



## 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**  
445 Hutchinson Avenue, Suite 550  
Columbus, Ohio 43235

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), 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)**

\_\_\_\_\_  
\_\_\_\_\_

**LIST COUNTIES YOU PRESENTLY SERVICE:**

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**SECTION B – ACCREDITATION**

INDICATE YOUR FACILITY'S ACCREDITING AGENCY BY CHECKING THE APPROPRIATE BOX BELOW:

- Accreditation Association for Ambulatory Care (AAHC)
- 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**

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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**

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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.

<b>SERVICE</b>	<b>ANCILLARY SERVICES</b>
<input type="checkbox"/> Abortion Services	<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"/> Anatomic Pathology Services	<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"/> Blood Bank	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cardiac Rehabilitation	<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"/> Cobalt Therapy	<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"/> Full Body	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Partial	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cystoscopy Services	<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"/> Diagnostic Radioisotope	<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"/> Electrocardiography	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Electroencephalography	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Endoscopy Service	<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"/> Hematologic Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Home Nursing Care (RN)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Interpretive Services:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cardiology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Neurology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Pathology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Radiology	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> IV Therapy	<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"/> Lithotripsy	<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"/> OB Anesthesia Svcs 24 Hour	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Oncology Services	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Organ Bank	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Ostomy Services	<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"/> Physical Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Radium Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Rehabilitation Therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Renal Dialysis Services	<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"/> Therapeutic Radioisotope	<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"/> X-ray Examination	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Other Services Provided Not Listed Above:**

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*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.

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SIGNATURE OF CHIEF ADMINISTRATOR OR AUTHORIZED DESIGNEE DATE

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PRINT NAME OF CHIEF ADMINISTRATOR OR AUTHORIZED DESIGNEE

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FACILITY NAME

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ADDRESS (street, city, state, zip)