning my professional competence and other qualification of membership.

I authorize The Federation of State Medical Boards of the United States to release information to Community Health Direct., and release The Federation of State Medical Boards of the United States form liability.

I and/or the policyholder agree to Hold Harmless my insurance carrier, stated herein, for release of said information. I and/or the policyholder hereby give permission for release to the Community Health Direct. verification of numbers and dates of malpractice settlements and adverse judgments filed against me in my professional practice(s).

SIGNATURE:_____

PRINTED NAME OF PERSON SUBMITTING THIS APPLICATION: _____

TITLE: _____

DATE: _____