Facility credentialing application instructions

Facility credentialing application instructions

The facility credentialing on the following pages must be completed for each location you are seeking to be credentialed and contracted with UnitedHealthcare.

Please include the following items for each location with your completed/signed application:

- ☐ Copy of current state license (if applicable)
- ☐ Evidence of current Medicare certification, including verification of survey completed within the last 36 months (if applicable)
- ☐ All appropriate accreditation certificates or letters for each location, including verification of survey completed within the last 36 months (if applicable)
- ☐ Copy of declaration sheet or certificate of insurance for current professional malpractice and comprehensive general liability insurance policies

If you have questions about this application process, please email **networkhelp@uhc.com.** Include your facility's full name, national provider identifier (NPI) number, tax identification number (TIN) and brief description of your request. A UnitedHealthcare representative will contact you within 2 business days from the receipt of your request.

Please submit the completed application and all required documentation using the online portal at **ncc-optum.secure.force.com/facilityRFP/.**

Please note:

Initial credentialing – Failure to legibly complete all sections of this application and submit current copies of all required documentation will result in processing delays.

Facility Credentialing Application

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Attach additional sheets when necessary.	
Type of facility (as listed on license or accreditation)	
☐ Skilled nursing facility Do you service adults? Yes ☐ No ☐ Do you service pediatrics? Yes ☐ No ☐	☐ Ambulatory surgery center
☐ Home health agency Do you provide private duty nursing? Yes ☐ No ☐ Do you provide personal care? Yes ☐ No ☐	☐ Dialysis center ☐ Hospice
☐ Clinical laboratories	☐ Diabetes education center
☐ Portable X-ray supplier	☐ Rural health center

☐ Comprehensive outpatient rehabilitation facilities (CORF)	☐ Hospital (specify type):
☐ Federally Qualified Health Center (FQHC)	☐ Other (please specify):

Facility demographics

Legal business name (as reported to the IRS):	Federal tax identification number (TIN):
Doing business as (dba) name (if applicable):	Hospital or health system affiliation: ☐ Not affiliated with any hospital/health system

Mailing/correspondence address:

City:	State:	ZIP code:	County:

Billing name (if different than dba):

Billing address:

City:	State:	ZIP code:	County:

Phone #:	Fax #:
Credentialing contact name:	Phone #:

Credentialing mailing/correspondence address:

City:	State:	ZIP code:	County:

Email address:	Fax #:

Primary location

Street address:

City:	State:	ZIP code:	County:

Phone #:	Fax #:

State license #: **Please provide a copy of state license* Expiration date:_____	CLIA #: Expiration date:_____
National provider identifier (NPI) #: (application cannot be processed without a valid 10-digit NPI #)	Taxonomy #:

Medicare certified? ☐ Yes ☐ No

**Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter.*

Medicare #:

Medicaid #:

Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of most recent accreditation report.

☐ Accreditation Commission for Health Care, Inc.	☐ Commission on Accreditation of Rehabilitation Facilities
☐ American Association for Accreditation of Ambulatory Surgery	☐ Commission on Office Laboratory Accreditation
☐ American Association for Ambulatory Health Care	☐ Community Health Accreditation
☐ American College of Radiology	☐ Det Norske Veritas Healthcare, Inc.
☐ American Osteopathic Association	☐ Healthcare Facilities Accreditation Program
☐ Center for Improvement in Healthcare Quality	☐ Joint Commission
☐ Not applicable	☐ Other

Professional liability: **** Please provide a copy of Current Liability Declaration Sheet*** Name of carrier: Effective date: Expiration date: Per incident: $ Per aggregate: $	**Comprehensive liability:** **** Please provide a copy of Current Liability Declaration Sheet*** Name of carrier: Effective date: Expiration date: Per incident: $ Per aggregate: $

Supplemental form

For each additional address, copy and complete this supplemental form.
Return all copies with the completed application.

Street address:

City:	State:	ZIP code:	County:

Phone #:	Fax #:
State license #: **Please provide a copy of state license* Expiration date: _____	CLIA #: Expiration date:_____
NPI #: (application cannot be processed without a valid 10-digit NPI #)	Taxonomy #:

Medicare certified? ☐ Yes ☐ No

**Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter.*

Medicare #:

Medicaid #:

Accreditation:
Does this site have the same accrediting agency as the primary address?

☐ Yes

☐ No. Please specify accrediting agency or NONE:_____

Policies & procedures:
Does this site follow the same policies and procedures as the primary facility?

☐ Yes

☐ No

Disclosure questions

Please answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.

1. Has the facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?	☐ Yes	☐ No
2. Has the facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?	☐ Yes	☐ No
3. Has the facility ever had its professional liability coverage canceled or not renewed?	☐ Yes	☐ No
4. Has the facility been denied accreditation by its selected accrediting body (e.g., TJC), or had its accreditation status reduced, suspended, revoked or in any way revised by the accrediting body?	☐ Yes	☐ No

Facility Attestation/Consent & Release form

Any alteration or failure to sign and date this form will result in the delay of processing this application.

By signing below, I attest that I am the duly authorized representative of the facility, that all information on the application pertains to the above-named facility, and that such information is current, complete and correct.

Your signature is required to complete this application.

Facility name: _____

Name (please print): _____

Title: _____

Signature: _____

Date: _____

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United Healthcare