NovaSys HEALTH

Provider Recredentialing Profile

Provider Information

Corporate Identification Information

Legal Business Name: (as reported to the IRS)	Federal Tax Identification Number (TIN):
Doing Business As (DBA) Name: (if applicable)	NPI for Facility being Credentialed: (Application cannot be processed without a 10-Digit NPI)
Corporate Address: (if different than facility address)	Primary Taxonomy:

_____ _____

Name of Chief Executive Officer Name of Chief Financial Officer

_____

Name of Managed Care Director

Is facility owned in whole or in part or managed by a hospital or health care system/organization?

☐ Yes ☐ No

If you answered yes, who? _____

Facility Information (Physical Location)

Facility Name _____

Street Address _____

City _____ State _____ Zip _____ County _____

Phone _____ Fax _____ Website _____

Administrator _____ Email _____

Credentialing Contact _____ Title _____

Phone _____ Fax _____ Email _____

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Payment/Remit Address

Name

Address:

Is this a bank lockbox for payments only? ☐ Yes ☐ No

City:	State:	Zip:	Phone:

Administration/Managed Care Correspondence Address

Name

Mailing Address:

City:	State:	Zip:	Phone:

Health Care Licensure
(Attach a copy of each license for this facility)

License Number	Licensing Agency	Initial Issue	Renewal	Expiration
		/ /	/ /	/ /
		/ /	/ /	/ /

Medicare Status

Is this facility participating in the Medicare program? ☐ Yes ☐ No ☐ Pending

Medicare Number:_____ Date of initial certification: / /

☐ Check here if this facility is <u>not</u> eligible for Medicare certification.

<u>HOSPITALS ONLY:</u> Has any Medicare certified hospital department (such as psychiatric) been discontinued in the past five years? ☐ Yes ☐ No

If yes, specify department: _____ Date of closing: / /

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Staffing

Does the facility validate the credentials for each licensed practitioner employed or contracted at the facility?

☐ Yes ☐ No

If yes, indicate how the facility/agency conducts the credentialing process for each practitioner:

Credentialing procedures are performed internally ☐

Credentialing procedures are outsourced/delegated. ☐

If your credentialing procedures are outsourced or delegated, please list the entity:

_____

If other, specify: _____

_____

If you do not validate credentials for each licensed practitioner employed or contracted at this facility, explain:

_____

_____

_____

_____

_____

Insurance

Complete this section and attach a copy of the facility's insurance certificate(s) that includes:

- Insurer(s) Affording Coverage
- Policy Number
- Effective date and expiration date
- Amounts of coverage
- This facility listed as covered by the policy
- Name and phone number of agency issuing policy

NOTE: We prefer the "Acord Certificate of Liability Coverage" form. Facilities covered by Government insurance should attach documentation detailing coverage.

1. Is this facility covered by commercial general liability insurance in the amount of $1 million per occurrence and $3 million aggregate? (Excess liability/umbrella coverage can be counted toward the $3 million aggregate amount.)

☐ Yes

☐ No (Please obtain the above amount of required coverage before submitting application)

☐ Facility is covered by government insurance

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Insurance

2. Is this facility covered by professional liability insurance in the amout of $1 Million per occurrence and $3 million aggregate? (Must be a facility/organizational policy, not an individual only policy. Excess liability/ umbrella coverage can be counted toward the $3 million aggregate amount.)

☐ Yes

☐ No (Please obtain the above amount of required coverage before submitting application)

☐ Facility is covered by government insurance

3. Has this facility's Commercial General or Professional liability insurance ever, for any reason, been denied, cancelled, non-renewed, or initially refused upon application?

☐ Yes - Explain below

_____

_____

☐ No

Attestation

Answer all questions below with yes or no. Provide a detailed explanation below for all questions answered yes. If necessary, use a separate sheet. **Do not submit a typed signature; a written signature is required.** Ensure the attestation is dated.

☐ Yes ☐ No 1. Has this facility ever had or currently have pending any legal actions against it excluding medical malpractice and frivolous law suits?

☐ Yes ☐ No 2. Has this facility ever been convicted of a crime, excluding misdemeanors?

☐ Yes ☐ No 3. Has any government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business?

☐ Yes ☐ No 4. At any time has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions now underway which may lead to such conclusions?

☐ Yes ☐ No 5. At any time, has this facility/organization been assessed a penalty or fined by a government agency or is the facility currently under investigation by the Medicaid or Medicare programs or any other government agency?

☐ Yes ☐ No 6. At any time, has any third party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management, quality of care issue, or for any other reason?

☐ Yes ☐ No 7. Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?

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Attestation

☐ Yes ☐ No 8. Has this facility, under any current, former name or business entity, ever had its accredidation revoked or suspended?

Explanation **including dates and times** for any question(s) answered Yes. Include the number of the question you are responding to.

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete 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 a Health Plan participating provider or cause for summary dismissal from the Health Plan.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

Printed Name of Authorized Representative

Authorized Representative's Title

Signature

Date