HOSPITAL APPLICATION FOR PARTICIPATION
PHYSICIANS HEALTH PLAN
PO Box 30377, Lansing, MI 48909-7877
517.364.8312

INSTRUCTIONS: Please provide answers to all questions. If the answer is none or if the question is not applicable to you or your organization, please so indicate. Please print or type your answers. If further space is needed for you to provide complete answers, please attach additional sheets of paper for such answers and indicate on the sheet the applicable question number. The hospital has the right to review information submitted in support of their credentialing application and the right to correct erroneous information. Physicians Health Plan does not discriminate consideration for application based solely on an applicant's race, ethnic/national identity, gender, age, sexual orientation, or the types of procedures or types of patients the applicant specializes in. Upon request, the hospital has the right to be notified of the status of their application.

I. IDENTIFICATION INFORMATION

A. Name of Applicant: _____
Name of Company and/or Subsidiary (Legal name of entity with which the agreement will be executed)

_____
Street City State Zip Phone

B. Name of Executive Officer and Title: _____

C. In accordance with Title 42 CFR § 455.104, list the names, addresses and social security number of all owners with 5% of more ownership of control interest:

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

D. In accordance with Title 42 CFR 455.106, list the names and social security number of any managing employee (such as general manager, business manager, administrators, directors or other individuals) who exercises operational or managerial control over or who directly or indirectly conducts day-to-day operation of your office or facility.

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

II. LICENSING INFORMATION – Please attach a copy of all current licenses and/or Medicare certification.

A. Please provide the following information:

State Date of License License Number Expiration Date

_____

_____

_____

B. Medicaid Provider #: _____ Medicare Provider #: _____

C. Has your Facility been accredited by any national accreditation organization? Yes ___ No ____

If **YES**, supply the name of the accreditation organization and relevant documentation. Include a copy of the accreditation certificate and the **SURVEY REPORT** for accrediting body. _____

_____

III. LIABILITY INSURANCE INFORMATION – Please attach a current copy/copies of your professional, business/general, and product liability (where applicable) insurance policies.

A. NAME OF PRESENT CARRIER EXPIRATION DATE

_____

_____

	Limits of Coverage		
	Per Occurrence	Aggregate	Remaining
Professional Liability	$ _____	$ _____	$ _____
Business/General Liability	$ _____	$ _____	$ _____
Product Liability	$ _____	$ _____	$ _____

B. NAME OF PRIOR CARRIER(S), if you have changed carriers within the last five years: _____

_____

_____

IV. OTHER INFORMATION

A. In which Michigan communities/counties do you provide services? _____

_____

B. In accordance with Title 42 CFR § 455.106 has any person who has ownership or control interest in the organization, is an agent or managing employee of the organization, ever been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs? Yes _____ No _____

If yes, please list the names and social security numbers of these individuals below:

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

_____ _____
Legal Name, Title Social Security Number (SSN)

C. Has the hospital, or employee or agent of hospital, been convicted of a felony or other act involving dishonesty, fraud, deceit or misrepresentation; or has the hospital, or employee or agent of the hospital been under investigation by appropriate legal authority with respect to such conduct? Yes _____ No _____

If **YES**, please explain: _____

_____

D. Has the hospital engaged in or been under investigation, with respect to conduct, in violation of state or federal law or standards of ethical conduct governing the business practice or conduct for which the hospital is or might have been disciplined or otherwise censured? Yes _____ No _____

If **YES**, please provide relevant documentation: _____

E. Has the hospital had restrictions placed on its business practices by a review board or other similar body or governmental agency? Yes _____ No _____

If **YES**, please provide relevant documentation: _____

V. GENERAL INFORMATION FOR CLAIMS PROCESSING AND PROVIDER DIRECTORY

Please complete this section for each location where you provide services. You may attach additional copies if needed. If accredited, please attach an additional copy for each location included in your accreditation.

Please circle the appropriate site:

Site One Site Two Site Three Site _____ Hours of Operation: _____

Street Address: _____ Phone: _____ Fax: _____

City, State, Zip Code: _____

Check Name: _____

Taxpayer ID# (Attach copy of W9): _____

Street Address to which checks should be mailed: _____

National Provider Identifier (Type 2 NPI): _____

Do you provide any services at this location under any additional NPI numbers? _____

If yes, please provide the additional NPI number(s) and services specific to that NPI.

_____

_____

Taxonomy Code: _____

Type of claim form used: CMS 1500 _____ UB 92 _____

Person to contact concerning claims/administrative questions:

_____

Name Title Phone E-Mail Address

Please complete the services/programs section on the following page for all services/programs provided at this location.

F. Check the boxes for all services/programs the hospital has available to members and complete any appropriate responses related to the services listed. Please complete this section for each location.

- ☐ Acute Inpatient Care
  Number of Beds _____
- ☐ Cardiac Surgery Program
- ☐ Cardiac Catheterization Services
- ☐ Critical Care Services/Intensive Care Units (ICU)
  Number of Beds _____
- ☐ Diagnostic Radiology
- ☐ X-Ray
- ☐ MRI
- ☐ CT Scan
- ☐ PET Scan
- ☐ Laboratory Services
- ☐ Hospital Med/Surgical
  Number of Beds_____
- ☐ Hospital OB
  Number of Beds_____
- ☐ Hospital Pediatric
  Number of Beds_____
- ☐ Inpatient Psychiatric Facility
  Number of Beds_____
- ☐ Sleep Lab
  Number of Beds_____
- ☐ Outpatient Substance Abuse
- ☐ Inpatient Substance Abuse
- ☐ Outpatient Behavioral Health
- ☐ Outpatient Dialysis
- ☐ Physical Therapy
- ☐ Occupational Therapy
- ☐ Speech Therapy
- ☐ Nuclear Cardiology
- ☐ Surgical Services (Outpatient or ASC)
- ☐ Skilled Nursing Facilities
  Number of Beds _____
- ☐ Inpatient Psychiatric Facility Services
  Number of Beds
- ☐ Orthotics and Prosthetics
- ☐ Home Health
- ☐ Durable Medical Equipment
- ☐ Outpatient Infusion/Chemotherapy
- ☐ Transplant Program

(Identify the types of transplants below)

☐ Heart ☐ Heart/Lung ☐ Kidney
☐ Liver ☐ Lung ☐ Pancreas

☐ Other Services: _____

_____

_____

ATTESTATION, RELEASE, AND SIGNATURE

I THE UNDERSIGNED, AS AUTHORIZED REPRESENTATIVE OF THE HOSPITAL, HEREBY CERTIFY THAT ALL INFORMATION CONTAINED IN THIS APPLICATION AND ALL THE ATTACHMENTS, ARE ACCURATE, COMPLETE AND TRUE.

THE HOSPITAL understands that:

(a) the information contained in this application will be kept confidential and will only be used for credentialing within Physicians Health Plan;

(b) any information contained in this application which subsequently is found to be false or intentionally misleading may result in denial of the application or termination of hospital's participation in Physicians Health Plan;

(c) it is the hospital's responsibility to promptly advise Physicians Health Plan of any changes or additions to the information contained in this application;

(d) all of the information contained in this application or its attachments is subject to Physicians Health Plan's investigation and review;

(e) this is an application only and the hospital's submission of this application does not automatically result in participation with Physicians Health Plan; and

(f) investigation of any information contained in this application or its attachments may be performed by a Credentials Verification Organization (CVO) designated by Physicians Health Plan and any authorization or release hereunder made is also given to any such CVO of Physicians Health Plan.

THE HOSPITAL certifies that the statement below is accurate, complete and true:

- The credentials of those physicians, podiatrists, dentists, and other allied health professionals who provide services on behalf of hospital have been reviewed by hospital, and hospital has in place a process whereby it regularly reviews the credentials of health care professionals that provide services on behalf of hospital.

THE HOSPITAL HEREBY RELEASES FROM LIABILITY ALL REPRESENTATIVES OF PHYSICIANS HEALTH PLAN, FOR THEIR ACTS PERFORMED IN GOOD FAITH AND WITHOUT MALICE IN CONNECTION WITH EVALUATING THIS APPLICATION. THE HOSPITAL RELEASES FROM ANY LIABILITY ANY AND ALL INDIVIDUALS AND ORGANIZATIONS WHO PROVIDE INFORMATION TO PHYSICIANS HEALTH PLAN, IN GOOD FAITH AND WITHOUT MALICE CONCERNING ITS APPLICATION. THE HOSPITAL HEREBY CONSENTS TO THE RELEASE AND EXCHANGE OF INFORMATION RELATING TO ANY DISCIPLINARY ACTION, SUSPENSION, OR CURTAILMENT OF PRIVILEGES TO PHYSICIANS HEALTH PLAN.

In the event the hospital is accepted for participation in Physicians Health Plan, the hospital consents to inspection of its patient records relating to Physicians Health Plan's enrollees as necessary for their peer review and utilization processes. The hospital further consents to the inspection by representatives of Physicians Health Plan of all documents that may be material to an evaluation of the hospital's professional competence and ethical qualifications.

The hospital understands that if its application is rejected for reasons relating to professional conduct or competence, Physicians Health Plan may report the rejection to the appropriate state licensing board, National Practitioner Data Bank, and/or the Healthcare Integrity & Protection Data Bank.

A PHOTOCOPY OF THIS DOCUMENT SHALL BE AS EFFECTIVE AS THE ORIGINAL.

Organization Name:_____

By:_____ Date: _____

Its:_____

CHECKLIST

(Please be sure to attach all applicable items before forwarding to PHP)

HOSPITAL
APPLICATION FOR PARTICIPATION

CHECK OFF	COPY ENCLOSED OF:	REFERENCE
	Current license, Medicare certification, DEA license, CLIA License, for organization	**II.**
	Survey Report from national accreditation organization (if applicable)	**II.** Attach copy of certificate and report
	Copy of current Professional, Business/General and Product Liability insurance policies *showing amount of coverage and dates of policy period*	**III.** A
	Signed Certificate and Release Form	Attached Form
	Copy of W-9 Form	Attach Copy of Form