Skilled Nursing Facility Credentialing and Recredentialing Application Instructions

Please include with your completed/signed application the following items for each location:

- ☐ Copy of current State License (if applicable)
- ☐ Copy of State Business License, confirming standing with State regulatory body
- ☐ Copy of Medicare Certification letter (if applicable)
- ☐ Copy of Certifications and/or Accreditation Certificates (e.g. TJC, CHAP, etc) indicating status or Quality Improvement Plan (if applicable)
- ☐ Copy of Facility Site Review (if applicable)
- ☐ Copy of Declaration Sheet and/or Certificate of Insurance for BOTH Current *Professional* Malpractice and Comprehensive *General* Liability Insurance Policies

If you have any questions, please contact **Provider Services at 1-800-798-2254, option 7**. Please submit completed application, along with all required documentation, by one of the following methods:

Email: sdu_providerserviceshelp@optum.com
(Please include the name of your facility and the words 'Credentialing Application' in the subject line)

Fax: 877-309-4862

Please Note:

Initial Credentialing – Failure to legibly complete all sections of this Application and submit current copies of all required documentation will result in processing delays.

Recredentialing – Submission of recredentialing information is a contractual obligation. Failure to complete all sections of this Application and submit current copies of all required documentation in a timely manner will be considered a request to terminate the facility's participation in our network.

Skilled Nursing Facility Credentialing Application

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Attach additional sheets when necessary.

Facility Demographics		
Legal Business Name (as reported to the IRS):	**Federal Tax Identification Number:**	
Doing Business As (dba) Name (if applicable):	**Hospital or Health System Affiliation:** ☐ Not affiliated with any hospital/health system	
Mailing/Correspondence Address:		
City:	**State:**	**Zip Code:**
Billing Name (if different than dba):		
Billing Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
Credentialing Contact Name:	**Phone #:**	
Credentialing Mailing/Correspondence Address:		
City:	**State:**	**Zip Code:**
Email Address:	**Fax#:**	

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Primary Location		
Street Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
State License # : **Please provide a copy of State License* **Expiration Date:**	**CLIA #:** **Expiration Date:**	
NPI #: (Application cannot be processed without a valid 10-digit NPI)		
Medicare Certified? ☐ **Yes** ☐ **No** **Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter* **Medicare #:**		
Medicaid #:		

Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of most recent accreditation report

☐ American Association for Accreditation of Ambulatory Surgery Facilities	☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
☐ American Association for Ambulatory Health Care	☐ Commission on Accreditation of Rehabilitation Facilities
☐ American College of Radiology	☐ American Osteopathic Association
☐ Healthcare Facilities Accreditation Program	☐ Accreditation Commission for Health Care Inc
☐ Commission on Office Laboratory Accreditation	☐ Joint Commission
☐ Community Health Accreditation	☐ Not Applicable

Professional Liability:	**Comprehensive Liability:**
** Please provide a copy of Current Liability Declaration Sheet*	** Please provide a copy of Current Liability Declaration Sheet*
Name of Carrier:	Name of Carrier:
Effective Date:	Effective Date:
Expiration Date:	Expiration Date:
Per Incident: $	Per Incident: $
Per Aggregate: $	Per Aggregate: $

Supplemental Form

For each additional address copy and complete this Supplemental Form

Return all copies with the completed application

Street Address:

City: | **State:** | **Zip Code:**

Phone #: | **Fax #:**

State License # : | **CLIA #:**

**Please provide a copy of State License*

Expiration Date: | **Expiration Date:**

NPI #:
(Application cannot be processed without a valid 10-digit NPI)

Medicare Certified? ☐ **Yes** ☐ **No**

**Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter*

Medicare #:

Medicaid #:

Accreditation:
Does this site have the same accrediting agency as the primary address:

☐ **Yes**

☐ **No - Please specify accrediting agency or NONE:**

Disclosure Questions

Please answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.	
1. Has the facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?	☐ Yes ☐ No
2. Has the facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?	☐ Yes ☐ No
3. Has the facility ever had its professional liability coverage cancelled or not renewed?	☐ Yes ☐ No
4. Has the facility been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?	☐ Yes ☐ No

Facility Attestation/Consent & Release Form

a) As a representative of the health care provider(s)/supplier(s) listed on this application, I understand that, as a contracted facility, the burden of producing adequate information for proper evaluation of licensure, accreditation, Medicare certification, malpractice insurance, malpractice history and sanctions indicated in this application is upon the contracted provider or its representative.

b) I further understand and acknowledge that The Facility(s) or designated agent will investigate the information in this application. By submitting this application, the provider(s)/supplier(s) agree to such investigation and to the HIPDB reporting and information as required by law as a part of the verification and credentialing process.

c) I authorize all individuals, institutions, entities of other hospitals or institutions with which the provider(s)/supplier(s) have been associated and all professional liability insurers with which the provider(s)/supplier(s) have had or currently have professional liability insurance, who may have information bearing on the provider(s)/supplier(s) licensure, accreditation, Medicare certification, malpractice or sanctions to consult with The Facility(s) or designated agent.

d) I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating the provider(s)/supplier(s) application, and waive all legal claims against any representative of The Facility(s) or its respective agent(s) who acts in good faith and without malice in connection with the investigation of this application.

e) I understand and agree that the authorizations and releases given by me herein shall be valid for three years according to The Facility(s) cycle of recredentialing provided the provider(s)/supplier(s) is actively pursuing or holds an active contract with The Facility(s).

f) The provider(s)/supplier(s) agree to exhaust all available procedures and remedies as outlined in the rules, regulations, and policies, and/or contractual agreements of The Facility(s) or its respective agent(s) before initiating judicial action.

g) I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application.

h) I further acknowledge that failure to communicate any relevant information or to release any and all required documentation and authorizations in support of this application may be considered a request to withdraw from the credentialing process and participation with The Facility.

I, the undersigned authorized agent, hereby attest and certify that all statements on this application are true, accurate, and correct to the best of my knowledge. I fully understand that any falsification of information or omissions from this application may be grounds for denial of this application as The Facility(s) Participating Provider or cause for summary dismissal from The Facility(s) or be subject to applicable state or federal penalties for perjury.

Further, I understand that acceptance of this application does not constitute approval or acceptance or participating status with The Facility(s) and grants this provider no rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this provider by The Facility(s).
I acknowledge that action on this application will be delayed until all required information is received and/or Verified

Your signature is required to complete this application.

Facility Name:

Name (Please Print):

Title:

Signature

Date: