ORGANIZATIONAL PROVIDER APPLICATION

Please complete each section thoroughly.
Type or print clearly in black ink.
Sign and date the application.

YOU MUST INCLUDE THE FOLLOWING WITH THIS COMPLETED APPLICATION
(use this checklist as a guide)

- ☐ State License
- ☐ Accreditation License & Certificate
- ☐ General Liability & Malpractice Coverage
- ☐ Medical Staff Bylaws
- ☐ Medical Staff Roster
- ☐ Patient Satisfaction Survey & Results
- ☐ Quality Management Plan
- ☐ Grievance Policy/Procedure
- ☐ Results of State and Medicare Surveys
- ☐ W-9 Form

SEE SECTION E FOR A COMPLETE LISTING OF ATTACHMENTS

Please return completed application form to:
OhioHealth Group
Attention: Kathy Savenko
445 Hutchinson Avenue, Suite 300
Columbus, Ohio 43235

Phone: (614) 566-0135 1-800-635-7207 Fax: (614) 566-0484

☐ Please check if a Medicare Number has been Assigned Your Facility.

THIS APPLICATION DOES NOT CONSTITUTE A CONTRACT.

Please furnish the information below indicating an "N/A" if an item is not applicable.

SECTION A – GENERAL INFORMATION (Please type or print legibly)

Hospital (Type) ______________________ Other (Type) ________________________

Facility Name ____

State License Number ____________________ Expiration Date______________ BILLING METHOD? HCFA / UB92__________

FACILITY ADDRESS (street, city, state, zip) | COUNTY

MAIN TELEPHONE NUMBER | FAX NUMBER | TAX ID NUMBER

BILLING ADDRESS | FAX NUMBER | COUNTY

MEDICAID PROVIDER NUMBER | MEDICARE (PART A) PROVIDER NUMBER | MEDICARE (PART B) PROVIDER NUMBER

CHIEF ADMINISTRATOR – Name & Title | TELEPHONE NUMBER

CONTACT PERSON – Name & Title | E-Mail Address | TELEPHONE NUMBER

MEDICAL DIRECTOR – Name & Specialty | TELEPHONE NUMBER

(Add a separate sheet listing contact names and telephone numbers for the following: Chief Financial Officer, Managed Care Director, Quality Management Director, Admitting/Registration Manager, Medical Records Manager, Patient Accounts/Billing Manager, Quality Assurance Manager, Social Services/Discharge Planning Manager, Utilization Review Manager, Medical Staff Office Contact.)

ARE YOU A: Corporation Partnership Joint Venture Other (please describe) ____________________

TAX STATUS & TYPE OF ORGANIZATIONAL CONTROL: Public/Government Private/Non-Profit Investor Owned/For-Profit

WHEN WAS YOUR ORGANIZATION ESTABLISHED: ____________________ OPENED: __________________________

PLEASE IDENTIFY PARENT COMPANY OR COMPANIES:

____

____

DO ANY HEALTHCARE FACILITY(IES), PHYSICAN(S), OR OTHER PROVIDERS(S) HAVE OWNERSHIP IN YOUR COMPANY?

Yes No If yes, please list below and specify your relationship with them and the percent of their ownership.

____

____

LIST ANY PHYSICIAN GROUP PRACTICES THAT STAFF YOUR FACILITY WHO BILL INDEPENDENTLY OF THE FACILITIES NAME AND TIN. (Include group name, TIN, contact name and phone number)

____

____

SECTION B – ACCREDITATION

INDICATE YOUR FACILITY'S ACCREDITING AGENCY BY CHECKING THE APPROPRIATE BOX BELOW:

- ❑ Accreditation Association for Ambulatory Care (AAAHC)
- ❑ Joint Commission on Accreditation of Health Care Organizations (JCAHO)
- ❑ Commission on Accreditation of Health Care Organization (CARF)
- ❑ American Osteopathic Association (AOA)
- ❑ Community Health Accreditation Program (CHAP)
- ❑ American College of Radiology (ACR)
- ❑ Medicare Certification Only
- ❑ Other ______________________________
- ❑ Not Accredited

IF ACCREDITED/CERTIFIED

Date of last accreditation/certification review: ______________________________

Duration of accreditation/certification: ______________________________

Next review date: ______________________________

Where there any contingencies or significant recommendation(s) from your last survey? Yes No

(If "yes", please describe and submit an action plan for addressing the recommendation(s)).

____

____

If NOT accredited, what is your expected date of accreditation? ______________________________

If accredited, please submit a copy of the current accreditation letter and certificate.

SECTION C – LIABILITY INFORMATION

GENERAL LIABILITY INFORMATION

____

GENERAL LIABILITY CARRIER POLICY NUMBER POLICY EXPIRATION DATE

____

ADDRESS (street, city, state, zip) TELEPHONE NUMBER

____

AMOUNT OF COVERAGE PER OCCURANCE ($) AMOUNT OF AGGREGATE COVERAGE ($)

MALPRACTICE LIABILITY INFORMATION

MALPRACTICE LIABILITY CARRIER POLICY NUMBER POLICY EXPIRATION DATE

ADDRESS (street, city, state, zip) TELEPHONE NUMBER

AMOUNT OF COVERAGE PER OCCURANCE ($) AMOUNT OF AGGREGATE
COVERAGE ($)

Number of prior judgments or settlements against the facility in the past 10 years: ____________________

Please list by year the number of suits in which you were a defendant with allegations of malpractice for the past 10 years. Also, indicate if a case is pending, or if there was a settlement or judgment and the amount of the same.

SECTION D – FACILITY REVIEW

DOES THE FACILITY HAVE AN AFFILIATE RELATIONSHIP WITH OTHER FACILITIES, I.E., SURGICAL CENTERS, LABORATORIES, RADIOLOGY CENTERS, ETC.? Yes No N/A

If "yes," please provide an attachment showing name, address, telephone number, contact person of each affiliate and a brief description of the affiliates relationship to the facility.

HAS THE FACILITY HAD:

1. Revocations or suspensions as a Medicare or Medicaid Provider? Yes No
2. Malpractice liability insurance cancellation in the past 5 years? Yes No
3. General liability insurance cancellation in the past 5 years? Yes No
4. State licensing investigations or actions? Yes No

Please include an explanation for any question(s) above which were answered "yes." If not accredited, please submit a copy of your latest HCFA review.

QUALITY/UTILIZATION REVIEW

1. Are the credentials and/or certifications of professional staff members & admitting physicians verified? Yes No
2. Are the credentials and/or certifications of professional staff members & admitting physicians verified biannually thereafter? Yes No
3. Is continuing education and/or re-certification required of your staff? Yes No
4. Is there a formal patient satisfaction or patient advocacy program? Yes No
5. Is there a formal patient satisfaction or patient advocacy program? Yes No
6. Does the facility have a written quality assurance/quality improvement (QA/AI) plan? Yes No
7. Is there a QA/QI Committee? Yes No
8. How frequently does that Committee conduct meetings? ____________________
9. Is there a Utilization Review Committee? Yes No
10. How frequently does that Committee conduct meetings? ____________________
11. What utilization review guidelines or protocol do you use? ____________________

If not accredited, please submit a copy of your most recent evaluation and QA/QI Plan, your method of assessing patient satisfaction and results of your last 2 patient satisfaction surveys.

SECTION E – ENCLOSURES

PLEASE SUBMIT THE FOLLOWING WITH YOUR COMPLETED AND SIGNED APPLICATION.

1. A copy of the facility's state license to operation.
2. If applicable, a current copy of the facility's accreditation letter and certificate.
3. Proof of current general liability and malpractice insurance coverage (policy face sheets or certificates of insurance).
4. Any explanation requested on this application including a list of malpractice settlements and judgments.
5. If applicable, a list of affiliated facilities showing name, address, contact person and brief description of relationship.
6. If not accredited, a copy of the facility's most recent evaluation and Quality Management Plan (Quality Assurance/Quality Improvement Plan.)
7. A list of the facility's staff including specialties and department heads or chiefs for each clinical service (directory).
8. A list of the facility's Board of Directors including name, occupation and organization.
9. A list of available services that can be rendered by the facility. (Please indicate any service subcontracted with the facility and indicate payment arrangements.)
10. If applicable, a copy of your hospital transfer policy.
11. If not accredited, a copy of your policy for resolving complaints and grievances.

(Hospital Addendum)

ORGANIZATIONAL PROVIDER

IS THE HOSPITAL A MEMBER OF THE AMERICAN HOSPITAL ASSOCIATION (AHA)? Yes No

DOES THE HOSPITAL HAVE ANY MAJOR TEACHING PROGRAMS? Yes No
(If "yes," please describe below or submit as an attachment to the application.)

DOES THE HOSPITAL HAVE ANY APPROVED RESIDENCY PROGRAMS? Yes No
(if "yes," please list programs and chairmen below or submit as an attachment to the application

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LICENSED BEDS/ADMISSION CHARGES

1. How many beds is the hospital licensed to operate ______
   2. How many beds is the hospital operating at this time for the following categories?

____Medical/Surgical ____ICU/CCU ____Nursery
____Skilled Nursing ____Rehabilitation ____Psychiatric
____OB ____Observation ____Other

3. What is the hospital's average occupancy rate over the last 12 months? ______
4. How many discharges did the facility have for the same period? ______
5. What is your average length of stay for non-Medicare patients? ______
6. What percent of your admissions are: Medicare______% Medicaid______%
7. What is your average waiting time for emergency services (after registration)? ______
8. What is your average number of ER visits per month over the last 12 months? ______
9. What is your average ER treatment time (from the time of registration to the time of discharge)? ______
10. How many operating rooms does the hospital have? ______

GOVERNING BODY/BOARD OF DIRECTORS

Is there a governing body/board of directors that meets at least once annually? Yes No

STAFFING

How does the hospital determine the nursing staff to patient ratio? Please provide a brief description.

____

____

What is the in-house arrival time for the following physicians in an emergency?

________General Surgeon ________Anesthesiologist ________Pediatrician

________Cardiologist ________Obstetrician

Does the hospital utilize surgical assistants? Yes No
If "yes," please provide a copy of your credentialing criteria used to qualify for this position.
Does the hospital utilize certified registered nurse anesthetists (CRNAs)? Yes No
If "yes," what is your ratio of CRNAs to anesthesiologist? ____________
Does the hospital have a fulltime or part-time Medical Director? Yes No
Number of fulltime Rns ____________
Number of fulltime LPNs ____________
Number of licensed lab technicians ____________
Number of certified registered nurse anesthetists (CRNAs) ____________
Number of licensed x-ray technicians ____________
Number of licensed pharmacists ____________
RN to active bed ratio ____________
LPN to active bed ratio ____________
Please provide your current ER staffing average by shift

	7am-3pm	3pm-11pm	11pm-7am
Physicians	________	________	________
Rns	________	________	________
LPNs	________	________	________
Technicians	________	________	________
Other (please specify)	________	________	________

Please provide group names, contact names, and phone number for hospital based ER physicians, anesthesiologists, pathologists and radiologists.

____

____

____

Please indicate the services that are available at your facility and indicate whether the services are contracted out.

SERVICE	CONTRACTED OUT?	
INTENSIVE CARE		
Burn Intensive Care	Yes	No
Coronary Intensive Care	Yes	No
Isolation Intensive Care	Yes	No
Medical Intensive Care	Yes	No
Neonatal Intensive Care	Yes	No
Neuro Intensive Care	Yes	No
Newborn Intensive Care	Yes	No
Pediatric Intensive Care	Yes	No
Pulmonary Intensive Care	Yes	No
Surgical Intensive Care	Yes	No
SPECIALTY CARE		
Communicable Disease Isolation Care	Yes	No
Definitive Observational Care	Yes	No
Hospice	Yes	No
Intermediate Care	Yes	No
Newborn Nursery Care	Yes	No
Post Partum Care	Yes	No
Premature Nursery Care	Yes	No
Protective Isolation Care	Yes	No
Rehabilitation Care	Yes	No
Telemetry Care	Yes	No
ACUTE CARE		
Medical Acute Care	Yes	No
Neonatal Acute Care	Yes	No
Pediatric Acute Care	Yes	No
Surgical Acute Care	Yes	No
SURGERY		
Dental Surgery	Yes	No
Gen. Surgery OR Svcs	Yes	No
Gynecologic Surgery	Yes	No
Neurologic Surgery	Yes	No
Open Heart Surgery Services	Yes	No
Ophthamologic Surgery	Yes	No
Orthopedic Surgery	Yes	No
Otolaryngologic Surgery	Yes	No
Plastic Surgery	Yes	No
Podiatry Surgery	Yes	No
Surgical Day Care (1 day)	Yes	No
Urologic Surgery	Yes	No
CHEMICAL DEPENDENCY		
ADULT ADOLESCENT		
Aftercare	Yes	No
Detox	Yes	No
Intensive Outpatient	Yes	No
Partial	Yes	No

SERVICE	CONTRACTED OUT?	
ANCILLARY SERVICES		
Abortion Services	Yes	No
Alternative Birth Center	Yes	No
Anatomic Pathology Services	Yes	No
Blood Collection & Processing	Yes	No
Blood Bank	Yes	No
Cardiac Rehabilitation	Yes	No
Clinical Pharmacologic Services	Yes	No
Cobalt Therapy	Yes	No
Computerized Axial Tomography	Yes	No
Full Body	Yes	No
Partial	Yes	No
Cystoscopy Services	Yes	No
Delivery Room Services	Yes	No
Diagnostic Radioisotope	Yes	No
Durable Medical Equipment	Yes	No
Electrocardiography	Yes	No
Electroencephalography	Yes	No
Endoscopy Service	Yes	No
Hearth Cath/Sterile Rm Svcs	Yes	No
Hematologic Services	Yes	No
Home Nursing Care (RN)	Yes	No
Inhalation Therapy	Yes	No
Interpretive Services:	Yes	No
Cardiology	Yes	No
Neurology	Yes	No
Pathology	Yes	No
Radiology	Yes	No
IV Therapy	Yes	No
Labor Room Services	Yes	No
Lithotrpsy	Yes	No
Magnetic Resonance Imaging (MRI or NMR)	Yes	No
OB Anesthesia Svcs 24 Hour	Yes	No
Occupational Therapy	Yes	No
Oncology Services	Yes	No
Organ Bank	Yes	No
Ostomy Services	Yes	No
Pharmacy w/FT Reg Pharmacist	Yes	No
Physicial Therapy	Yes	No
Radium Therapy	Yes	No
Rehabilitation Therapy	Yes	No
Renal Dialysis Services	Yes	No
Services of Intensivist or Full time Dir of Intensive Care	Yes	No
Therapeutic Radioisotope	Yes	No
Total Parental Nutrition Services	Yes	No
X-ray Examination	Yes	No
PSYCHIATRIC SERVICES		
ADULT ADOLESCENT		
Intensive Outpatient	Yes	No
Outpatient Program	Yes	No

SECTION F - ATTESTATION

All information provided on this application or in connection with this application is complete and accurate to the best of the facility's knowledge. The facility understands that this application does not entitle the facility to participate in OhioHealth Group's networks. The facility agrees that entities providing information in good faith, pursuant to this release, shall not be liable for any act or omission related to the evaluation or verification of information contained in this application. All information submitted to OhioHealth Group by such entities will be treated as confidential. It is further understood that if the facility is accepted as an OhioHealth Group Participating Facility, it shall provided ready access and copies to OhioHealth Group upon request, of any and all medical records that the facility maintains for any OhioHealth Group members. The facility further agrees to notify OhioHealth Group in a timely manner of any changes to the information provided on the application.

The facility hereby authorizes any accrediting body, governmental entity, association, organization, person or insurance company to release the information requested herein and to provide confirmation of the answers contained herein to OhioHealth Group or any affiliate or subsidiary of OhioHealth Group. This authorization shall be valid for so long as the facility is an OhioHealth Group contracted provider. A copy of the signature is as binding as the original.

____

SIGNATURE OF CHIEF ADMINISTRATOR OR AUTHORIZED DESIGNEE   DATE

____

PRINT NAME OF CHIEF ADMINISTRATOR OR AUTHORIZED DESIGNEE

____

FACILITY NAME

____

ADDRESS (street, city, state, zip)

Please return completed application form and all supporting documents to:

OhioHealth Group
Attn: Kathy Savenko
445 Hutchinson Avenue, Suite 300
Columbus, Ohio 43235