

ADVANTAGE CARE NETWORK, INC.

FREE STANDING FACILITY APPLICATION

Advantage Care Network, Inc. is committed to the provision of high quality care to our clients and their beneficiaries. Proper provider credentialing is the cornerstone of this effort. This application will provide us with the information necessary to carry out this effort.

INSTRUCTIONS

1. ANSWER ALL QUESTIONS. An incomplete application cannot be processed.
2. A responsible party must sign and date the application.
3. If you need more space, please attach extra sheets.
4. Please provide all lists and/or attachments requested.
5. Copies of the following documents MUST accompany the application:
 - a) State License
 - b) Fee Assessments
 - c) Medicare/Medicaid Certification
 - d) Face Sheet with coverage information from professional liability insurance policy
 - e) Quality Control/Assessment Policy
 - f) Physician credentialing criteria and application
6. Mail complete application to:
Advantage Care Network, Inc.
7430 Remcon Circle, Bldg. C
El Paso, Texas 79912

1. Facility Name: _____

Address: _____

2. Phone Number: _____ Fax Number: _____

3. Facility Manager: _____

4. Billing Department Contact: _____

Phone Number/Extension: _____

5. Hours of Operation: _____

6. Tax ID Number: _____

7. Does your facility do any "Package" billing? _____

If yes, please explain: _____

8. Do any of the physicians (or their immediate families) that provide services and/or refer patients to your facility, have any ownership interests? _____ Yes _____ No

If yes, please explain detail of ownership: _____

9. Please list any foreign language proficiencies of your staff: _____

10. Is your facility fully accessible to the handicapped patients? _____ Yes _____ No

LICENSURE / REIMBURSEMENT

11. Are you fully licensed by the State of Texas? _____ Yes _____ No

License Number: _____ Expiration Date: _____

Are you fully licensed by the State of New Mexico? _____ Yes _____ No

License Number: _____ Expiration Date: _____

12. Has your license ever been suspended or revoked or has your facility been subject to any type of sanctions (warnings, probation, citation, etc.)? _____ Yes _____ No

If yes, please provide full detail: _____

13. Are you currently receiving reimbursement from Medicare and Medicaid? _____ Yes _____ No

If no, please explain: _____

If yes, have you ever had any disciplinary actions taken against your facility? _____ Yes _____ No

If yes, please explain: _____

14. Have you ever been suspended or terminated, or had any other sanctions applied to you by any third party payer (BC, BS, TPA's commercial carriers, HMOs or PPOs)? _____ Yes _____ No

If yes, please explain: _____

PROFESSIONAL LIABILITY INSURANCE

15. Name of Insurer: _____

Address: _____

Coverage Limits: _____ Deductible: _____

Effective Date: _____ Expiration Date: _____

Any Restrictions: _____

16. Please list details of all malpractice judgements, settlements and pending cases in which your facility was or is a defendant. Are there any such cases? _____ Yes _____ No

If yes, please explain: _____

*If your facility self funds this liability, please attach actual statement supporting solvency of the program.

17. Has your facility ever:

Been terminated by a professional liability carrier?	_____	Yes	_____	No
Been refused coverage by a professional liability carrier?	_____	Yes	_____	No
Been rated by a carrier as an increased risk?	_____	Yes	_____	No

If yes to any of these please explain: _____

18. Do you require that physicians and other providers that provide services in your facility carry professional liability insurance? _____ Yes _____ No

If yes, amount: _____ If no, please explain: _____

19. Do you credential physicians/providers that provide services in your facility? _____ Yes _____ No

If no, please explain: _____

*If yes, please attach a copy of the credentialing criteria and application.

QUALITY

20. Does your program have a formal quality assessment/control program? _____ Yes _____ No
 If yes, please attach a copy of the program.

21. Please list/attach problems that have been identified by the program and corrective actions that have been taken:

22. Is your facility staffed and equipped to handle cardiopulmonary resuscitation? _____ Yes _____ No

23. Do you have a formal transfer agreement with a full service hospital for emergencies? _____ Yes _____ No

If yes, Hospital Name: _____

Distance: _____ Driving Time: _____

If no, please explain how you would handle an emergency: _____

SERVICE

24. Please check the category that best describes your facility:

- _____ Free Standing Surgical Facility
- _____ Free Standing Radiology Facility
- _____ Full Service Diagnostic Facility
- _____ Other _____
- _____ Other _____

25. Please check and/or list categories of services available in your facility.

- | | |
|---|--------------------------|
| _____ Surgical Facilities (operating rooms, recovery rooms, etc.)
(Attach a list of procedures that are allowed) | _____ General Anesthesia |
| _____ Cardiac Diagnostic Testing
(Attach a list of procedures allowed) | _____ Vascular Radiology |
| _____ Nuclear Medicine | _____ MRI |
| _____ Clinical Laboratory | _____ Endoscopies |
| _____ General Radiology | _____ Ultrasonography |
| _____ CAT Scanning | _____ Radiation Therapy |
| | _____ Clinical Pathology |

CONDITIONS OF APPLICATION

By applying for appointment as a participating status, the facility hereby:

- Acknowledge that I, as an applicant for membership in **Advantage Care Network, Inc.**, need to produce adequate information for a proper evaluation of my professional, ethical, and other qualifications for membership and for resolving any doubts about such qualifications;
- pledge to provide for continuous care for my patients, and to refrain from delegating the responsibility of any aspect of the care of my patients to any practitioner not qualified to undertake that responsibility;
- authorize **Advantage Care Network, Inc.**, its Medical Director and their representatives of all documents that may be material to an evaluation of my qualifications and competence and consent to the release of such information. I hereby release from liability **Advantage Care Network, Inc.**, its officers, directors, employees and agents for their acts performed and statements made, in good faith and without malice, in connection with evaluating my application, my credentials and qualifications. I hereby release from liability any and all individuals and organizations who provide information to **Advantage Care Network, Inc.**, its Medical Director and their representatives, in good faith and without malice, concerning my professional competence, background, experience, ethics, character utilization practice patterns, health status and other qualifications to be a Participating Provider in **Advantage Care Network, Inc.** I am aware that the release from liability is an express condition to my application for and acceptance of membership in **Advantage Care Network, Inc.**, and continuation as a Participating Provider in the PPO Network;
- signify my willingness to meet with **Advantage Care Network, Inc.**, representative in regard to my application, if necessary;
- acknowledge that any material misstatements in or omissions from this application constitute cause for denial of membership in the PPO Network or cause for summary dismissal from the PPO Network;
- recognize that the application process is a continuous process, that PPO Network will credential and continuously recredential me and that the authorizations, acknowledgements, consents, pledges and releases provided in this application will remain in effect for purposes of credentialing and recredentialing until revoked by me in writing; and
- understand that submission of this application is not an assurance of acceptance to the **Advantage Care Network, Inc.**, and if not accepted it is not a reflection of the quality of the facility.

All information submitted in this application is true and complete to the best of my knowledge and belief. A photostatic copy of this original statement constitutes my written authorization and request to release any and all documentation relevant to this application. Such photostatic copy shall have the same force and effect as the signed original.

Date

Signature

Printed Name

Title

PARTICIPATING FACILITY

**** Necessary requirements to process application ****

CHECK LIST

- ❑ **STEP 1:** Application

- ❑ **STEP 2:** All current and valid License.
 Medicare/Medicaid Certification
 Professional Liability Insurance
 Quality Control / Assessment Policy
 Physician Credentialing Criteria

- ❑ **STEP 3:** Fee Assessments