



**2736 Meadow Church Rd, Suite 300, Duluth, GA 30097**

**CREDENTIALING APPLICATION FOR SPECIALTY PROVIDERS**

Type of Health Care Facility/Provider \_\_\_\_\_ Date of Application: \_\_\_\_\_

Agency/Organization Name \_\_\_\_\_ Federal Tax ID # \_\_\_\_\_

Does your agency/organization do business under another name? (IF YES, WHAT NAME?) \_\_\_\_\_

Email Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County \_\_\_\_\_

Telephone Number :( ) \_\_\_\_\_ Fax Number :( ) \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

Mailing/Correspondence Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

Weekend / Holiday Hours: \_\_\_\_\_

**KEY MANAGEMENT STAFF AND PHONE NUMBERS**

Contact Person \_\_\_\_\_ Telephone: \_\_\_\_\_

President/CEO \_\_\_\_\_ Telephone: \_\_\_\_\_

Administrator/Executive Director \_\_\_\_\_ Telephone: \_\_\_\_\_

Director of Nursing \_\_\_\_\_ Telephone: \_\_\_\_\_

Medical Director \_\_\_\_\_ Telephone: \_\_\_\_\_

Business Manager \_\_\_\_\_ Telephone: \_\_\_\_\_

**PAYMENT OFFICE LOCATION**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Contact Person(s): \_\_\_\_\_

**LICENSURE/CERTIFICATION---Please include copies of all licenses and certificates for your facility**

State License/Registration # : \_\_\_\_\_ : \_\_\_\_\_ :  
: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

Business/Vendor License# : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

Medicaid Provider # : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_  
: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

Medicare Provider # \_\_\_\_\_ Medicare Certification: \_\_\_Yes \_\_\_No

NPI Number: \_\_\_\_\_ NCPDP#: \_\_\_\_\_

Pharmacy Permit/License # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_  
TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

CLIA Accreditation: Registration # \_\_\_\_\_ Waiver # \_\_\_\_\_

State Laboratory Permit: Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Bedding/Upholstery License (DME providers only): \_\_\_ Yes \_\_\_ No Expiration Date: \_\_\_\_\_

**ACCREDITATION - IF APPLICABLE**

**Indicate all Organizations and attach a copy of each certificate of accreditation and report from last survey.**

Accrediting Body \_\_\_\_\_ Accrediting Status \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey, if known \_\_\_\_\_

Accrediting Body \_\_\_\_\_ Accrediting Status \_\_\_\_\_

Expiration Date: \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey, if known \_\_\_\_\_

**ADDITIONAL SITE INFORMATION (For those facilities with more than one location)**

**Duplicate this page for each location operated by your Facility.**

Agency/Organization Name: \_\_\_\_\_ TIN # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

Weekend / Holiday hours \_\_\_\_\_

**LICENSURE/CERTIFICATION (for additional location)**

**Complete information as applicable and submit a copy of each certificate as applicable.**

State License/Registration # : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

Medicaid Provider # : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

Medicare Provider # \_\_\_\_\_ Medicare Certification: \_\_\_ Yes \_\_\_ No

NPI Number: \_\_\_\_\_ NCPDP#: \_\_\_\_\_

Pharmacy Permit/License # : \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

: \_\_\_\_\_ : \_\_\_\_\_ : \_\_\_\_\_

Laboratories: CLIA Status: Registration# \_\_\_\_\_ Waiver # \_\_\_\_\_

Bedding/Upholstery License (**DME providers only**): \_\_\_ Yes \_\_\_ No Expiration Date: \_\_\_

**ACCREDITATION (for additional location)**

**Attach a copy of each certificate of accreditation and report from last survey.**

Accrediting Body \_\_\_\_\_ Accrediting Status \_\_\_\_\_

Expiration Date \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey, if known \_\_\_\_\_

**COVERED SERVICES**

**Identify specific service categories to be provided**

<b>Service</b>	<b>Y/N</b>
Skilled Nursing Evaluation- RN	
Skilled Nursing Visit- RN	
High Tech RN Visit	
High Tech RN Hourly	
RN Hourly	
Skilled Nursing Visit- LPN	
High Tech LPN Visit	
High Tech LPN Hourly	
LPN Hourly	
Home Health Aid (HHA) Hourly	
Home Health Aid (HHA) Visit	
Companion- Hourly	
Therapy Evaluation- (PT/ST/OT)	
Therapy Visit	
Masters Social Work (MSW) Visit	

Provide a listing and description of each service and/or items being provided.

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**SERVICE AREAS AND OFFICE LOCATIONS OF PROVIDER ORGANIZATION**

Geographic Service Area (**List states and counties served**):

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Does your organization use a telephone answering service after hours? \_\_\_\_\_ Who? \_\_\_\_\_

Describe your agencies/organization's after-hours coverage policy and procedure \_\_\_\_\_

**LIABILITY INFORMATION --- Attach separate sheet with explanation to all questions answered "Yes"**

1. Has your Facility ever been disciplined by any state licensing or other authorizing agency or have you ever been reprimanded, or fined by any state agency that disciplines healthcare facilities?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
2. Has your Facility ever been reprimanded, censured, excluded, suspended, or disqualified by the Medicare, Medicaid, or CLIA Program?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
3. Has the pharmacy license ever been suspended or otherwise limited for your Facility?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
4. Has your Facility ever been canceled, non-renewed, or restricted by insurance carrier?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
5. Has your Facility ever had membership in a professional organization revoked, reduced, denied, or suspended?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

**Please Indicate what products/services you can provide to Cypress Care by HCPC Code.**

All "A" HCPC Codes

Exceptions to "A" Codes:

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All "E" HCPC Codes

Exceptions to "E" Codes:

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All "K" HCPC Codes

Exceptions to "K" Codes:

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All "L" HCPC Codes

Exceptions to "L" Codes:

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All "Q" HCPC Codes

Exceptions to "Q" Codes:

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All "V" HCPC Codes

Exceptions to "V" Codes:

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**PLEASE ATTACH THE FOLLOWING TO THE APPLICATION (If Applicable)**

**\*\*\*Must be included for all provider types**

- 1. Copy of W-9 Form\*\*\***
- 2. Copies of Current Professional/Liability Face sheets of each insurance policy\*\*\***
- 3. Copy of Current State License(s) and other certifications**
- 4. Copy of Pharmacy Permit**
- 5. Copy of Current CLIA Lab Certificate**
- 6. Copy of Accreditation Certificates (JCAHO, AOA, CHAP, ABC or AAAHC)**
- 7. Detailed explanation to any questions answered “Yes” in LIABILITY INFORMATION section**
- 8. Brochures and other literature about your organization**
- 9. Credentialing Criteria for professional staff and independent contractors**

**Note: If you are a Home Health Agency, Hospice, Skilled Nursing Facility or Ambulatory Surgical Center and your facility is not accredited the following must also be included:**

- 1. Copy of HCFA/CMS State Licensure Survey and Revisit (if deficiencies on licensure survey)**
- 2. Copy of Corrective Action Plan**
- 3. Copy of Current QI/UM Program with appropriate signature pages, QI/UM policies and procedures, including the QI Work plan, QI Activities Annual Report, Outcomes based studies, Patient Bill of Rights including QA Committee, organizational chart, patient satisfaction surveys, and Risk Management Plan.**

## Consent for release of Information release of Liability

### AUTHORIZATION

I hereby affirm and attest that all statements, answers, and information contained in this application are true to the best of my knowledge, information, and belief. I understand that falsification, misrepresentation, or omission of any facts(s) requested will be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon the basis of this application.

I hereby give permission to CYPRESS CARE, its affiliates and the employees, agents and representatives thereof to obtain information about the operation of this facility. I consent to the release of photocopies/duplication of any of the foregoing, or verbal statements, by hospital administrators, chiefs of clinical departments of hospitals, insurance companies or regulatory agencies that this facility has either conducted business or is associated/affiliated with. Such information may be released to the above named entity and its affiliates or to representatives of such entity and its affiliates.

I hereby release from liability and agree to hold harmless any person or entity who or which provides the above described information as authorized herein.

I hereby release from liability and agree to hold harmless all employees, agents and representative of the above named entity and its affiliates for their acts performed and statements made in connection with obtaining, reviewing and evaluating the credentials and qualifications of this facility. I further acknowledge my cooperation by consenting to the production of such information about services rendered to their clients. The determination of whether the facility is qualified to serve as a provider of services is the reason such information is needed for review and evaluation by the above-named organization and their representatives.

### RELEASE OF LIABILITY

I understand of my right to review information obtained by CYPRESS CARE from any outside primary sources to evaluate my credentialing application. I further agree that a photocopy of this document will serve as a duplicate original.

\_\_\_\_\_

Representative Name (Print)

\_\_\_\_\_

Signature

\_\_\_\_\_

Title

\_\_\_\_\_

Date