Highmark Wholecare
Organizational Provider Participation Application

(Hospital/Ancillary Credentialing Application)

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable or not available and reason. Attach additional sheets when necessary. Separate forms may be required for each practice location and provider type.

Business Information

Facility/Ancillary Classification:	Federal Tax Identification Number:

Legal Name of Applicant:
Doing Business As (DBA):
Primary Office Address:

City:	State:	Zip Code:	County:

Primary Phone:	Primary Fax:	Web Address:

Mailing Address (if different from Primary)	City	State	Zip Code
Billing Address:	City:	State:	Zip Code:

Billing Phone:	Billing Fax:	Email Address:

Credentialing Address:	City:	State:	Zip Code:

Credentialing Contact:	Credentialing Phone:	Credentialing Fax:	Credentialing Email Address:

Legal Notice Address:	City:	State:	Zip Code:

Attention:

Ownership: Status:	Privately Owned	Publicly Owned	Government Owned
	For Profit	Not For Profit	

Part of a Multi-Facility Chain? Yes No	If Yes, Name of Parent Company:
Interpreters Available Company Wide? Yes No	Options for Interpretation Services On-Site Telephonic Video None

Languages Interpreted				
English	Spanish	Sign	Other Language	Other Language

Business Staff Contacts

Chief Executive Office:	Phone:
Chief Financial Officer:	Phone:
Medical Officer:	Phone:
Billing Contact:	Phone:
Appeals/Grievances Contact:	Phone:

Licensure/Certification

Please complete the following information as applicable to your facility/ancillary service. Submit a current copy of each certificate. For facilities with several locations, please complete the Site Specific Information section for each location within this questionnaire.

State Licensure/Registration Number:		Expiration Date:
Medicaid Provider Number:	Medicare Provider Number:	National Provider Identifier Number (NPI):
Therapy Providers, Please Indicate Medicare Certification:	CORF ORF	OPT

Accreditation

Please indicate all organizations that have accredited your facility, e.g., JOINT COMMISSION, CARF, AAPH, ACR, AAAHC, CHAP, ABC, etc. Please attach a copy of each certificate of accreditation. If Facility/Ancillary is not accredited by an appropriate accrediting body, submit your last state survey.

NOTE: Highmark Wholecare® may also complete a site visit for adequate assessment of quality.

Accreditation Body:		JC HCO#:	
Accreditation Status:	Expiration Date:	Recent Survey:	Expected Next Survey:

Non-Accredited Facilities

Last Survey Date: Compliant	Deficiencies Found (Attach Documentation Detailing Deficiencies)
Date Corrective Action Plan Submitted:	** Submit copies of Recent State Survey, Corrective Action Plans and Revisit Reports

Liability and Insurance Information

Please attach a copy of the declaration page (face sheet) of each insurance policy indicating current status, coverage effective dates and coverage amounts.

Type of Coverage	Policy Effective Dates	Policy End Date	Limit Per Claim	Aggregate Limit	Umbrella Limit
Professional Liability			$	$	$
General Liability			$	$	$

Policy Number(s): ____

Name of Professional Carrier: ____

Name of General Carrier: ____

Liability Information/Disclosure Questions

If you answer "YES" to any of the following questions, please provide details on a separate sheet of paper.

1. Has your facility/ancillary service been disciplined by any state licensing or other authorizing agency, or have you been reprimanded, or fined by any state agency that disciplines healthcare facilities of ancillary services within the last five years?	Yes	NO	
2. Has your facility/ancillary service been reprimanded, censured, excluded, suspended, or disqualified by the Medicare, Medicaid, or CLIA programs within the last five years?	Yes	NO	
3. Has the pharmacy license been suspended or otherwise limited for your facility/ancillary service within the last five years?	Yes	NO	N/A
4. Have any malpractice suits, arbitrations or other proceedings been instituted against your facility/ancillary service in the last five years? If yes, please indicate the number of open cases and the number of settled cases.	Yes	NO	
5. Has your facility/ancillary service been canceled, non-reviewed, or restricted by an insurance carrier within the last five years?	Yes	NO	
6. Has your facility/ancillary service had membership in a professional organization revoked, reduced, denied, or suspended within the last five years?	Yes	NO	

Release of Liability and Attestation of Truth

The facility/ancillary consents to the review of records and documents that may be material to any evaluation of the facility's competence. Facility/ancillary releases from liability individuals and organizations that provide information, including otherwise privileged or confidential information to Highmark Wholecare ® representatives in good faith and without malice concerning the facility's competence.

Facility/ancillary certifies that all the information in this application is correct and complete. Any information in this application that is later determined to be false may result in contract termination. Facility/ancillary is aware that review of the information in this application will form the basis for the Highmark Wholecare ® credentialing assessment process regarding facility/ancillary's participation in the Highmark Wholecare ® network.

Facility/ancillary certifies that all the information in this application is correct and complete for all sites listed on this application. If necessary attach a separate disclosure and attestation for additional sites, as applicable.

______________________________	______________________________
Printed Name of Facility/Ancillary Representative	Signature
______________________________	______________________________
Title	Date

Site Specific Information

Duplicate this page as necessary and complete the following for each location operated by your facility/ancillary service. Please include copies of all site -specific documentation as listed below.

Facility Classification:				Federal Tax Id Number:
Legal Name of Applicant:				
Doing Business As (DBA):				
Primary Office Address:				
City:	State:	Zip Code:	County:	
Mailing Address (if different from Business):		City:	State:	Zip Code:
Primary Phone:	Primary Fax:		Web Address:	

Languages Spoken By Office Personnel				
English	Spanish	Sign	Other Language	Other Language

Interpreters Available? Yes No	Options for Interpretation Services On-Site Telephonic Video None

Languages Interpreted				
English	Spanish	Sign	Other Language	Other Language

Licensure/Certification

Please complete the following information as applicable to your facility/ancillary service. Submit a current copy of each certificate.

State Licensure/Registration Number:		Expiration Date:
Master Provider Index Number (MPI):	Medicare Provider Number:	National Provider Identifier Number (NPI):
Therapy Providers, Please Indicate Medicare Certification: CORF ORF OPT		

Accreditation

Please indicate all organizations that have accredited your facility, e.g., attach a copy of each certificate of accreditation and the report from the last survey.

Accreditation Body:		JC HCO#:	
Accreditation Status:	Expiration Date:	Recent Survey:	Expected Next Survey:

Non-Accredited Facilities

Last Survey Date:	Compliant	Deficiencies Found (Attach Documentation Detailing Deficiencies)
Date Corrective Action Plan Submitted:	** Submit copies of Recent State Survey, Corrective Action Plans and Revisit Reports	

The below fields must be completed for all of the following provider types that practice within the facility: Audiology (AUD), Physical/Occupational /Speech Therapy (PT/OT/SP), FQHC, RHC, CBHC, Urgent Care *. Practitioners practicing at an Ambulatory Surgery Center – ONLY if billing on a HCFA 1500 form. Please include a copy of current license for each provider listed.

SITE SPECIFIC INFORMATION *** All required fields, as applicable.**

Name of Group:

Address:

Panel Size: **Age Limit**: (Panel size and Age Limits are only applicable to FQHC, RHC, CBHC, and Urgent Care)

Medicare#:

Medicaid #:

Tax ID:

1. How do you bill? Professional Only Technical Only Professional & Technical

2. On what form do you bill? HCFA 1500 UB 92

3. Will Highmark Wholecare receive a separate bill from the physician for professional services? Yes No

Add/Remove	First Name	M.I	Last Name & Suffix	DOB	Gender	Ethnicity	Degree	Specialty	NPI	SSN	Medicare #	Medicaid #	License #

SITE SPECIFIC INFORMATION

Address (list address): ____

Facility/Ancillary Services Check List

Please fill out what specific services you provide. Please check all boxes that apply. This is important in how we list what services you offer in the directory. If site specific please repeat this page as many times as needed listing the address at the top.

Ambulance:

- ☐ Advanced Life Support (ALS)
- ☐ Basic Life Support (BLS)
- ☐ Wheelchair Van

Durable Medical Equipment:

- ☐ Bedside Commodes
  - o Specialty
  - o Standard
- ☐ Breast Pumps
- ☐ Breast Prosthesis/Bras
- ☐ Catheters
- ☐ Crutches
- ☐ Enteral Supply (oral)
- ☐ Hospital Beds
- ☐ Hoyer Lifts (non-standard lifts)
- ☐ Incontinence Supplies
  - o Diapers
  - o Pull-Ups
- ☐ Insulin Pumps
- ☐ Molded Shoes
- ☐ Ostomy Supplies
- ☐ Respiratory Equipment
  - o Bi-PAP
  - o C-PAP
- ☐ Rifton Equipment
- ☐ Specialty Mattresses
- ☐ Splints/braces
- ☐ Support Stockings
- ☐ TENS Units
- ☐ Walkers
  - o Specialty
  - o Standard
- ☐ Wheelchairs
  - o Customized
  - o Standard
- ☐ Wound Care Supplies

Abuse Centers:

- ☐ Physical Abuse
- ☐ Sexual Abuse

Audiology:

- ☐ Hearing Aids
- ☐ Speech Therapy

Home Health:

- ☐ Home Health Aides
- ☐ Hospice
- ☐ Mom/Baby Maternity Visits
  - o Prenatal
  - o Postpartum
- ☐ Ostomy Nurse
- ☐ Private Duty
  - o Home Health Aides
  - o RN, LPN care
- ☐ Psychiatric Visits
- ☐ Social Worker
- ☐ Therapy Home Visits
  - o Adult OT
  - o Adult PT
  - o Adult ST
  - o Pediatric OT
  - o Pediatric PT
  - o Pediatric ST

Skilled Nursing Facility:

- ☐ TPN
- ☐ Tracheostomy
- ☐ Ventilator Dependent Patients
- ☐ Wound-Vac Care
- ☐ Dialysis
- ☐ Long-Term Care
- ☐ Bariatric Beds/Services

Rehabilitation Hospital/Free-Standing Therapy:

- ☐ Adult Occupational Therapy
- ☐ Adult Physical Therapy
  - o Aquatic Therapy
- ☐ Adult Speech Therapy
- ☐ Pediatric Occupation Therapy (<21 years)
  - o Autism Services
- ☐ Pediatric Physical Therapy (<21 years)
  - o Autism Services
- ☐ Pediatric Speech Therapy (<21 years)
  - o Autism Services

Continued on Next Page...

SITE SPECIFIC INFORMATION

Address (list address): ____________________

Facility/Ancillary Services Check List - Cont'd...

Please fill out what specific services you provide. Please check all boxes that apply. This is important in how we list what services you offer in the directory. If site specific please repeat this page as many times as needed listing the address at the top.

Hospital Services:

- ☐ Cardiac Catheterization Services
- ☐ Cardiac Surgery Program
- ☐ Critical Care Services - Intensive Care Units (ICU)
- ☐ Diagnostic Radiology
- ☐ Inpatient Psychiatric Facility Services
- ☐ Mammography
- ☐ Occupational Therapy
- ☐ Outpatient Infusion/Chemotherapy
- ☐ Physical Therapy
- ☐ Skilled Nursing Facilities
- ☐ Speech Therapy
- ☐ Surgical Services (Outpatient or ASC)

Behavioral Health Special Clinics:

- ☐ Centers of Opioid Excellence (Medicaid)
- ☐ Opioid Treatment Program Clinic (Medicare, please include certification)

Preferred Lab for Locations (ie Labcorp, etc): ____________________

County Checklist

- *This is required for any provider who provides services in the home or delivery based providers. This includes DME services. This gives members and providers greater insight into the community your company services.*

Please list the counties the Facility/Ancillary will be servicing below:

☐ ***Covers All Pennsylvania Counties***

if not select those regions and or counties below that apply:

County where Services are provided

South West Region – Greater Allegheny

☐ All Counties, if not select those below that apply

☐ Allegheny
☐ Armstrong
☐ Beaver
☐ Bedford
☐ Blair
☐ Butler
☐ Cambria
☐ Fayette
☐ Greene
☐ Indiana
☐ Lawrence
☐ Somerset
☐ Washington
☐ Westmoreland

North East Region

☐ All Counties, if not select those below that apply

☐ Bradford
☐ Carbon
☐ Centre
☐ Clinton
☐ Columbia
☐ Juniata
☐ Lackawanna
☐ Luzerne
☐ Lycoming
☐ Mifflin
☐ Monroe
☐ Montour
☐ Northumberland
☐ Pike
☐ Schuylkill
☐ Snyder
☐ Sullivan
☐ Susquehanna

Lehigh – Capital Region

☐ All Counties, if not select those below that apply

☐ Adams
☐ Berks
☐ Cumberland
☐ Dauphin
☐ Franklin
☐ Fulton
☐ Huntingdon
☐ Lancaster
☐ Lebanon
☐ Lehigh
☐ Perry
☐ York

South East Region– Greater Philadelphia Region

☐ All Counties, if not select those below that apply

☐ Bucks
☐ Chester
☐ Delaware
☐ Montgomery
☐ Philadelphia

North West Region

☐ All Counties, if not select those below that apply

☐ Cameron
☐ Clarion
☐ Clearfield
☐ Crawford
☐ Elk
☐ Erie
☐ Forest
☐ Jefferson
☐ McKean
☐ Mercer
☐ Potter
☐ Venango
☐ Warren