OhioHealth Group

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
155 E Broad St, Ste 1700
Columbus, Ohio 43215

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), 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

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 Hill
445 Hutchinson Avenue, Suite 300
Columbus, Ohio 43235