

# ORGANIZATION/FACILITY CREDENTIALING/RECREDENTIALING APPLICATION

#### **CURRENT COPIES OF DOCUMENTS TO BE SUPPLIED WITH COMPLETED APPLICATION INCLUDES:**

- Current accreditation certificates
- Current State license (issued by a State Department of Health or Human Services Division)
- Current Drug Enforcement Administration (DEA) certificate (as applicable)
- Current Liability Insurance face sheet/certificate or a letter if coverage is self-insured or copy of surety bond

ORGAN	NIZATION/FACILITY 1:					
Name			Facility	/ Type:		
Comple	te Address					
City			State	Zip Code		
Phone N	Number:		Fax Number:			
Federal	Tax ID Number:		NPI Number:			
Contact	t Person		Phone	Fax	<del></del>	
Contact	t Address					
City			State	Zip Code		
Email A	ddress:	<del></del>	Does your facility provide lan	nguage translation/i	nterpreter services? ☐ Yes ☐ I	۷o
Licensu	ıre: Number	_ ls your license i	n good standing with the Sta	te? □ Yes □ No		
Medica	re: Number	_ Is your Medicare	e certification in good standir	ng? □ Yes □ No	Not Medicare certified $\square$	
DEA:	Number	(If applicable to	your organization/facility.)			
	Carriers Nar insured orga	ne, Name of Organi anizations/facilities	ization/Facility covered, Date , please provide a letter	es of Coverage and	surety bond which includes the Amount of Coverage. For self-	
			copy of your accreditation	n certificate(s) and	mark those that apply:	
	The Joint Commission (	` '	hcare Organizations (NIAHO	or DNV - Dot Norsk	o Voritae)	
	American Osteopathic A		ilicare Organizations (NIAHO	of Divy – Det Norsk	e ventas)	
_	Commission on Accred		tion Facilities (CARF)			
			Health Care, Inc. (AAAHC)			
	Community Health Accr					
			Ambulatory Surgery Facilities	s, Inc. (AAAASF)		
	Accreditation Commiss	ion for Health Care,	Inc. (ACHC)	,		
	Oregon Hospice Associ	ation (OHA)				

## Non-Accredited Facilities: Please provide the most recent copy of your State and/or Medicare survey/audit

Required for the following non-accredited facilities: Hospitals, Skilled Nursing/Rehab Facilities, Behavioral Health Facilities, Home Health Agencies/Home IV/Hospice, Ambulatory Surgical Centers, Birthing Centers.

#### Survey/audit documents must include:

□ Council on Accreditation (COA

Healthcare Quality Association on Accreditation (HQAA)

- Any identified deficiencies
- □ Correction action plan(s)

Other\_

#### Please Respond To The Following Questions:

Do you have a procedure/process in place to deal proactively with preventable patient errors or known potential errors?	□ Yes □ N
Has the organization ever been convicted of a criminal offense related to healthcare?	□ Yes □ N
Is the organization currently debarred, excluded, or otherwise ineligible for participation in Federal healthcare programs?	□ Yes □ N
Does the facility have any current sanctions from any government agency? If yes, provide a detailed explanation and	□ Yes □ N
corrective actions.	

ORGANIZATION/FACILITY 2	
Name	

Name		Fa	acility Type:			_
Comple	ete Address					
City		State	Zip	Code		_
Phone	Number:	Fax Number: _				
Federa	Tax ID Number:	NPI Number:				
Contac	t Person	Phone		_Fax		
Contac	t Address					_
City		State	Zip	Code		_
Email A	Address:	Does your facility provid	le language tran	slation/ir	nterpreter services?	∃ Yes □ No
Licensu	ure: Number	Is your license in good standing with the	e State? □ Yes	□No		
Medica	re: Number	Is your Medicare certification in good st	tanding? 🗆 Yes	□No	Not Medicare certif	fied □
DEA:	Number	(If applicable to your organization/facility	y.)			
Accrec	The Joint Commissing National Integrated American Osteopath Commission on Acceditation Association Accreditation Community Health American Association Accreditation Community Health Council on Accreditation Healthcare Quality American Accreditation Accre	Accreditation for Healthcare Organizations (NIA hic Association (AOA) creditation of Rehabilitation Facilities (CARF) ciation for Ambulatory Health Care, Inc. (AAAHO Accreditation Program (CHAP) on for Accreditation of Ambulatory Surgery Fac nission for Health Care, Inc. (ACHC) sociation (OHA)	AHO or DNV – D	et Norsk	-	ply:
Non-A		: Please provide the most recent copy of yo	 our State and/o	or Medic	are survev/audit	
Re He	quired for the followin	ng non-accredited facilities: Hospitals, Skilled No IV/Hospice, Ambulatory Surgical Centers, Birthi s must include: iencies	ursing/Rehab Fa		•	lities, Home
Please	•	ollowing Questions:				
Do you Has the Is the o	have a procedure/pro e organization ever beorganization currently of e facility have any curre	ocess in place to deal proactively with preventable en convicted of a criminal offense related to he debarred, excluded, or otherwise ineligible for pent sanctions from any government agency? If yes	althcare? articipation in Fe	ederal he	althcare programs?	Yes No Yes No Yes No

	Name		Facilit	y Type:	
omple	te Address				
ity			State	Zip Code	
hone N	Number:		Fax Number:		
ederal	Tax ID Number:		NPI Number:		
ontact	t Person		Phone	Fax	
ontact	t Address				
ity			State	Zip Code	
mail A	ddress:	Do	es your facility provide la	nguage translation/int	erpreter services?   Yes
icensu	ıre: Number	Is your license in g	good standing with the Sta	ate? □ Yes □ No	
/ledica	re: Number	Is your Medicare o	ertification in good stand	ing? □ Yes □ No	Not Medicare certified $\square$
EA:	Number	(If applicable to you	ır organization/facility.)		
iability	/ Insurance: Please pro	ovide a current copy of	our liability insurance factory	ce sheet/certificate/su	rety bond which includes the Amount of Coverage. For se
,			, please provide a letter.	ates of Soverage and	Amount of Governge. For Sc.
	insured l <u>ited Facilities</u> : <i>Pl</i> eas	organizations/facilities e provide a current co		-	-
\ccred	insured lited Facilities: Pleas The Joint Commissio	organizations/facilities e provide a current co n (TJC)	, please provide a letter.  py of your accreditatio	n certificate(s) and I	mark those that apply:
ccred	insured lited Facilities: Pleas The Joint Commissio	organizations/facilities e provide a current co n (TJC) ccreditation for Healthca	, please provide a letter.	n certificate(s) and I	mark those that apply:
Accred	insured lited Facilities: Pleas The Joint Commissio National Integrated A American Osteopathic Commission on Accre	e provide a current connection (TJC) coreditation for Healthca (Association (AOA) editation of Rehabilitation	please provide a letter.  py of your accreditation  are Organizations (NIAHO  n Facilities (CARF)	n certificate(s) and I	mark those that apply:
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Accred	insured lited Facilities: Pleas The Joint Commissio National Integrated A American Osteopathic Commission on Accre Accreditation Associa Community Health Ac	e provide a current conn (TJC) coreditation for Healthco Chassociation (AOA) editation of Rehabilitation for Ambulatory Heactereditation Program (Chassociation	pp of your accreditation are Organizations (NIAHO n Facilities (CARF) alth Care, Inc. (AAAHC)	<b>n certificate(s) and I</b> or DNV – Det Norske	mark those that apply:
Accred	insured lited Facilities: Pleas The Joint Commissio National Integrated A American Osteopathic Commission on Accre Accreditation Associat Community Health Ac American Association Accreditation Commi	e provide a current conn (TJC) cereditation for Healther Association (AOA) editation of Rehabilitation ation for Ambulatory Healther Cereditation Program (Chan for Accreditation of Amssion for Health Care, In	pp of your accreditation are Organizations (NIAHO n Facilities (CARF) alth Care, Inc. (AAAHC) HAP) abulatory Surgery Facilitie	<b>n certificate(s) and I</b> or DNV – Det Norske	mark those that apply:
Accred	insured lited Facilities: Pleas The Joint Commissio National Integrated A American Osteopathic Commission on Accre Accreditation Associat Community Health Ac American Association Accreditation Commi Oregon Hospice Asso	e provide a current conn (TJC) ccreditation for Healthcate Association (AOA) editation of Rehabilitation attion for Ambulatory Healthcate Careditation Program (Chan for Accreditation of Amssion for Health Care, Insciation (OHA)	pp of your accreditation are Organizations (NIAHO n Facilities (CARF) alth Care, Inc. (AAAHC) HAP) abulatory Surgery Facilitie	<b>n certificate(s) and I</b> or DNV – Det Norske	mark those that apply:
Accred	insured lited Facilities: Pleas The Joint Commissio National Integrated A American Osteopathic Commission on Accre Accreditation Associat Community Health Ac American Association Accreditation Commi Oregon Hospice Associ	e provide a current conn (TJC) ccreditation for Healthcate Association (AOA) editation of Rehabilitation attion for Ambulatory Healthcate Careditation Program (Chan for Accreditation of Amssion for Health Care, Insciation (OHA)	pp of your accreditation are Organizations (NIAHO n Facilities (CARF) alth Care, Inc. (AAAHC) HAP) nbulatory Surgery Facilities (ACHC)	<b>n certificate(s) and I</b> or DNV – Det Norske	mark those that apply:

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## Survey/audit documents must include:

- □ Any identified deficiencies
- ☐ Correction action plan(s)

## Please Respond To The Following Questions:

Do you have a procedure/process in place to deal proactively with preventable patient errors or known potential errors?	□ Yes □ No
Has the organization ever been convicted of a criminal offense related to healthcare?	□ Yes □ No
Is the organization currently debarred, excluded, or otherwise ineligible for participation in Federal healthcare programs?	□ Yes □ No
Does the facility have any current sanctions from any government agency? If yes, provide a detailed explanation and corrective	□ Yes □ No
actions.	

Name	F	acility Type:	
Complete Address			
City	State	Zip Code	
Phone Number:	Fax Number:		
ederal Tax ID Number:	NPI Number	·	
Contact Person	Phone	Fax	
Contact Address			
	State		
	Does your facility provi	•	
	Is your license in good standing with the		
	Is your Medicare certification in good s		Not Medicare certified □
	(If applicable to your organization/facilit	•	Not wedicare certified :
	ovide a current copy of your liability insurance Name, Name of Organization/Facility cover	ed, Dates of Coverage ar	nd Amount of Coverage. For se
Carriers	organizations/facilities, please provide a let		go
Carriers insured	organizations/facilities, please provide a let e provide a current copy of your accredit	tter.	_

Required for the following non-accredited facilities: Hospitals, Skilled Nursing/Rehab Facilities, Behavioral Health Facilities, Home Health Agencies/Home IV/Hospice, Ambulatory Surgical Centers, Birthing Centers.

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Does the facility have any current sanctions from any government agency? If yes, provide a detailed explanation and corrective actions.

For any other organizations/facilities that are part of your contract, included complete additional copies of the above form.	ling those listed below, please
AUTHORIZATION/ATTESTATION:	
I authorize and consent to the release of information necessary for evaluation or and hold harmless any person or organization furnishing such information.	f this application. I release from liability
I understand and agree that discovery of false or intentionally omitted material in the application or termination of any contract awarded in consideration of this a	
I understand this submitted application will be considered in evaluating contract networks sponsored by LifeWise Health Plan of Washington.	ing or continued contracting status in
I understand that medical records will be subject to inspection by representative	s of LifeWise.
I understand that completion and submission of this application does not autom any LifeWise provider network, but that such status is dependent, in part, on eva This application is not a contract.	, •
I understand that until I am notified that this application is approved, and a writte may not represent myself as a contracted provider in any LifeWise provider netw provider with LifeWise, I may continue in that status while evaluation of this app	ork. However, if I am already a contracted
I grant LifeWise staff or agent permission to conduct an on-site review with prior	notification.
I certify that the information contained in this application is complete, accurate a	and true.
Authorized Signature	Date
Print Name	Title