Corporate Credentialing Department
2370 Corporate Circle #300
Henderson, NV 89074
Ph (702) 910-3950
Fax (702) 778-2264

ANCILLARY/FACILITY CREDENTIALING APPLICATION CHECKLIST

It is critical that all the below elements on this checklist are returned with P3 credentialing application.
(Please use this checklist as a guide)

	Complete the 5-page Application Form ***including date and signature***. Must be dated within the last 120 days. *Please do not leave anything blank. If something does not apply, please put N/A.*
	Copy of current W9 with group's legal name on file with IRS
	Copy of all State/Federal Licenses (Business License, Dept of Public Health Cert, CLIA etc.)
	Copy of Malpractice Insurance Coverage
	Copy of Accreditation, Certification, or Centers for Medicare & Medicaid Services (CMS) State Survey & Letter insubstantial compliance or Site Evaluation • Note: Any hospital or ancillary facility that is not accredited requires a CMS State Survey or Site Evaluation
	Copy of Medicare certification

Acceptable Accrediting Bodies for your Facility Type:

Ambulatory Surgery Center: AAAHC, AAAASF, TJC, AOA, HFAP, ACHC, (IMQ Transitioning to close)	**Clinical Lab:** TJC, HFAP, COLA, CLIA, CAP, other CMS approved sources	**Comprehensive Outpatient Rehabilitation Facilities:** CARF/CCAC, TJC	**Critical Access Hospital:** HFAP, DNV, TJC
	DME: CHAP, ACHC, TCT, CARF	**End-Stage Renal Dialysis Facility:** NDAC	**Federally Qualified Health Center:** TJC, AAAHC
Home Health: ACHC, CHAP, TJC	**Hospice:** CHAP, TJC, ACHC	**Hospital:** AOA, HFAP, DNV, TJC, CIHQ, ACHC	**Pharmacy:** ACHC, TCT
Portable X-Ray Suppliers: DPH & FDA	**Psychiatric Hospital:** TJC, DNV	**Rural Health Clinic:** AAAASF, TCT	**Skilled Nursing Facilities:** CARF/CCAC, TJC

AAAASF (American Association for Accreditation of Ambulatory Surgery Facilities)	
AAAHC (Accreditation Association for Ambulatory Health Care)	COA (Council on Accreditation)
AADE (American Association of Diabetes Educators)	COLA (Commission on Laboratory Accreditation)
ACHC (Accreditation Commission for Health Care)	DNV (Det Norske Veritas)
AOA (American Osteopathic Association)	DPH (Department of Public Health)
CAP (College of American Pathologists)	FDA (Food and Drug Administration)
CARF (Commission on Accreditation of Rehabilitation Facilities)	HFAP (Healthcare Facilities Accreditation Program)
CCAC (Continuing Care Accreditation Commission)	HIS (Hospital Information System)
CHAP (Community Health Accreditation Program)	IMQ (Institute for Medical Quality)
CIHQ (Center for Improvement in Healthcare Quality)	NDAC (National Dialysis Accreditation Commission)
CLIA (Clinical Laboratory Improvement Amendments)	TCT (The Compliance Team)
CMS (Centers for Medicare and Medicaid Services)	TJC (The Joint Commission)

****Please note that there could be other Approved Accreditations not on the list

FACILITY CREDENTIALING APPLICATION

ALL BACKUP INFORMATION MUST BE SUBMITTED WITH THE APPLICATION

TYPE OF ORGANIZATION:

- ☐ Ambulatory Surgery Center
- ☐ Home Health Agency
- ☐ Hospital
- ☐ Skilled Nursing Facility/Nursing Home
- ☐ Durable Medical Equipment
- ☐ Rural Health Clinic
- ☐ Federally Qualified Health Center
- ☐ Portable X-Ray Suppliers
- ☐ Laboratory
- ☐ Hospice
- ☐ Rehabilitation Hospital
- ☐ Diabetes Education
- ☐ Dialysis Center
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Other Facility: _____

DEMOGRAPHIC INFORMATION:

Facility Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Email: _____

Tax ID: _____ NPI: _____

Taxonomy Code: _____ How does the facility bill:

Medicaid Number: _____ UB _____
*(*MUST INCLUDE APPROVAL LTR)* HCFA _____

Medicare Number: _____ Both _____
*(*MUST INCLUDE APPROVAL LTR)*

CREDENTIALING CONTACT INFORMATION:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

BILLING ADDRESS:

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

Email: _____

ACCESSIBILITIES:

Does this facility meet ADA accessibility requirements? ☐ YES ☐ NO

Does this facility offer handicapped access for the following?

- Building? ☐ YES ☐ NO
- Parking? ☐ YES ☐ NO
- Restroom? ☐ YES ☐ NO

Other handicapped access? _____

_____

Does this facility offer other services for the disabled? ☐ YES ☐ NO

Text Telephony (TTY)? ☐ YES ☐ NO

American Sign Language? ☐ YES ☐ NO

Mental/Physical Impairment Services? ☐ YES ☐ NO

Other disability services? _____

_____

Accessible by public transportation?

- Bus? ☐ YES ☐ NO
- Subway? ☐ YES ☐ NO
- Regional Train? ☐ YES ☐ NO

Other transportation access? _____

_____

LANGUAGES:

Non-English languages spoken by facility personnel? _____

_____

Interpreters available? ☐ YES ☐ NO

Languages interpreted? _____

_____

FACILITY HOURS:

	Start	End
Sunday:	_____	_____
Monday:	_____	_____
Tuesday:	_____	_____
Wednesday:	_____	_____
Thursday:	_____	_____
Friday:	_____	_____
Saturday:	_____	_____

24/7 Phone Coverage? ☐ YES ☐ NO

Answering Service? ☐ YES ☐ NO

Instructions to call answering service? ☐ YES ☐ NO

*****PLEASE NOTE*** ALL Current Licensure and Certification copies *MUST BE ATTACHED***

FACILITY LICENSURE:

State License / Certification required? ☐ YES ☐ NO

Certificate or License Number: _____ Expiration Date: _____

*****PLEASE NOTE*** ALL Current Accreditation copies *MUST BE ATTACHED***

If the Facility is NOT Accredited, you *MUST* attach your most recent Site Visit Survey

ACCREDITATION:

Medicare Certification: _____ Exp. Date: _____

JCAHO: _____ Exp. Date: _____

CHAP: _____ Exp. Date: _____

AAAHC: _____ Exp. Date: _____

AAAASF: _____ Exp. Date: _____

CARF: _____ Exp. Date: _____

ACHC: _____ Exp. Date: _____

HFAB/AOA: _____ Exp. Date: _____

DNV/NIAHO: _____ Exp. Date: _____

OTHER (NAME): _____ Exp. Date: _____

RESTRICTIONS:

List any license/certification/accreditation sanctions or restrictions: _____

_____

_____

_____

Updated 02.13.20

FACILITY CREDENTIALING APPLICATION

DISCLOSURE OF OWNERSHIP, BUSINESS TRANSACTIONS & EXCLUSIONS STATEMENT FOR PROVIDERS

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care organizations that contract with the Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **This statement must be completed whether or not you have any information to report.**

OWNERSHIP &CONTROL INTERESTS (42 CFR 455.104)

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you, as a Provider, have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

	Full legal name	Address	% of Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

	Full legal name	Address	% of Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

	Full Name of Business or Organization	Name of Other	Address	SSN or FEIN	% of Ownership Interest
1					
2					
3					

SIGNIFICANT BUSINESS TRANSACTIONS (42 CFR 455.105)

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists please indicate this with an "N/A."

	Full Legal Name	Address	SSN or FEIN	% of Owner Interest
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

	Name of Wholly Owned Supplier	Address	SSN or FEIN	Nature of Business Transaction
1				
2				
3				

EXCLUDED INDIVIDUALS OR ENTITIES (42 CFR 455.106)

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any type of your managing Employees, Agents or Subcontractors who have ever:

Been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

□ Yes □ No

Been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

□ Yes □ No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

□ Yes □ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity and reason for answering "Yes" (i.e. conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

	Full Legal Name	Address	SSN or FEIN	Reason
1				
2				
3				

CERTIFICATION AND ATTESTATION

I certify that the information provided herein, is true and accurate. Additions or revisions out the information above will be submitted to the MCO immediately upon change. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation.

Printed Name: _____ Date: _____

Signature: _____ Title: _____

Email Address: _____

I attest and certify that I have answered the above application questions truthfully and that information given in or attached to this application is accurate and completed to the best of my knowledge. I understand that, as a condition to making this application, any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for rejection of my request for participation with P3 Health Partners Network.

Printed Name: _____ Date: _____

Signature: _____ Title: _____

Please send this Application with the applicable documents to the following email for your market:

NV: P3NetworkSolutions@P3hp.org

AZ: ProviderRelations@P3hp.org

OR: ProviderRelationsOR@P3hp.org