**INSTRUCTIONS**: This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Accompany this application with the documents listed in the cover letter. **This application must be completed in its entirety, signed and dated; incomplete applications may be returned or nullified.**

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| **SERVICE TYPE** |
| [ ]  Primary Care[ ]  Family Planning | [ ]  Acupuncture[ ]  Specialty Clinic, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Surgical Center[ ]  Other, please specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **CLINIC INFORMATION (Parent Organization / Primary Location)** |
| **Clinic Name** |  | **Year Opened** |  |
| **Clinic Address** |  |
| **Billing Address** |  |
| **Organization Type** | [ ]  Non-profit Corporation [ ]  Professional Corporation [ ]  Government entity  | [ ]  Limited Liability Corporation (LLC)[ ]  Subsidiary[ ]  Other: |
| **Doing Business As (DBA) If different** |  | Is this a fictitious business name?[ ]  Yes [ ]  No |
| **Telephone** |  | **Fax** |  |
| **Email** |  | **Web address** |  |
| **CLAIMS INFORMATION** |
| **Mode of Claims Submission** | [ ]  837 / 5010 Direct [ ]  Paper (CMS 1500 / UB 04)[ ]  837 / 5010 Via Clearinghouse. Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Claims Submitter Contact** | Name |  |
| Phone |  | Fax |  |
| Email |  |

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| **FACILITY LICENSURE INFORMATION** |
| **Type** | **Number** | **Expiration Date** |
| NPI  |  | n/a |
| TIN  |  |  |
| CA State License |  |  |
| DEA |  |  |
| CMS Certification |  |  |
| **Other Certifications and Accreditations (provide a copy of certification letter)** |
| [ ]  AAAASF[ ]  AAAHC[ ]  AADE | [ ]  ACHC[ ]  AOA[ ]  CARF | [ ]  CCAC[ ]  CHAP[ ]  CLIA | [ ]  COLA[ ]  DNVNIAHO[ ]  FDA | [ ]  HFAP[ ]  IHS[ ]  TJC |

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| **SITE VISIT** |
| 1. In the past 36 months, has the facility had an onsite visit by a government agency (e.g. CMS or DHCS)

[ ]  Yes; Date of the visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (answer questions 2)[ ]  No |
| 1. Were there any deficiencies found during the last full scope survey?

[ ]  Yes (answer questions 2) [ ]  No |
| 1. Have all the deficiencies corrected?

[ ]  Yes (answer questions 2)  |
| [ ]  No, please explain: |
| **NOTE**: Attach a copy of the most recent onsite survey; if citations were issued, include a copy of the Corrective Action Plan.  |

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| **ACCESSIBILTY, HOURS OF OPERATIONS, LANGUAGE** |
| **Accessible by Public Transportation**  | [ ]  Yes [ ]  No | **Block to Nearest Bus Stop** |  |
| **Hours of Operations** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** |
| **Open** |  |  |  |  |  |  |  |
| **Close** |  |  |  |  |  |  |  |
| **Languages Capability** | [ ]  English [ ]  Spanish [ ]  Chinese [ ]  Other [ ]  TTY/TDD |

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| **CLINIC KEY CONTACTS** |

|  |  |  |  |
| --- | --- | --- | --- |
| **Role** | **Name and Title** | **Phone** | **Email Address** |
| CEO |  |  |  |
| COO |  |  |  |
| Medical Director |  |  |  |
| Clinic Manager |  |  |  |
| Billing |  |  |  |
| Credentialing |  |  |  |
| Compliance |  |  |  |

I hereby affirm that the information submitted to San Francisco Health Plan and any addenda hereto is true and complete to the best of my knowledge and furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my Service Agreement.

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| **Signature** (Stamp Is Not Acceptable) | **Printed Name and Title** | **Date** |

**INSTRUCTIONS**: This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered. Please do not use abbreviations when completing the application. Accompany this application with the documents listed in the cover letter. **This application must be completed in its entirety, signed and dated; incomplete applications may be returned or nullified.**

**Complete a separate application for each location for which your organization is contracting.**

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| **ADDITIONAL LOCATION**  |
| **Clinic Name** |  | **Year Opened** |  |
| **Clinic Address** |  |
| **Telephone** |  | **Fax** |  |
| **Email** |  | **Web address** |  |
| **Type** | **Number (if different from primary location)** | **Expiration Date** |
| NPI  |  | n/a |
| TIN  |  |  |
| CA State License |  |  |
| DEA |  |  |
| CMS Certification |  |  |
| **SITE VISIT** |
| 1. In the past 36 months, has the facility had an onsite visit by a government agency (e.g. CMS or DHCS)

[ ]  Yes; Date of the visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (answer questions 2)[ ]  No |
| 1. Were there any deficiencies found during the last full scope survey?

[ ]  Yes (answer questions 2) [ ]  No |
| 1. Have all the deficiencies corrected?

[ ]  Yes (answer questions 2)  |
| [ ]  No, please explain: |
| **NOTE**: Attach a copy of the most recent onsite survey; if citations were issued, include a copy of the Corrective Action Plan.  |
| **ACCESSIBILTY, HOURS OF OPERATIONS, LANGUAGE** |
| **Accessible by Public Transportation**  | [ ]  Yes [ ]  No | **Block to Nearest Bus Stop** |  |
| **Hours of Operations** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** |
| **Open** |  |  |  |  |  |  |  |
| **Close** |  |  |  |  |  |  |  |
| **Languages Capability** | [ ]  English [ ]  Spanish [ ]  Chinese [ ]  Other [ ]  TTY/TDD |

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| **ATTESTATION QUESTIONS** |

**Please answer the following questions “yes” or “no.” If your answer to questions A through K is “yes,” or your answer to question N is “no,” please provide full details in a separate sheet.**

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| 1. Has this organization, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law related to: (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?
 | [ ]  Yes [ ]  No |
| 1. Has this organization, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law related to theft, fraud, embezzlement, breach of fiduciary duty or other financial misconduct in connection with the delivery of a heather care item or service?
 | [ ]  Yes [ ]  No |
| 1. Has this organization, under any current or former name or business identity, ever had any felony or misdemeanor convictions, under Federal or State law related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 Code of Federal Regulations Section 1001.1001 or 1001.201?
 | [ ]  Yes [ ]  No |
| 1. Has this organization, under any current or former name or business identity ever had any felony or misdemeanor convictions, under Federal or State law relating to the unlawful manufacture, distribution, prescription, or dispending of a controlled substance?
 | [ ]  Yes [ ]  No |
| 1. Has this organization ever had the State license involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the State license in anticipation of any of these actions; or are any of these actions pending with the respect to the State license?
 | [ ]  Yes [ ]  No |
| 1. Has this organization ever been charged, suspended, fined, disciplined, or otherwise sanctioned, submitted to probationary conditions, restricted or excluded, or has the facility voluntarily relinquished eligibility to provide services or accepted conditions on its eligibility to provide services for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending?
 | [ ]  Yes [ ]  No |
| 1. Has this organization had its membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan health maintenance organization (HMO), preferred provider organization (PO), private payer (including those that contract with public programs), medical society, professional association or other health delivery entity or system), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or note renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending?
 | [ ]  Yes [ ]  No |
| 1. Has this organization ever had any other regulatory agency (OSHA, etc.) deny, revoke, suspend, not renew, place under probation, subject to disciplinary action or otherwise limited or curtail operations; or are any actions pending from any other regulatory agency?
 | [ ]  Yes [ ]  No |
| 1. Has the facility ever had accreditation by an organization (CLIA, TJC, etc.) involuntarily deny, revoke, suspend, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished the accreditation in anticipation of any of these actions; or are any of these actions pending with respect to any such accreditation?
 | [ ]  Yes [ ]  No |
| 1. Has this organization ever been placed under temporary government ordered management?
 | [ ]  Yes [ ]  No |
| 1. Has this organization ever permitted the appointment of a receiver for its business or its assets?
 | [ ]  Yes [ ]  No |
| 1. Do you understand that subject to proper confidentiality restrictions and authorizations, medical records might be subject to on site review by SFHP representatives for peer review, utilization review, and quality assurance purposes?
 | [ ]  Yes [ ]  No |
| 1. Does this organization currently participate or have you ever participated as a provider in the Medi-Cal program in another’s state’s Medicaid program?
 | [ ]  Yes [ ]  No |

I hereby affirm that the information submitted to San Francisco Health Plan and any addenda hereto are true, current, and complete to the best of my knowledge and beliefs and it is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of the Service Agreement.

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| **Applicant Signature** (Stamp Is Not Acceptable) | **Printed Name** | **Date** |

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| **INFORMATION RELEASE / ACKNOWLEDGEMENTS** |

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials and qualifications and performance (“credentialing information”) by and between “this Healthcare Organization” and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations (IPAs), health care service plans, health maintenance organizations (HMOs), preferred provider organizations (PPOs), other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents - collectively “Healthcare Organizations,”) for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of peer records, and to protect peer review information from being further disclosed.

I am informed and acknowledge that federal and state laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including, but not limited to, California Business and Professions Code Section 809 et seq., if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (i) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, within fourteen (14) days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me, by the Medical Board of California taken or pending, including, but not limited to, any accusation filed, temporary restraining order or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization, which has resulted in the filing of a Section 805 report (or any subsections) with the Medical Board of California, appropriate licensing board or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding any minor traffic violations); or (vii) my receipt of written notice of any adverse action against me under the Medicare or Medicaid programs, including, but not limited to, fraud and abuse proceedings or convictions.

I pledge to provide continuous care for my patients.

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

Photocopy of this document shall be as effective as the original.

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| **Applicant Signature** (Stamp Is Not Acceptable) | **Printed Name** | **Date** |

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| **PROVIDER RIGHTS** |

**Right to Review**

The provider has the right to review information obtained by the Healthcare Organization for the purpose of evaluating that provider's credentialing or recredentialing application. This includes non-privileged information obtained from any outside source (e.g., malpractice insurance carriers, state licensing boards), but does not extend to review of information, references or recommendations protected by law from disclosure.

The provider may request to review such information at any time by sending a written request, via certified letter, to the Credentialing Department at the Healthcare Organization's offices. The Credentialing Department of the Healthcare Organization's offices, will notify the practitioner within 72 hours of the date and time when such information will be available for review at the Credentialing Department office.

**Right to be informed of the Status of Credentialing/Recredentialing Application**

Providers may request to be informed of the status of their credentialing/recredentialing application. The provider may request this information by sending a written request by letter, email or fax to the Credentialing Department of the Healthcare Organization's offices. The provider will be notified in writing by fax, email or letter no more than seven working days of the current status of the application with respect to outstanding information required to complete the application process.

**Notification of Discrepancy**

Providers will be notified in writing via fax, email or certified letter, when information obtained by primary sources varies substantially from information provided on the practitioner's application. Examples of information at substantial variance include reports of practitioner's malpractice claims history, actions taken against a practitioner's license/certificate, suspension or termination of hospital privileges or board certification expiration when one or more of these examples have not been self-reported by the practitioner on his/her application form. Providers will be notified of the discrepancy at the time of primary source verification. Sources will not be revealed if information obtained is not intended for verification of credentialing elements or is protected from disclosure by law.

**Correction of Erroneous Information**

If a provider believes that erroneous information has been supplied to Healthcare Organization by primary sources, the provider may correct such information by submitting written notification to the Credentialing Department. Providers must submit a written notice, via certified letter, along with a detailed explanation to the Credentialing Department at the Healthcare Organization, within 48 hours of the Healthcare Organization's notification to the provider of a discrepancy or within 24 hours of a provider's review of his/her credentials file.

Upon receipt of notification from the provider, the Healthcare Organization will re-verify the primary source information in dispute. If the primary source information has changed, correction will be made immediately to the provider's credentials file. The provider will be notified in writing, via certified letter, that the correction has been made to his/her credentials file. If, upon review, primary source information remains inconsistent with practitioner's notification, the Credentialing Department will so notify the provider via certified letter. The provider may then provide proof of correction by the primary source body to Healthcare Organization's Credentialing Department via certified letter at the address below within 10 working days. The Credentialing Department will re-verify primary source information if such documentation is provided.

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| **Applicant Signature** (Stamp Is Not Acceptable) | **Printed Name** | **Date** |