[DATE]

Dear Facility/Organizational Provider:

Thank you for your interest in becoming a member of the AlphaCare network of providers. In accordance with our commitment to quality care and service for our members, we need to conduct an assessment of your organization prior to accepting you as a participating provider.

Please complete and submit the information requested in this form in its entirety within ten (10) business days, and return it to us by mail to the following address:

Credentialing Department
335 Adams Street, 26th Floor
Brooklyn, NY 11201
Phone: (855)652-5742
Email: ProvRel@alphacare.com

In addition to the information contained in the below application, please be sure to include a copy of supporting documents:

1. Attestation and Consent for Release of Information Signed and Dated
2. License/ Operating certificate
3. Evidence of Joint Commission and other accreditation
4. Most recent accreditation survey
5. Copy of most recent site visit report conducted by any city or state contracting authority
6. Copy of CLIA (if applicable)
7. Proof of Professional & General Liability Insurance coverage (Face sheet of current insurance policy, including coverage limits of at least $1M/$3M and effective/expiration dates)
8. Malpractice/Liability Claims History Details
9. IRS Form W-9 (Tax ID #)
10. NPI #
11. Proof of current CMS approved HIPAA, Fraud, Waste & Abuse Training completion/program

Thank you again for choosing to become a participating organizational provider for AlphaCare.

ORGANIZATIONAL PROVIDER APPLICATION

Instructions: Please complete all items on this form. If there is an item that is not applicable to your practice, please indicate with "N/A". Do not leave any area blank.

PROVIDER INFORMATION

Legal Facility / Organization Name: _____

DBA/Trade Name: _____

Address: _____

(Corporate/Mailing) _____

_____ _____ _____ _____
City State Zip Code County

( ) _____ ( ) _____
Telephone Fax

Organization Email: _____

Chief Executive Officer: _____

( ) _____ ( ) _____
Telephone Fax

Chief Financial Officer: _____

( ) _____ ( ) _____
Telephone Fax

Additional Contact Person: _____ Title: _____

( ) _____ ( ) _____
Telephone Fax

Tax ID Number: _____ Years of operation: _____

Ownership Name: _____ Ownership Name: _____

Ownership Percentage: Ownership Percentage:

Is your facility affiliated with any other health care organization (s) through corporate linkage or other formal arrangement? If so, please provide the following information (list additional affiliations on a separate page.)

Facility/Service Name: _____

Address: _____

Phone# & Contact Person: _____

_____

Tax ID#: NPI#

_____

Billing Address: Payee Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Tax ID Number: _____ NPI Number: _____
(if different from corporate)

Electronic Claims Submission ☐ Yes ☐ No Does your business have internet access? ☐ Yes ☐ No

If no to either, please explain _____

On a bus route? ☐ Yes ☐ No Name of bus route(s) if applicable: _____

Is the location accessible to the disabled? Internally: ☐ Yes ☐ No Externally: ☐ Yes ☐ No

PROFESSIONAL LICENSE/CERTIFICATES

Medicaid Certification / Participant ☐ Yes ☐ No ☐ N/A Medicare Certification / Participant ☐ Yes ☐ No ☐ N/A

State Medicaid Provider Number: _____ Medicare Provider Number: _____

State Licensed? ☐ Yes ☐ No Licensing Authority: _____
(Provide copy as attachment)

License #: _____ Effective Date: _____ Expiration date: _____

Accreditation Status Is this facility accredited ? ☐ Yes ☐ No
(Attach certificate & most recent survey)

_____ Effective Date _____ Expiration Date _____ Date of last survey

Federal survey review? (CMS) _____ Effective Date _____ Expiration Date _____ Date of last survey
(Please attach copy of latest survey results)

Professional Liability and comprehensive general liability insurance:
(Please attach copy as proof of coverage)

Professional

Carrier: _____ Term: _____

General

Carrier: _____ Term: _____

SERVICE INFORMATION

- ☐ **Free Standing Ambulatory Care Center**
- ☐ **Home Health Services**
- ☐ **Optometry Services**
- ☐ **Speech Pathology**
- ☐ **Audiological Services**
- ☐ **I.V. Therapy**
- ☐ **Orthotics and Prosthetics**
- ☐ **Surgery Center**
- ☐ **Comprehensive Outpatient Rehabilitation Facility (CORF)**
- ☐ **Laboratory**
- ☐ **Physical Therapy**
- ☐ **X-Ray supplier**
- ☐ **Diagnostic Imaging Center**
- ☐ **Medical Supplies**
- ☐ **Rehabilitation Center**
- ☐ **Free Standing Dialysis Centers**
- ☐ **Durable Medical Equipment**
- ☐ **Occupational Therapy**
- ☐ **Orthotic Footwear**
- ☐ **Social Day Care**
- ☐ **Personal Emergency Response System**
- ☐ **Non-Emergency Transportation**
- ☐ **Hospice**
- ☐ **Assisted Long-term Care Facility**
- ☐ **Skilled Nursing Facility**
- ☐ **Adult Day Health Care**
- ☐ **Home Delivered or Congregate Meals**
- ☐ **Social and Environmental Supports**
- ☐ **Other** _____

Additional services and areas of specialization: _____

What is your Geographic service area? _____

Monday:	_____	a.m. to	_____	p.m.	Saturday:	a.m. to	p.m.
Tuesday:	_____	a.m. to	_____	p.m.	Sunday:	a.m. to	p.m.
Wednesday:	_____	a.m. to	_____	p.m.			
Thursday:	_____	a.m. to	_____	p.m.			
Friday:	_____	a.m. to	_____	p.m.			

Is sign language interpretation available? ☐ Yes ☐ No

Do you access to language interpreter services? ☐ Yes ☐ No

Is there any amplification device available to help the hard of hearing (e.g. pocket talker device)? ☐ Yes ☐ No

Can you provide patient care instructions/materials in large print and braile? ☐ Yes ☐ No

Please indicate all languages spoken by your staff: _____

How many active patients are accessing your facility or utilizing your service during the course of a year? _____

Does your facility or service have patient specific age limitations? ☐ Yes ☐ No

If “Yes”, please specify: _____

Do you possess an after hours policy? ☐ Yes ☐ No

If “Yes”, please explain:

QUALITY ASSURANCE/ PLAN QUESTIONAIRE

Do you have a quality improvement process in place? If yes, please attach a brief summary as an attachment.	☐ Yes	☐ No
Do you have a process in place to verify credentials of professional staff?	☐ Yes	☐ No
Do you have a policy on conducting background checks on staff?	☐ Yes	☐ No
Do you have a Code of Conduct?	☐ Yes	☐ No
Do you have an employee training program that includes, at a minimum, HIPAA privacy, Fraud, Waste and Abuse and security (confidentiality)?	☐ Yes	☐ No
Do you have a process in place to measure and collect patient satisfaction? If yes, please describe your most recent patient satisfaction measure and instrument used.	☐ Yes	☐ No
Does your organization have an Emergency Contingency and Access Plan? If yes, please provide a copy.	☐ Yes	☐ No
Do you have a policy in Advanced Directives?	☐ Yes	☐ No

Skilled Nursing Facilities and Home Care Agencies: If you respond "no" to the above question regarding Advance Directive policy, please include a copy of the specific section of your institutional policy/ process which addresses Advance Directives.

DIAGNOSTIC IMAGING

If the answer is "No" to any of the following questions, please provide details on a separate sheet

1. Diagnostic Imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction or supervision of physicians qualified to perform those procedures?	☐ Yes	☐ No
2. Diagnostic Imaging machines are registered and inspected according to state/ federal law?	☐ Yes	☐ No
3. Technicians, physicians and other personnel who work with imaging machines comply with state law regarding monitoring? Are there copies of logs for monitoring readily available?	☐ Yes	☐ No
4. Screening and Diagnostic Mammography services are provided?	☐ Yes	☐ NO

LABORATORY

If the answer is "Yes" to the following question, please provide a copy of CLIA Certificate. If the answer is "No" to the following question, please provide details on separate sheet

1. Does the laboratory meet the requirements of Federal Public Law, Clinical Laboratory Improvement Amendments of 1988 (CLIA)?	☐ Yes	☐ No

PHARMACY

If the answer is "Yes" to the following questions, please provide a copy of any DEA Registration Certificates and Pharmacy licenses. If the answer is "No" to following question, please provide details on separate sheet.

1. Does this facility dispense medication?	☐ Yes	☐ No
2. Do you compound medications on-site?	☐ Yes	☐ No
3. Can a patient fill a prescription at this facility?	☐ Yes	☐ No

DISCLOSURE QUESTIONAIRE

(For the purpose of this questionnaire "you, yours, "is defined as owner, supplier, provider and/ or practitioner attached to your organization" If you answer "Yes" to any of the following questions, please attach an explanation)

1. Has your license to practice ever been surrendered, refused, restricted (including Probation) suspended, revoked, reprimanded, or censured in this or any other state or country? ☐ Yes ☐ No

2. Has the facility ever had membership in any professional organization refused, suspended, restricted, revoked, or censured for any reason other than non-payment? ☐ Yes ☐ No

3. To your knowledge, are there any professional misconduct proceedings pending (in which the facility is a part) in this or any other state? ☐ Yes ☐ No

4. Does your facility have any reasons for any inability to perform the essential functions as a provider, with or without accommodation? ☐ Yes ☐ No

5. Have any judgments, settlements, findings, decisions, or any other determinations of any kind whatsoever been entered or made in any medical professional misconduct proceedings wherein your facility is a part of? ☐ Yes ☐ No

6. Has the facility or any person associated with your facility ever been denied , restricted, debarred, excluded or terminated from participation for reimbursement from the Medicare and Medicaid programs or Federal Health Care Program **?** ☐ Yes ☐ No

7. Has the facility's professional liability insurance ever been denied, canceled, or non-renewed for any reason? ☐ Yes ☐ No

8. Has an officer, director or any person associated with your facility ever been convicted of, pled guilty to, or pled "nolo Contendere" to any criminal offense including but not limited to an act of violence, child abuse, a sexual offense or any illegal drug or substance? ☐ Yes ☐ No

9. Has the corporation, an officer, a board member or anyone associated with your facility ever been convicted of any crime other than minor traffic infractions? ☐ Yes ☐ No

10. Has the corporation, an officer, a board member or anyone associated with your facility ever been involved in the sale, purchase or use of any illegal drug or substance? ☐ Yes ☐ No

ATTESTATION

I understand that AlphaCare of New York, Inc. (ACNY), is responsible for the evaluation of our professional competence and qualifications and has the obligation to inquire into license, accreditation and professional conduct. I consent to communication of information and documents between AlphaCare and our institution/organization and understand the ACNY may verify any information included in this application including New York State License and Professional Liability coverage.

I hereby affirm and represent that all statements and information contained in this application are true to the best of my knowledge. I agree to inform ACNY, promptly of any change in the information provided in this application. I understand that false or misleading information or the withholding of information deemed relevant by ACNY will disqualify this provider application from consideration as an ACNY participating provider.

I present this information and arrange for the submission of other information as part of the credentialing process, in the expectation that this information will be kept confidential and will be released or disclosed only as part of current and future credentialing peer review and quality assessment processes.

I hereby affirm that our institution/ organization has a quality management plan and agrees to cooperate with the quality management activities of ACNY, including giving ACNY access to medical records to the extent permitted by New York State law. If required, our institution/ organization will provide an employee evidence of employee credentialing, orientation completion, required in-service, physical examination and criminal verification check.

In signing this application, I acknowledge that this information is provided to ACNY for the purpose of developing a contract with the applicant organization. I further understand that my completion and submission of this application only entitles the applicant organization to be considered as a participating provider. I understand that any decision with respect to my becoming a participating ancillary provider with ACNY remains the sole discretion of ACNY. ACNY may, by means, which it may choose, determine the truth or accuracy of all statements made herein. I agree to inform ACNY promptly if any material change in such information occurs, whether before or after my entering into an agreement with ACNY for the provisions of ancillary services.

This attestation is granted with the understanding that ACNY will take responsible measures to maintain the confidentiality of this information.

Print Name of Officer	Title
Signature of Officer	Date