Hospital and Ancillary Provider Application

Please answer the questions below. If a question is not applicable, indicate by documenting "N/A" in the space provided.

1. Legal Name ____

2. Main Location ____
   (street)

   ____
   (city) **(state)** **(zip)**

3. Phone Number ________________ Fax ________________ Email ______________________

4. Website ______________________

5. Office Hours ____

6. Location Information (**check all that apply**)

Handicap Access		Public Transportation	
24 Hour Phone Coverage		Weekend Late Hours	
Electronic Medical Records		Level III Perinatal Facility	
Radiology Services		OB/GYN Services (**OB, GYN or both?**)	
Perform Mammograms		TDD Service	
Lab Services		TDD Phone # _______ - ________ -	
Surgical Suite		Other -	
Child Care		Other -	

7. Language(s) spoken ____

   Language(s) written ____

   If there are additional locations that will be participating, please attach a list with names, addresses, contact information, services performed and languages. Thank you!

8. Primary Contact Name ____

9. Phone Number ________________ Fax ________________ Email ______________________

10. Name of Chief Executive Officer ____

11. Name of Chief Medical Officer ____

12. State Licensure Number(s) ______________________ **(Attach a copy of the license certificate(s))**

13. Medicare ID Number ______________________ Medicaid ID Number ______________________

14. National Provider Identifier (NPI) ______________________

15. Accredited? YES [ ] NO [ ] Name *(TJC, AOHA, etc.)* ______________________ Expiration Date ____________

If yes, attach copy of certificate. If no, submit copy of latest CMS or State site visit report.

16. Medicare Certification YES [   ] NO [   ] Date ___________________________

17. Tax Identification Number ____ **(Attach copy of SS-4 or W-9)**

18. Reporting name and address as they appear on your IRS W-9 form

____

____

____

19. Complete the following information for the most recent fiscal year

Time Period _________________ (month/year) **to** __________________ (month/year)

Service	Licensed Beds	Staffed Beds	Occupancy Rate
General Acute Care			
Hospice			
Inpatient Psych			
Inpatient Rehab			
Skilled Nursing Facility			
Other -			
Other -			
Total			

20. Has the institution been sanctioned, placed on probation, or lost accreditation, licensure, or certification status during the last five years by any of the following?

Organization	Yes	No
The Joint Commission/AOHA		
State Licensure		
Medicaid/Medicare		
P.R.O.		
Other -		

If you answered yes to any of the above, describe the nature of the sanction, reason and date below

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____

____

21. List all individuals* with ownership or controlling interest of 5% or more of the organization **(if applicable and optional for Meridian Health Plan of Illinois applicants)**

Name ____

Address ____

____
*Individuals listed will be reviewed for inclusion on the Excluded Parties List System

22. List all Managing employees* along with their social security number below **(optional for Meridian Health Plan of Illinois applicants)**

    A managing employee is a "general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operations of an institution, organization, or agency

    Name ____
    *Individuals listed will be reviewed for inclusion on the Excluded Parties List System

    Social Security Number ____

23. Has any person who has ownership or controlling interest in the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the programs? No [ ] Yes [ ]

24. Has any agent or managing employee for the provider ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or the Title XX services program since the inception of the programs? No [ ] Yes [ ]

25. If yes to either of the two previous questions, list their names and social security numbers below

    Name ____

    Social Security Number ____

26. Are you aware of any pending investigations by Medicare, Medicaid, state or federal agency or are you aware of any situation which may result in a claim or suit?

    If yes, explain (attach additional explanation if necessary) ____

    ____

    ____

27. Provide the following information on medical staff **(if applicable)**

Provider Name (including Degree)	Hospital Staff Privileges	Board Certification Status/Licensure	Office Location and Phone

28. HCBS Waiver Services **(if applicable)**

Ancillary Provider shall furnish proof of certification to MHP prior to the performance of any HCBS Services

[ ] Adult Day Service
[ ] Adult Day Service Transportation
[ ] Case Management (Administrative Claim)
[ ] Community Transition Services
[ ] Environmental Accessibility Adaptations – Home
[ ] Supported Employment
[ ] Home Health Aide
[ ] Nursing, intermittent
[ ] Nursing, skilled (RN and LPN)
[ ] Occupational Therapy
[ ] Physical Therapy
[ ] Speech Therapy
[ ] Prevocational Services
[ ] Habilitation – Day
[ ] Homemaker
[ ] Home Delivered Meals
[ ] Personal Assistant
[ ] Personal Emergency Response System (PERS)
[ ] Respite
[ ] Specialized Medical Equipment and Supplies
[ ] Supportive Living Facilities
[ ] Behavioral Services (M.A. and Ph.D.)
[ ] Other________________________________

29. **Participation Statement**

I fully understand that any misrepresentation in, or omission from this application that has bearing on qualifications constitutes cause for denial of credentialing or summary dismissal from participation with Meridian Health Plan. All information submitted in this application is warranted to be true and correct.

In making this application to Meridian Health Plan, I agree to abide by all rules, regulations and policies that may be promulgated from time to time. I am also familiar with the principles and standards which govern my specialty and profession, and agree to be bound by those as well.

I understand and agree that as an applicant for Meridian Health Plan, I have the burden of producing adequate information for proper evaluation of credentials, including professional competence, character, ethics and other qualifications, and I am responsible for resolving any questions about qualifications.

Signature ___________________________________ Title _____________________________________

Printed Name _________________________________ Date _____________________________________

Thank you for completing your application for participation! Did you attach the following?

a. Copy of SS-4 or W-9 form
b. Copy of state license certificate(s)

c. **Medicare certification documentation**
d. **Accreditation documentation**
e. **CMS or State site visit report (if no accreditation)**
f. **Copy of your malpractice insurance policy cover sheet**
g. **Copy of your program brochures (optional)**