



ORGANIZATIONAL HOSPITAL 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 Hill
445 Hutchinson Avenue, Suite 550
Columbus, Ohio 43235

Phone: (614) 566-0108 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 _____ **NPI#** _____

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), PHYSICIAN(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
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ADDRESS (street, city, state, zip)	TELEPHONE NUMBER
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AMOUNT OF COVERAGE PER OCCURANCE (\$) COVERAGE (\$)	AMOUNT OF AGGREGATE
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MALPRACTICE LIABILITY INFORMATION

MALPRACTICE LIABILITY CARRIER	POLICY NUMBER	POLICY EXPIRATION DATE
ADDRESS (street, city, state, zip)		TELEPHONE NUMBER
AMOUNT OF COVERAGE PER OCCURANCE (\$) COVERAGE (\$)	AMOUNT OF AGGREGATE	

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/QI) 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)

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?	SERVICE	CONTRACTED OUT?
INTENSIVE CARE		ANCILLARY SERVICES	
<input type="checkbox"/> Burn Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Abortion Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Coronary Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Alternative Birth Center	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Isolation Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Anatomic Pathology Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medical Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Blood Collection & Processing	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neonatal Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Blood Bank	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neuro Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cardiac Rehabilitation	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Newborn Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Clinical Pharmacologic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pediatric Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cobalt Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pulmonary Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Computerized Axial Tomography	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgical Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Full Body	<input type="checkbox"/> Yes <input type="checkbox"/> No
SPECIALTY CARE		<input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Communicable Disease Isolation Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cystoscopy Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Definitive Observational Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Delivery Room Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Hospice	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Diagnostic Radioisotope	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Intermediate Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Durable Medical Equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Newborn Nursery Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Electrocardiography	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Post Partum Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Electroencephalography	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Premature Nursery Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Endoscopy Service	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Protective Isolation Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hearth Cath/Sterile Rm Svcs	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rehabilitation Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Hematologic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Telemetry Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Home Nursing Care (RN)	<input type="checkbox"/> Yes <input type="checkbox"/> No
ACUTE CARE		<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Medical Acute Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Interpretive Services:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neonatal Acute Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Cardiology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pediatric Acute Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Neurology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgical Acute Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pathology	<input type="checkbox"/> Yes <input type="checkbox"/> No
SURGERY		<input type="checkbox"/> Radiology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dental Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> IV Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Gen. Surgery OR Svcs	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Labor Room Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Gynecologic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Lithotripsy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neurologic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Magnetic Resonance Imaging (MRI or NMR)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Open Heart Surgery Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> OB Anesthesia Svcs 24 Hour	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ophthalmologic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Orthopedic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Oncology Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Otolaryngologic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Organ Bank	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Plastic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Ostomy Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Podiatry Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Pharmacy w/FT Reg Pharmacist	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Surgical Day Care (1 day)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Urologic Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Radium Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
CHEMICAL DEPENDENCY		<input type="checkbox"/> Rehabilitation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> ADULT	<input type="checkbox"/> ADOLESCENT	<input type="checkbox"/> Renal Dialysis Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Aftercare	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Services of Intensivist or Full time Dir of Intensive Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Detox	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Therapeutic Radioisotope	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Intensive Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Total Parental Nutrition Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> X-ray Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No
PSYCHIATRIC SERVICES			
<input type="checkbox"/> ADULT	<input type="checkbox"/> ADOLESCENT		
<input type="checkbox"/> Intensive Outpatient	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<input type="checkbox"/> Outpatient Program	<input type="checkbox"/> Yes <input type="checkbox"/> 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 Hill
445 Hutchinson Avenue, Suite 300
Columbus, Ohio 43235