ALTERWOOD HEALTH
Quality Care. Better Health.

FACILITY / ANCILLARY APPLICATION

Provider Identification			
Legal Business Name:			
Doing Business As: (if applicable)			
Contact Person:	Email:	Phone:	Fax:
Tax ID #:	Medicaid #:	Medicare #:	NPI #:

Provider Type

Facility __ Hospital __ Inpatient Rehab Hospital __ Hospice

__ Ambulatory Surgery Center __ Skilled Nursing Facility __ Sub Acute

Ancillary (*check all that apply*)

☐	Acupuncture	☐	Hospice (Outpatient)	☐	Durable Medical Equipment
☐	Ambulance	☐	Laboratory	☐	Home Health
☐	Audiology	☐	Sleep Disorders Clinic	☐	Home Infusion
☐	Birthing Center	☐	Orthotics and Prosthetics	☐	Dialysis
☐	Physical Therapy	☐	Occupational Therapy	☐	Speech Therapy
☐	Urgent Care Center	☐	Other		
☐	Imaging Facility	( ) MRI/MRA, ( ) Open MRI, ( ) CT Scan, ( ) PET/CT, ( ) Nuclear Medicine, ( ) Ultrasound, ( ) Mammography, ( ) Flouroscopy, ( ) X-Ray, ( ) DEXA, ( ) Calcium Scoring			

Serves the following counties: (List all that apply)

Maryland

☐	Allegany	☐	Calvert	☐	Charles	☐	Harford	☐	Prince George's	☐	Talbot
☐	Anne Arundel	☐	Caroline	☐	Dorchester	☐	Howard	☐	Queen Anne's	☐	Washington
☐	Baltimore City	☐	Carroll	☐	Frederick	☐	Kent	☐	Somerset	☐	Wicomico
☐	Baltimore	☐	Cecil	☐	Garrett	☐	Montgomery	☐	St Mary's	☐	Worcester

Washington DC ☐

Delaware:

☐	New Castle	☐	Kent	☐	Sussex

Primary Office / Service Address

Practice Location Name:

Address:

Contact Person:	Email:	Phone:	Fax:

Office Hours: _____ Sun _____ Mon _____ Tues _____Wed _____ Thurs _____ Fri _____ Sat

List any non-English languages spoken:

Does this office location meet ADA accessibility requirements? __ Y __ N

Check All That Apply:

Handicap Accessible: __ Building __ Parking __ Restroom

Services for Disabled: __ Text Telephone __ Sign Language __ Mental/Physical Impairment

Transportation Accessible: __ Bus __ Regional Train __ Subway

Secondary Office / Service Address

Practice Location Name:

Address:

Contact Person:	Email:	Phone:	Fax:

Office Hours: _____ Sun _____ Mon _____ Tues _____Wed _____ Thurs _____ Fri _____ Sat

List any non-English languages spoken:

Does this office location meet ADA accessibility requirements? __ Y __ N

Check All That Apply:

Handicap Accessible: __ Building __ Parking __ Restroom

Services for Disabled: __ Text Telephone __ Sign Language __ Mental/Physical Impairment

Transportation Accessible: __ Bus __ Regional Train __ Subway

Billing Information Name (Billing Name):

Payment Address:

City: State: ZIP: Do you bill electronically? __ Y __ N

Contact Person:

Name of EHR system:	Email:	Phone:	Fax:

Licensure			
State:	Date of License:	License #:	Expiration Date:
State:	Date of License:	License #:	Expiration Date:
CLIA Certificate #: (if applicable)			

Accreditation / Certification		
Type of Accreditation:	Date of Accreditation:	Next Survey Date:
If Not Accredited: Have you had an on-site survey by CMS or a State Agency? __ Y __ N Date of Last Survey: ___/___/___		
Credentialing		
Does your organization credential providers? __Y __ N		
Does your organization monitor credentialed staff for exclusions from the Medicaid/Medicare Programs? __ Y __ N		

General and Professional Liability Insurance	
General Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ___ Occurrence Based ___ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $
Professional Liability Coverage	
Current Carrier Name:	
Policy Number:	Coverage Type: ___ Occurrence Based ___ Claims Based
Effective Date:	Expiration Date:
Per Incident: $	Aggregate: $

ATTACHMENTS

Please submit all applicable documents from the list below, with your completed and signed application and contract.

1. Copy of all licenses required to operate as a health care facility (by location)
2. Copy of accreditation certificate or letter
3. Certificate of Insurance Coverage
4. Copy of most recent CMS or state survey including your corrective action plan if deficiencies were cited, or cover letter from CMS/State Agency stating facility is in substantial compliance
5. Copy of CLIA Certificate for each location, if applicable
6. A completed W-9 for each Tax ID
7. **ASC ONLY-**
   Complete roster of providers participating with the facility to include:
   a. Provider Name
   b. NPI
   c. Specialty
   d. Area(s) of specialization (i.e. knee replacement, endoscopy, joint injection, etc)

Standard Authorization, Attestation and Release

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with Alterwood Health (hereinafter referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification , corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations , managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions , military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics , behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary pro-ceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and with- out malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s) , or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization , Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization , Attestation and Release , all references to the Entity, its Agent(s) , and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true , correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing , and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s) . I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules, and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature: _____ Print Name: _____

Date: _____