HealthChoice, LLC
Network Credentialing Application
Facility/Ancillary Applicants
Please Type or Print your answers.

Dear HealthChoice Network Applicant:

We are pleased to provide your facility with the enclosed HealthChoice Credentialing application. Please read all instructions carefully, complete the application, and return it to Health Choice, LLC. This form must be returned within thirty (30) days.

- The HealthChoice Facility Credentialing application will be considered complete when **ALL** requested information has been provided and verified by the HealthChoice Credentialing Department.

- All areas must contain a response. **If the question is not applicable to your type of facility, please indicate "N/A" in the space provided.** The application must be signed and dated by a duly appointed representative of the facility.

- If more space is needed than provided on the original application, please use additional sheets.

- **This Application does not guarantee acceptance in the HealthChoice Network. Participation in this Network will not become effective unless and until HealthChoice, at its discretion, accepts this application and the parties execute a mutually acceptable participation agreement or attachment to an existing participation agreement.**

- HealthChoice will verify the information on the Credentialing Application prior to evaluating the facility's qualifications to fulfill network needs.

- All facilities seeking to participate in the HealthChoice Network must meet or exceed these minimum standards.

    - Current, valid, unrestricted state license
    - Absence of loss of license
    - Medicare Certification; if applicable
    - Accreditation by a nationally recognized body applicable to the facility type: i.e. Joint Commission on Accreditation for Healthcare Organizations (JCAHO), Accreditation Association for Ambulatory Health Care (AAAHC), Commission on Accreditation of Rehabilitation Facilities (CARF), and others. (Health Choice may substitute Centers for Medicare and Medicaid Services (CMS) review or Health Choice site visit and Credentialing and recredentialing criteria for Medical Staff if the institution is non-accredited.)
    - Malpractice coverage that is reasonable and acceptable for facility or institution type.
    - General Liability coverage which is reasonable and acceptable for facility or institution type
    - Absence of evidence that participation in federal and/or state programs has not been limited suspended or terminated, nor sanctions, fines, or penalties incurred during participation.

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Facility Information			
Name of Facility:		Type:	
Primary Physical (List all locations, add sheets if needed) Street City State Zip			
Telephone: ( )	Fax: ( )	E-mail:	
Tax ID Number(s): (Attach copy of W9)	NPI Number(s):	Year Business Established:	
Credentialing Contact:		E-mail:	

Choose your facility's services:

☐ Outpatient testing	☐ Urgent Care Center	☐ Durable Medical Equipment
☐ Outpatient surgery	☐ Home Health Care	☐ Acute Care Hospital
	☐ Outpatient Pharmacy	☐ Other

Describe services:

Key Contacts	
Business Manager:	Telephone: ( )
Medical Director:	Telephone: ( )
Other:	Telephone: ( )
Facility Owner(s): (Please include % of ownership)	
Key Correspondent Name: (For notifications, newsletters, credentialing updates, etc.)	
Telephone: ( )	E-mail:

	Y	N	N/A
Are physicians providing service at the facility (anesthesia, pathology, radiology, etc) members of MetroCare Physicians, Inc.?			
If no, will facility bill globally to include these services?			
Is facility available to MetroCare Physicians other than your owners?			
Do you want to participate in the HealthChoice Workers' Compensation network?			
Are you willing to pay the annual participation fee HealthChoice providers are assessed? **The annual fee for this type of facility will be:**			

Billing			
Does your facility use:	☐ UB 04	☐ HCFA 1500	☐ Both
Payment Name: (If different from above)			
Payment Address: Street City State Zip			
Telephone: ( )	Fax: ( )		

Networks/Client List Information

Identify all healthcare networks/client lists in which you are participating:

What type of product lines does your facility participate?

☐ Medicare	☐ Commercial	☐ Other
☐ Medicare Advantage	☐ Workmen's Comp	
☐ Medicaid/TN Care	☐ Health Insurance Exchange (HIE)	

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Professional License & Accreditations Please attach copies of license/accreditations			
You must attach a detailed explanation for any question to which you respond "Yes" **Has your facility ever had any of the following denied, revoked, suspended, not renewed, placed under probation, subjected to disciplinary action or otherwise limited or curtailed; or have you voluntarily relinquished any of the following in anticipation of any such action against you; or are any of these actions pending with respect to any of the following?**			
State License:	Number:	Expires/Date: / /	Sanctions? Yes No
JCAHO:	Number:	Expires/Date: / /	Sanctions? Yes No
Medicare:	Number:	Expires/Date: / /	Sanctions? Yes No
Medicaid:	Number:	Expires/Date: / /	Sanctions? Yes No
CLIA:	Number:	Expires/Date: / /	Sanctions? Yes No
AAAHC, etc.:	Number:	Expires/Date: / /	Sanctions? Yes No
Other certificates or licenses appropriate to your facility?	Number:	Expires/Date: / /	Sanctions? Yes No

Insurance (MUST have face sheet of all types of Certificate of Insurance showing policy number and expiration date)	
Has this facility's professional liability insurance ever been terminated or restricted, or modified (i.e. reduced limits, restricted coverage, surcharged), or has this facility ever been denied professional liability insurance? Yes No	
Professional Liability Insurance Carrier:	
Policy Number:	Expiration Date:
What amounts of Professional Liability and/or Malpractice Insurance does the facility carry?	
Per Occurrence: $	Aggregate: $
What amounts of General Liability Insurance does the facility carry?	
Per Occurrence: $	Aggregate: $
General Liability Insurance Carrier:	
Policy Number:	Expiration Date:

Please include a numeric value for each question:

Malpractice action(s):	Number of pending claims:
Number of closed claims in the past 5 years: (Closed claims include dismissals, awards, judgments, dropped suits, and non-suits)	Number of closed claims in the past 10 years: (Closed claims include dismissals, awards, judgments, dropped suits, and non-suits)

Hospital Affiliations	
If applicable, list hospitals with which you have transfer agreements:	
1.	2.
3.	4.

Outpatient Services Facilities and Hospitals		
Is your outpatient facility located in or adjacent to a physician's office or medical clinic or group? Yes No		
Are all admissions less than 24 hours? Yes No	If no, what % of admissions are over 24 hours?	
Are laboratory or radiology services available on site? Yes No		
If yes, are they provided and billed by your facility? Yes No	If no, list name and telephone of providers:	
Name:		Telephone: ( )

Credentialing Criteria
Please attach a copy of your Credentialing Criteria and all prerequisites imposed by the facility on practitioners rendering care at your facility.

Physician Roster Using separate attachments, please list the following information for all physicians with privileges at your center. The list should include Hospital Based Professionals that have privileges in the facility, their degree, and their respective specialties.	
Name:	Specialty:
Professional Title:	Office Telephone: ( )
State License:	Board Certified:

Hospital & Facility Based Contracted Professional Services (If applicable, please supply this information for ER Physicians, Radiology, Anesthesia, Pathology, etc.)			
Organization Name:			
Contact Person:			
Payment Address:			
Street	City	State	Zip
Telephone: ( )	Fax: ( )		
Relationship to facility:			
Does any other entity (in its bill to insurers or the insured) include fees for your facility? Yes No If yes, please supply the same information for these entities:			

Organization Name:			
Contact Person:			
Payment Address:			
Street	City	State	Zip
Telephone: ( )	Fax: ( )		
Relationship to facility:			

Below is a checklist of information that may require a hard copy and/or attachment.
Please note: attachments marked with an asterisk must have hard copies accompany the application.

- ☐ Corporate affiliated entities
- ☐ *License(s)
- ☐ *Certification(s)
- ☐ *Accreditation(s)
- ☐ Facility based/Contracted services
- ☐ Outpatient services
- ☐ Insurance claims history
- ☐ *Certificate of Professional Liability
- ☐ *Certificate of General Liability
- ☐ Networks information
- ☐ Physician roster
- ☐ Credentialing criteria
- ☐ *Copy of W-9

I certify that the information in this application is true and correct. I understand that misrepresentation may result in my non-selection, or, if discovered after selection, in my termination as a provider. I understand that this application does not entitle me to participation in HealthChoice, L.L.C. I authorize HealthChoice to consult with and inspect all documents from individuals and organizations having information bearing on my qualifications, and authorize the copy of my signature on this application to be as binding as the original. I agree that HealthChoice, its representatives, and any individuals or entities providing information to HealthChoice, L.L.C. in good faith shall not be liable for any act or omission related to the evaluation or verification contained in this application. I further agree to notify HealthChoice in a timely manner of any change to the information requested in this application. Information requested in this application that is not publicly available will be treated as confidential by HealthChoice. This application is only in effect six months from the date of receipt. After six months the facility/ancillary facility must re-apply.

Completed by:

Authorized Signature: _____

Please print name: _____

Title: _____ Date: _____

Hospital/Facility: _____

Telephone: _____

Please return Completed Application to:

Health Choice, L.L.C.
Attn: Blayne Burns
1661 International Place, Suite 202
Memphis, TN 38120

HealthChoice Exhibit A

Facility Name and TIN: _____

Rev Code	CPT / HCPCS	Mod	Description of Service	Rate

Exclusions: (please list) _____

_____

Form used to file claims: (Yes or No)

UB _____

HCFA _____

Mark (X) appropriate payment mythology:

Fee Schedule _____

Discount Off Total Charges _____

Per Diem _____

Package Price/Case Rate _____

Completed By: _____

Date: _____