OhioHealth Group

ORGANIZATIONAL ANCILLARY 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
- ☐ Provider Services Index

SEE SECTION E FOR A COMPLETE LISTING OF ATTACHMENTS

Please return completed application form to:
OhioHealth Group
Attention: **Kathy Hill**
155 E Broad St, Ste 1700
Columbus, Ohio 43215

Phone: (614) 566-0108 1-800-635-7207 Fax: (614) 566-0403

☐ 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)

☐ Long-Term Care ☐ Home Health Agency
☐ Ambulatory Surgical Center ☐ 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/PHONE NUMBER 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)

LIST COUNTIES YOU PRESENTLY SERVICE:

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.

SECTION E - 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 F – PROVIDER SERVICES INDEX

Please indicate the services that are available at your facility.

SERVICE	
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

Other Services Provided Not Listed Above:

_____

_____

Please attach any informational materials regarding services or programs provided. (Optional)

SECTION G – 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 completed Provider Services Index of all 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. In not accredited, a copy of your policy for resolving complaints and grievances.

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)