CARE to CARE
MULTI-SPECIALTY MANAGEMENT

485 Madison Avenue – Suite 202
New York, NY 10022
Phone - 212-747-1000
Fax – 212-867-3371

FACILITY CREDENTIALING APPLICATION

CREDENTIALING CHECKLIST

Primary Facility Name: _____

Physician Name: _____

(Please duplicate this page for every physician to be credentialed)

FACILITY INFORMATION

☐ Facility application completed in its entirety and signed/dated by Authorized signatory

☐ Copy of all current facility licenses/certifications for each site

☐ W-9 Form

☐ Copy of Organization's Commercial General Liability Insurance and Professional Liability Insurance Face Sheets covering all sites

☐ All current equipment ACR, FDA, JCAHO or Other Accreditation Certificates by site, as applicable

PLEASE SUBMIT APPLICATION AND ALL SUPPORTING DOCUMENTS TO:

Care to Care
485 Madison Avenue Suite 202
New York, NY 10022
Attn: Credentialing Department

Fax #: (212) 867-3371
Email: credentialing@caretocare.com

Phone #: (888) 836-3899

CORPORATE ORGANIZATION INFORMATION

CORPORATE ORGANIZATION INFORMATION

Please complete only if different from the individual facility.

Corporation Name (As Filed With The IRS):	
DBA:	
Corporate Federal Tax ID#:	
Corporate Address:	
Corporate Zip Code:	
Corporate County:	
Corporate Telephone #:	
Corporate Fax #:	
Corporate Office Contact Name & Title:	
Corporate Contact E-Mail Address:	

BILLING/REMITTANCE INFORMATION

If billing/remittance address and contact information is different from above, please complete the following:

Billing Company Name:	
Address, State Zip:	
Telephone #:	
Fax #:	
Contact Name & Title:	
Contact Telephone #:	
Contact Fax #:	

CORRESPONDENCE LOCATION INFORMATION

Location Name:	
Complete Address:	
Telephone #:	
Fax #:	
Credentialing Contact:	
Credentialing Contact Telephone #:	
Credentialing Contact Fax #:	
Credentialing Contact E-Mail Address:	

PART I: INDIVIDUAL FACILITY INFORMATION

(This part must be completed for each facility location. Please make additional copies as needed for each facility location)

Facility Tax ID # _____

FACILITY INFORMATION *(as you would like it to appear in a directory)*

Facility Name:	
Address & Zip Code:	
County:	
Telephone #:	
Fax #:	
Areas Served By Facility: (County/Zip Codes)	
Facility Medicare #:	
Facility Medicaid #:	
Facility NPI #:	

FACILITY CONTACT INFORMATION

Facility Scheduling Contact Name and Title:	
Facility Scheduling Contact Phone #:	
Facility Scheduling Fax #:	
Contact E-mail Address:	
Medical Director:	
Website:	

TYPE OF FACILITY

☐ **Free Standing Imaging Facility** ☐ **Physician's Office** ☐ **Hospital-Based Facility**
☐ **Mobile Services Unit** ☐ **Other**_____

FACILITY LICENSURE

Is your facility licensed by the state? ☐ Yes ☐ No ☐ N/A
If yes, please give the following information for each license type:

Facility Licensure/Certification *(Attach copies of all licensures and certificates)*

State	Type of License	License Number	Expiration Date

FACILITY INFORMATION

Hours of Operation:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

What is the average waiting time (days) to obtain a routine appointment in your office?

CT		MR		PET		Screening Mammo	

What is the average waiting time to obtain an urgent appointment?

CT		MR		PET		Diagnostic Mammo	

Do you offer sedation?	☐ Yes	☐ No
Do you accept worker's compensation cases?	☐ Yes	☐ No
Handicapped accessible?	☐ Yes	☐ No
Hearing impaired accommodations? (TTY/TDD)	☐ Yes	☐ No
Hearing impaired accommodations? (ASL)	☐ Yes	☐ No
Languages spoken by staff at this location:		

FACILITY INSURANCE

Please complete the information below with the liability insurance information for the facility.
(Attach copies of all policy certificates.)

Type Of Insurance	Carrier Name	Policy Number	Policy Terms		Limits of Liability	
			From Date	To Date	Occurrence	Aggregate
General Liability Insurance						
Professional Liability Insurance						
Facility Other Liability Insurance						

FACILITY EQUIPMENT

Equipment Summary: Please check all services you provide at your facility and complete all equipment specifications.

Services Facility Provides: *(Check all that apply)*

☐ CT
☐ EMG
☐ MRI
☐ Myelography
☐ PET
☐ Arthrography
☐ Bone Densitometry
☐ Breast MRI & MR Guided
Breast Biopsy
☐ Fluoroscopy
☐ IVP
☐ Mammography
☐ Ultrasound
☐ X-ray
☐ CTA
☐ Doppler Studies
☐ PET-CT
☐ Low Dose CT
☐ Echocardiography
☐ EKG
☐ Holter Monitoring
☐ MRA
☐ Nuclear Cardiography
☐ Nuclear Medicine
☐ Other
☐ CCTA

Equipment Specifications: If more than one unit for any above modality, please add and number each piece of equipment. (Attach copies of current accreditation certificates.)

MRI

Manufacturer /Model:		Year manufactured:		Field strength:	
Table weight Limits:			Software:		
ACR Accreditation #:			Date of last upgrade:		
Coils:					
Frequency of Routine Maintenance:					
Choose one:		☐ Open ☐ Close			
Do you perform MRA?	☐ Yes ☐ No		Mobile Unit Only?	☐ Yes ☐ No	

COMPUTERIZED TOMOGRAPHY (CT)

Manufacturer /Model:		Year manufactured:		Slices per Rotation:	
Capabilities:					
ACR Accreditation #:			Date of last upgrade:		
Frequency of Routine Maintenance:					
Mobile Unit Only?		☐ Yes ☐ No			
Do you perform CTA?		☐ Yes ☐ No			
If yes: CTA of Lower Extremities ☐ Yes ☐ No or Coronary CTA ☐ Yes ☐ No					

MAMMOGRAPHY

Manufacturer/Model:		Year manufactured:	
Capabilities:			
ACR Accreditation #:		Date of last upgrade:	
Frequency of Routine Maintenance:			
FDA Accreditation #		Mobile Unit Only?	☐ Yes ☐ No

ULTRASOUND

Manufacturer/Model:		Year manufactured:	
Transducers:			
ACR Accreditation #:		Date of last upgrade:	
Frequency of Routine Maintenance:		Mobile Unit Only?	☐ Yes ☐ No

NUCLEAR MEDICINE

ACR or ICANL Accreditation #:		Capabilities:	
Is this equipment utilized primarily for cardiac nuclear imaging?			☐ Yes ☐ No
Manufacturer/Model:		Year manufactured:	
Current NRC License #:		Current State Materials License #:	
Date of Last Upgrade:		Frequency of Routine Maintenance:	
SPECT Capable	☐ Yes ☐ No	If Yes, # of Heads:	☐ Yes ☐ No
Mobile Unit Only?	☐ Yes ☐ No		

RADIOLOGRAPHY/FLUOROSCOPY

Manufacturer/Model:		Year manufactured:	
Capabilities:			
Date of Last Upgrade:		Frequency of Routine Maintenance:	
Mobile Unit Only?	☐ Yes ☐ No		

PET OR PET-CT

Scanner Type:		Year manufactured:	
Capabilities:			
Date of Last Upgrade:		Frequency of Routine Maintenance:	
ACR Accreditation #:		Mobile Unit Only?	☐ Yes ☐ No

BONE DENSITOMETRY

Manufacturer/Model:		Year manufactured:	
Capabilities:			
Date of Last Upgrade:		Frequency of Routine Maintenance:	
DEXA?	☐ Yes ☐ No	Fan Beam?	☐ Yes ☐ No

DECLARATION OF FACILITY AND NON-PHYSICIAN PROFESSIONAL INFORMATION

(Please complete one for each facility location.)

Primary Facility Name: _____

Primary Facility Address: _____

1) Have there ever been, or are there currently, any claims, settlements, or judgments against your Facility, even if not resulting in monetary damages, or have you received any notice of "Intent to File"? If yes, attach explanation.
   ☐ Yes ☐ No

2) Has your facility ever had any general or professional liability insurance coverage canceled, declined or modified (i.e. reduced limits, restricted coverage), or has any renewal ever been refused, or has your facility voluntarily given up coverage? If yes, attach explanation.
   ☐ Yes ☐ No

3) Has your facility ever been denied membership or renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization, with the exception of “no network need” or professional society, or is such action pending? If yes, attach explanation.
   ☐ Yes ☐ No

4) Has any Professional Conduct Board or any State Board of Medical Examiners disciplined any of your facility staff or has any Staff member been reprimanded, or disciplined by any state or federal agency that disciplines physicians or allied health professionals? If yes, attach explanation.
   ☐ Yes ☐ No

5) Has your facility ever been reprimanded, censured, excluded, suspended, or disqualified from Federal or State Programs? If yes, attach explanation.
   ☐ Yes ☐ No

6) Has your facility state license ever been revoked, suspended, or subject to probation or any conditions or limitations in any state? If yes, attach explanation.
   ☐ Yes ☐ No

7) Have any of your licensed non-physician professional staff licenses ever been revoked, suspended, or subject to probation or any conditions or limitations in any state? If yes, attach explanation.
   ☐ Yes ☐ No

FACILITY ATTESTATION

I_____(name) on behalf of_____(primary facility name), hereinafter Facility, hereby authorize Care to Care, IPA, LLC and its agencies to consult with administrators and members of medical staffs of hospitals, facilities, malpractice carriers and organizations with which Facility or its licensed professional staff has been associated, who may have bearing on the Facility's qualifications. Facility further consents to inspection of all records and documents that may be material to facility's evaluation. Facility agrees to abide by the terms of the Agreement with Care to Care, IPA,LLC, as well as the policies that may be adopted by Care to Care, IPA, LLC concerning the conditions, criteria, and standards of participation in the provider panel.

Facility shall provide immediate notice to Care to Care, IPA, LLC of any circumstance that limits any of the facility's ability to provide the Radiological services as outlined in the application.

All physicians providing services at facility are duly licensed in the state in which they practice, and are Board Certified or eligible to sit for board certification in their specialty. All technologists and other non-physician medical personnel are duly licensed and/or certified. As employer of Facility non-Physician staff, I confirm that none of my employed professionals have been sanctioned by State or Federal Licensing authorities and that no employees of Facility have a criminal background. By the signature below I hereby attest that all information contained herein is complete and accurate, and I agree to provide information as requested to support this application.

X_____

Medical Director or Facility Administrator

_____ _____

Print Name/Title Date

PART II: FACILITY PHYSICIAN ROSTER

Primary Facility Name: _____

ROSTER INFORMATION

Please list all physicians rendering services at this location.

1. _____ Medical Director
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____

If the physician is practicing at multiple locations, please provide a roster of all locations with the physician's respective effective date.

What professional training and experience requirements must a physician meet to practice at your facility?