Health Resources
Development Service
Oklahoma State
Department of Health

Managed Care Systems
1000 NE 10th Street
Oklahoma City, OK 73117-1299
Phone 405.271.6868
http://hrds.health.ok.gov

Uniform Credentialing Application

63 O.S. 2011, Section 1-106.2

This form must be completed in full and typed or printed legibly (i.e. do not state "see CV"), unless the credentialing entity to which you are applying advises you otherwise. Write "N/A" in areas that do not apply to you. All time must be accounted for since entry into medical or other professional school. If additional space is needed to complete information or explanations, use Section 14.

Name of facility/organization this application will be submitted to:_____

_____

Date:_____

SUBMIT THIS FORM TO THE HOSPITAL, MANAGED CARE ORGANIZATION, OR OTHER ENTITY REQUIRING CREDENTIALS VERIFICATION. THE COMPLETED APPLICATION MAY BE SUBMITTED TO HOSPITALS, AMBULATORY SURGERY CENTERS, MANAGED CARE ORGANIZATIONS, AND OTHER ENTITIES REQUIRING CREDENTIALS VERIFICATION.

PLEASE DO NOT SEND THE APPLICATION TO THE OKLAHOMA STATE DEPARTMENT OF HEALTH

SECTION 1: PERSONAL INFORMATION

Name _____
Last First Middle Suffix

Professional Degree _____ Gender: ☐ Male ☐ Female

Other Name By Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Other Name By Which You Have Been Known _____

Dates This Name Was Used: From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___ NPID (formerly UPIN)_____

Date of Birth: ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Place of Birth Citizenship

_____
Visa Type Visa Number (provide copy) Expiration Date

_____
Your Personal Medicare Number Your Personal Medicaid Number

SECTION 2: DIRECTORY INFORMATION

Mailing Address For All Credentialing Correspondence: _____
Street Address

_____
Suite Number City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Emergency or Pager Number

( )
Answering Service Number E-Mail Address

Contact Person For Credentialing Correspondence: _____

This Section continues on next page.

-Section 2 Continued-

Office Street Address: _____
Street Address

_____
Suite Number | City | State | Zip Code

( ) _____ ( ) _____ ( ) _____
Phone Number | Fax Number | Emergency or Pager Number

( ) _____
Answering Service Number | E-Mail Address

Office Mailing Address: _____
Street Address

_____
Suite Number | City | State | Zip Code

( ) _____ ( ) _____ ( ) _____
Phone Number | Fax Number | Emergency or Pager Number

( ) _____
Answering Service Number | E-Mail Address

Office Billing Address (If Different From Claims Payment Address): _____
Street Address

_____
Suite Number | City | State | Zip Code

( ) _____ ( ) _____ ( ) _____
Phone Number | Fax Number | Emergency or Pager Number

( ) _____
Answering Service Number | E-Mail Address

Claims Payment Address (If Different From Office Billing Address): _____
Street Address

_____
Suite Number | City | State | Zip Code

( ) _____ ( ) _____ ( ) _____
Phone Number | Fax Number | Emergency or Pager Number

( ) _____
Answering Service Number | E-Mail Address

Make Checks Payable To: _____

SECTION 3: CURRENT PROFESSIONAL PRACTICE

		0%
Primary Specialty (or field of practice)	Subspecialty	% Of Time
		0%
Secondary Specialty	Subspecialty	% Of Time

Do you wish to be listed as:
☐ Primary Care Provider ☐ Specialist ☐ Hospitalist ☐ On-Call ☐ Other (specify)_____
If you are a primary care physician, list special diagnostic or treatment procedures performed in your office(s):

_____

_____

☐ Yes ☐ No Are you accepting new patients?
☐ Yes ☐ No Are you willing, in the future to accept new patients?
☐ Yes ☐ No Do you admit your own patients to hospitals?
If no, please explain how your patients will be admitted, which hospital and who will provide patient care.
☐ Yes ☐ No Are you willing to accept current patients if they convert to the healthcare plan to which you are applying?
☐ Yes ☐ No Are you a member of an Independent Practice Association or a Physician Hospital Association? If yes, complete the following:

Name: _____

_____
Street Address Suite Number

_____
City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Answering Service Number

Name: _____

_____
Street Address Suite Number

_____
City State Zip Code

( ) ( ) ( )
Phone Number Fax Number Answering Service Number

List any restrictions on your practice (i.e. patient age and gender): _____

SECTION 4: EDUCATION

Medical/Dental/Graduate Professional Schools

List all, completed or not. Continue in Section 14 if needed.

(1) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ to ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(2) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

(3) _____
Institution Degree Awarded

_____
Mailing Address City State Zip Code

Telephone Number: (_____) _____

Dates Attended (mo/day/year) From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___

Graduation Date ___ ___ - ___ ___ - ___ ___ ___ ___

Foreign Medical Graduates:

ECFMG #_____

SECTION 5: TRAINING
Internship/Residency/Fellowship/Preceptorship/Other

List all, completed or not. If you require additional space, continue in Section 14, or attach a separate sheet.

(1) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____
Was program successfully completed: ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(2) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____
Was program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(3) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____
Was program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

(4) Type of Program:
☐ Internship ☐ Residency ☐ Fellowship ☐ Preceptorship ☐ Other (specify) _____
Was program successfully completed? ☐ Yes ☐ No

Specialty | Institution | Your Program Director

Address | City | State | Zip Code | ( ) Phone Number

Dates Attended (mo/day/year) From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

SECTION 6: ACADEMIC APPOINTMENTS

List all, past and present. If additional space is needed, copy this sheet or continue in Section 14.

(1) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____ From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(2) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____ From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

(3) _____ (_____)_____
Institution and Address City State Zip Code Phone Number

_____ From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___
Position/Rank Inclusive Dates (mo/day/year)

SECTION 7: HEALTH CARE AFFILIATIONS

List, in chronological order, **all hospital/health system affiliations** where you have ever been employed, practiced, associated, or privileged for the purpose of providing patient care. Do not list affiliations that were part of your training (Section 5). If additional space is required, copy this sheet or continue in Section 14.

Indicate which of these is your "current primary and secondary admitting facility" (where you currently spend the greatest portion of your time).

(1) _____ ☐ Primary ☐ Secondary
Facility Name

_____ (_____)_____
Complete Mailing Address City State Zip Code Telephone Number

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

(2) _____ ☐ Primary ☐ Secondary
Facility Name

_____ (_____)_____
Complete Mailing Address City State Zip Code Telephone Number

From: ___ ___ - ___ ___ - ___ ___ ___ ___ **to** ___ ___ - ___ ___ - ___ ___ ___ ___ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

This section continues on next page.

-Section 7 Continued-

(3) _____ ☐ Primary ☐ Secondary
Facility Name

_____ ( )
Complete Mailing Address City State Zip Code Telephone Number

From:__ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Appointment (mo/day/year) Staff Category

_____
Reason for Discontinuance Department or Service

SECTION 8: OTHER PROFESSIONAL WORK HISTORY

List, chronologically, **all** professional work history (i.e. clinics, partnerships, solo/group practices, employment). Include secondary agencies or clinics such as public health and family planning where you perform duties. Account for all time gaps of thirty (30) days or more. If additional space is needed, copy this page or continue in Section 14.

(1) _____
Name and Nature of Affiliation

_____ ( )
Mailing Address City State Zip Code Telephone Number

From:__ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(2) _____
Name and Nature of Affiliation

_____ ( )
Mailing Address City State Zip Code Telephone Number

From:__ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

(3) _____
Name and Nature of Affiliation

_____ ( )
Mailing Address City State Zip Code Telephone Number

From:__ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __ _____
Dates of Affiliation (mo/day/year) Reason for Discontinuance

US Military/Public Health Service

List all medical and surgical locations and dates.

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

_____
Location Branch of Service

From: __ __ - __ __ - __ __ __ __ **to** __ __ - __ __ - __ __ __ __

_____
Location Branch of Service

SECTION 9: PROFESSIONAL LICENSES

List all **pending, current, and past** professional licenses, registrations, and certifications to practice in your field. Include states where you have ever applied to practice. Examples of "type" of license are MD, DO, DDS, PA, DC, CRNA, MSW, etc.

State	Type	Number	Original Date of Issue	Expiration Date
Oklahoma			__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __
			__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __
			__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __
			__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __

USMLE/ECFMG Number _____ Certification Date __ __ - __ __ - __ __ __ __

SECTION 10: CERTIFICATIONS AND REGISTRATIONS

List all other current certifications and registrations.
(DEA=Federal Drug Enforcement Administration; BNDD=the Oklahoma CDS; CDS=Controlled Dangerous Substances)

State	Type	Number	Original Date of Issue	Expiration Date
	DEA		__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __
	DEA		__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __
Oklahoma	BNDD		__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __
	CDS		__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __

BOARD CERTIFICATION

Are you Board Certified? ☐ Yes ☐ No _____ Name of Board

Date Initially Certified	Date Most Recently Recertified	Date Certification Expires
__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __	__ __ - __ __ - __ __ __ __

☐ Yes ☐ No Have you ever been examined by any specialty board but failed to pass? If yes, provide details.

This section continues on next page.

-Section 10 Continued-

SUBSPECIALTY CERTIFICATION AND ADDED QUALIFICATIONS

Subspecialty or Added Qualification | Name of Board

__ __ - __ __ - __ __ __ __ Date Initially Certified

__ __ - __ __ - __ __ __ __ Date Most Recently Recertified

__ __ - __ __ - __ __ __ __ Date Certification Expires

Subspecialty or Added Qualification | Name of Board

__ __ - __ __ - __ __ __ __ Date Initially Certified

__ __ - __ __ - __ __ __ __ Date Most Recently Recertified

__ __ - __ __ - __ __ __ __ Date Certification Expires

BOARD QUALIFICATIONS

☐ Yes ☐ No If you are not certified, are you qualified to sit for the exam in a primary or subspecialty board or added qualification?

☐ Yes ☐ No Are you planning to take the exam?

☐ Yes ☐ No Are you scheduled to take the exam? If yes, attach confirmation letter.

Date Scheduled:

Oral __ __ - __ __ - __ __ __ __

Written __ __ - __ __ - __ __ __ __

Other __ __ - __ __ - __ __ __ __

Subspecialty or Added Qualification | Name of Board

Date Qualified __ __ - __ __ - __ __ __ __ Date Qualification Expires __ __ - __ __ - __ __ __ __

Classifications:

☐ Yes ☐ No Are you certified in CPR? Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Basic Life Support (BLS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Advanced Cardiac Life Support (ACLS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Health Care Provider (CoreC) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Advanced Trauma Life Support (ATLS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Neonatal Advanced Life Support (NALS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Pediatric Advanced Life Support (PALS) Expires __ __ - __ __ - __ __ __ __

☐ Yes ☐ No Other_____ Expires __ __ - __ __ - __ __ __ __

SECTION 11: OFFICE INFORMATION
Primary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group ☐ Other (specify)_____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No | Reference Lab? ☐ Yes ☐ No | On Site? ☐ Yes ☐ No

CLIA ID # _____ CLIA Waiver # _____

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?
If yes, please list:_____
☐ Yes ☐ No Other:_____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone ( )_____

Name _____ Specialty _____ Telephone ( )_____

Name _____ Specialty _____ Telephone ( )_____

Name _____ Specialty _____ Telephone ( )_____

☐ Yes ☐ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 11: OFFICE INFORMATION
Secondary Office

Group Name | Name As It Appears On Your W-9 (if applicable) | Business Owned By

Type of Practice:

☐ Solo ☐ Partnership ☐ Single-Specialty Group ☐ Multi-Specialty Group ☐ Other (specify)_____

Office Manager | Nurse Coordinator

Group Medicare Number | Group Medicaid Number | IRS Tax ID Number

Does this office have lab service? ☐ Yes ☐ No | Reference Lab? ☐ Yes ☐ No | On Site? ☐ Yes ☐ No

CLIA ID # _____ | CLIA Waiver # _____

Does your office have the following:

☐ Yes ☐ No Radiology
☐ Yes ☐ No EKG
☐ Yes ☐ No Audiology
☐ Yes ☐ No Treadmill
☐ Yes ☐ No Sigmoidoscopy
☐ Yes ☐ No Wheelchair/handicapped access?
☐ Yes ☐ No Other services for the disabled?

If yes, please list:_____

☐ Yes ☐ No Other:_____

List all independent licensed non-physicians working in this office.

Name	Provider Type	License Number

Fluent Languages:

You _____

Your Staff _____

Other Resources _____

☐ Yes ☐ No Does this office meet all state and local fire, safety and sanitation requirements?

☐ Yes ☐ No Do you provide 24-hour, seven day a week coverage?

Office Hours:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
From:							
To:							

List name, specialty, and phone number of physicians covering your practice in your absence. Attach an additional sheet if necessary.
Note: These practitioners must be affiliated with the organization to which you are applying.

Name _____ Specialty _____ Telephone ( ) _____

Name _____ Specialty _____ Telephone ( ) _____

Name _____ Specialty _____ Telephone ( ) _____

Name _____ Specialty _____ Telephone ( ) _____

☐ Yes ☐ No Do you or your business own, operate, manage or participate in any medical enterprise or business?
If yes, explain on a separate attachment.

SECTION 12: COPIES OF REQUIRED DOCUMENTS

Please include a copy of the following with this application. Practitioner should check off needed items that are being attached to this application.

Attached	Item
☐	Oklahoma Bureau of Narcotics and Dangerous Drugs Registration (BNDD)
☐	Current Federal DEA Registration Certificate
☐	Emergency Care Training Certificates (CPR, etc., if certified)
☐	Photo Identification
☐	Curriculum Vitae
☐	Tax Identification Information Form W-9

SECTION 13: ATTESTATION

All information and documentation contained in this application is true, correct and complete to my best knowledge and belief. I further acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for staff membership, privileges, or participation.

Name (printed) _____

Signature _____ Date _____

NOTE:
Practitioners are reminded that each organization <u>will</u> require submission of additional information.

SECTION 14: ADDITIONAL INFORMATION

This page is furnished for your convenience in completing questions or providing additional information. Please make as many copies of this page as you require to fully answer all questions.

As appropriate, note section number and question number that you are addressing.

Supplemental - Oklahoma Organizational Provider Types

ORGANIZATION INFORMATION				
Legal Name of Organization:				
DBA Name of Organization: (If applicable)				
Historic Name(s) of Organization: (If under same ownership)				
Hospital or Health System Affiliation: (If applicable)				
Organization Medicare Number:			Organization Medicaid Number:	
Organization Tax identification number (TIN):			Organization National Provider Identifier (NPI):	
Site-specific Medicare Number: (Attach a copy of CMS Letter)			Site-specific Medicaid Number:	
Site-specific Tax identification number (TIN):			Site-specific National Provider Identifier (NPI):	
Ownership Type: (Select one) ☐ Sole proprietorship ☐ City/County/State owned ☐ Corporation/LLC/Partnership ☐ Federally owned				Select One: ☐ For profit ☐ Non-profit
Products:	☐ HMO	☐ PPO	☐ Medicare	☐ Medicaid

ORGANIZATION TYPE	
☐ Hospital	☐ Home Health Agency
☐ Skilled Nursing Facility	☐ Free-Standing Surgery Center
☐ Hospice	☐ Clinical Laboratories
☐ Comprehensive Outpatient Rehabilitation	☐ Outpatient Physical Therapy ☐ Speech Pathology
☐ Opioid Treatment Program (OTP)	☐ End-Stage Renal Disease
☐ Outpatient Diabetes Self-Management Training Facility	☐ Portable X-Ray Suppliers
☐ Rural Health Clinic	☐ Federally Qualified Health Center (FQHC)
☐ Mental Health Inpatient	☐ Mental Health Residential
☐ Mental Health Ambulatory	☐ Substance Abuse Inpatient
☐ Substance Abuse Residential	☐ Substance Abuse Ambulatory
☐ Other:	

Supplemental - Oklahoma Organizational Provider Types

PHYSICAL LOCATION INFORMATION	
Accessibilities	
□ American with Disabilities Act (ADA) Compliant	□ Telehealth services are available
□ TDD Capability	□ Interpreters Available
□ Is this location on a public transportation route?	□ No □ Yes(explain)_____

License and Credentials

□ Check here if this location is not required to be licensed, certified, or registered by a State agency.
(Attach a copy of all)

Type of Credential	State	Number	Additional Notes/Info
State License:			
State Registration:			
State Certification:			
DEA:			
CLIA:			
Other:			

Liability Insurance

(Attach a copy of the facility professional/general liability insurance face sheet.)

Professional Liability Insurance

Current Carrier Name:	
Policy Type: (malpractice, general, standard, etc.)	
Policy Number:	
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

General Liability Insurance

Current Carrier Name:	
Policy Type: (malpractice, general, standard, etc.)	
Policy Number:	
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

Federal Tort Claims Act Insurance

(Attach a copy of proof of liability insurance or evidence of applicability for this location.)	
Entity Name:	
Entity Type:	
Grant Number:	
Start Date:	End Date:

Site Visit

(Attach a copy of most recent on-site or attach cover letter from government agency stating facility is in substantial compliance.)

1. Has the facility had a post-licensing on-site visit by a government agency such as the Department of Health or CMS within the past 36 months?
   - □ Yes – Date of most recent standard survey: _____
   - □ No – Successful completion of a health plan on-site may be required to complete credentialing.
2. Were any deficiencies cited during the last full survey?
   - □ Yes
   - □ No
   - □ N/A – no recent survey

   If yes, attach documents defining deficiencies.

Supplemental - Oklahoma Organizational Provider Types

Accreditation/Certification

☐ Check here if the facility is NOT accredited.	
List Accreditation/Certification Organization and Attach Copies of Current Certification:	
☐ The Joint Commission (TJC)	☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)	☐ Continuing Care Accreditation Co (CCAC)
☐ Community Health Accreditation for Healthcare (ACHC)	☐ Healthcare Facilities Accreditation Program (AOA HFAP)
☐ American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)	☐ American College of Radiology (ACR)
☐ National Integrated Accreditation for Healthcare Organizations (DNV-NIAHO)	☐ Council on Accreditation (COA)
☐ Clinical Laboratory Accreditation (COLA, Inc.)	☐ American Association of Diabetes Educators (AADE)
☐ Indian Health Service (HIS)	☐ Commission on Accreditation for Home Care New Jersey (NJCAHC)
☐ Commission for the Accreditation of Birth Centers (CABC)	☐ Intersocietal Accreditation Commission (IAC)
☐ Substance Abuse and Mental health Services Administration (SAMHSA)	☐ Det Norske Veritas (DNV)
☐ Other:	

Supplemental - Oklahoma Organizational Provider Types

ADDITIONAL LOCATION ADDENDUM

(If applicable)

COPY PAGE FOR EACH ADDITIONAL LOCATION

Service Location 2 of ___
Demographics

Location Name:		
Site Address:		
City:	State:	Zip:
Site NPI:	Site Medicare Number: (Attach a copy of CMS Letter)	Site Medicaid Number:

License and Credentials

☐ Check here if this location is not required to be licensed, certified, or registered by a State agency.
(Attach a copy of all)

Type of Credential	**State**	**Number**	**Additional Notes/Info**
State License:			
State Registration:			
State Certification:			
DEA:			
CLIA:			
Other:			

Liability Insurance

(Attach a copy of the facility liability insurance face sheet.)	
Current Carrier Name:	
Policy Number:	
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

Accreditation/Certification

☐ Check here if the facility is NOT accredited.
List Accreditation/Certification Organization and Attach Copies of Current Certification.

Accessibilities

☐ American with Disabilities Act (ADA) Compliant	☐ Telehealth services are available
☐ TDD Capability	☐ Interpreters Available

Supplemental - Oklahoma Organizational Provider Types

ORGANIZATIONAL SERVICE PROVIDER SCREENING

1) Please select the method utilized to verify the license/certification of individuals rendering services for your organization:
   - ☐ Online directory with the appropriate State and/or Federal licensure or certification board
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain):_____

2) Please indicate the method utilized to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:
   - ☐ Online directly with the appropriate State and/or Federal licensure or certification board
   - ☐ Obtaining a current copy of the license/certification
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe): _____
   - ☐ No process (please explain):_____

3) Please indicate the method utilized to verify the identity of individuals rendering services for your organization:
   - ☐ Verification of a state driver's license or other government identification
   - ☐ Background check agency, contacted organization or vendor
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain): _____

4) Please indicate the method utilized to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a health-care related crime (including but not limited to health care fraud; patient abuse; and the unlawful manufacture, distribution, prescription, or dispensing of controlled substance) are rending services:
   - ☐ Federal and/or State criminal background check(s)
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Search a State 'Misconduct Registry' or equivalent
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain): _____

5) Has your organization or any of its authorized representatives ever been convicted of, pleaded guilty to, or pleaded nolo contendere to any legal actions (excluding medical malpractice and misdemeanors)?
   - ☐ No ☐ Yes (provide an explanation):_____

6) Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?
   - ☐ No ☐ Yes (provide an explanation):_____

7) Has your organization ever been the subject of an investigation or ever been terminated, suspended sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military, or State Department of Health program?
   - ☐ No ☐ Yes (provide an explanation):_____

8) At any time, has any third-party payer ever revoked, reduced, denied or suspended your organization's participation due to inappropriate utilization management or quality of care issues?
   - ☐ No ☐ Yes (provide an explanation):_____

9) At any time, has any license or certification held by the organization or its branch locations ever been revoked, denied, or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are these any actions or investigations currently under way which may lead to one of these outcomes?
   - ☐ No ☐ Yes (provide an explanation):_____

Supplemental - Oklahoma Organizational Provider Types

10) Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed, or special rated for any reasons other than the carrier's termination of operations in your State? ☐ No ☐ Yes (provide an explanation):_____
11) At any time, has any third-party payer ever revoked, reduced, denied, or suspended your organization's participation due to inappropriate utilization management or quality of care issues? ☐ No ☐ Yes (provide an explanation):_____
12) Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)? ☐ No ☐ Yes (provide an explanation):_____
13) Has the facility been denied accreditation by its selected body (e.g., TJC), or has its accreditation status been reduced, suspended, revoked, or in any way revised by the accrediting body? ☐ No ☐ Yes (provide an explanation):_____
14) Does each service location associated with the facility follow the policies and procedures as defined by the facilities service location? ☐ No ☐ Yes (provide an explanation):_____

Supplemental - Oklahoma Organizational Provider Types

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:
As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grant the Managed Care Organization permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Managed Care Organization to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply the Managed Care Organization with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for the Managed Care Organization to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support the Managed Care Organizations quality improvement and utilization review programs.

ATTESTATION:
I certify the information on this entire application is complete, accurate, and current. I acknowledge that any misstatements in or omissions from this application constitute for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that decision of participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with, the Managed Care Organization and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by the Managed Care Organization. All services rendered to its members must be individually authorized until a written notice of participation and conditions of participation is issued by the Managed Care Organization.

This facility complies with all federal, state and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify the applicant does not employ or contract with any individual convicted of a felony for a health-care related crime, including but not limited to health care fraud, patient abuse and the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

I certify that the on-line exclusion lists for the Health and Human Services Office of Inspector General (http://oig.hhs.gov/exclusions/exclusions_list.asp) and System for Award Management (https://www.sam.gov/portal/public/SAM/) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal health care program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal health care program.

The individual executing this attestation is duly authorized and has the proper authority and proper authorization to execute this attestation and does so with the intent to fully bind facility to the truthfulness of its answers.

Authorized Signer: _____ Date: _____

Printed Name of Signer: _____

Authorized Signer Title: _____Signer's Email Address: _____

Printed Facility Name: _____