AZAHP

Facility Credentialing and Recredentialing Application

Please complete each section leaving no blank spaces. Clearly state if information requested is not applicable. Attach additional sheets when necessary.

Type of Facility (As listed on License or Accreditation)	
☐ Skilled Nursing Facility	☐ Ambulatory Surgery Center
☐ Home Health Agency	☐ Dialysis Center
☐ Laboratory Center	☐ Hospice
☐ Portable X-ray Supplier	☐ Diabetes Education Center
☐ Out-Patient Medical Rehab Center	☐ Rural Health Center
☐ Federally Qualified Health Center	☐ Hospital (Specify Type):
☐ Other (Please Specify):	

Facility Demographics	
Legal Business Name (as reported to the IRS):	**Federal Tax Identification Number:**
Doing Business As (dba) Name (if applicable):	**Hospital or Health System Affiliation:** ☐ Not affiliated with any hospital/health system
Mailing/Correspondence Address:	
City: / **State:** / **Zip Code:**	
Billing Name (if different than dba):	
Billing Address:	
City: / **State:** / **Zip Code:**	
Phone #:	**Fax #:**
Credentialing Contact Name:	**Phone #:**
Credentialing Mailing/Correspondence Address:	
City: / **State:** / **Zip Code:**	
Email Address:	**Fax#:**

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Primary Location		
Street Address:		
City:	**State:**	**Zip Code:**
Phone #:	**Fax #:**	
State License # : ***Please provide a copy of State License*** **Expiration Date:**_____	**CLIA #:** **Expiration Date:**_____	
NPI #: **(Application cannot be processed without a valid 10-digit NPI)**		
Medicare Certified? ☐ **Yes** ☐ **No** ***Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter*** **Medicare #:** _____		
Medicaid #: _____		

Please indicate if this location has been reviewed by any of the accrediting authorities listed below and provide a copy of most recent accreditation report	
☐ American Association for Accreditation of Ambulatory Surgery	☐ Det Norske Veritas National Integrated Accreditation for Healthcare Organizations
☐ American Association for Ambulatory Health Care	☐ Commission on Accreditation of Rehabilitation Facilities
☐ American College of Radiology	☐ American Osteopathic Association
☐ Healthcare Facilities Accreditation Program	☐ Accreditation Commission for Health Care Inc.
☐ Commission on Office Laboratory Accreditation	☐ Joint Commission
☐ Community Health Accreditation	☐ Not Applicable

Professional Liability: **** Please provide a copy of Current Liability Declaration Sheet*** Name of Carrier: _____ Effective Date: _____ Expiration Date:_____ Per Incident: $_____ Per Aggregate: $_____	**Comprehensive Liability:** **** Please provide a copy of Current Liability Declaration Sheet*** Name of Carrier: _____ Effective Date: _____ Expiration Date:_____ Per Incident: $_____ Per Aggregate: $_____

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Supplemental Form

For each additional address copy and complete this Supplemental Form

Return all copies with the completed application

Street Address:		
City:	**State:**	**Zip Code:**

Phone #:	**Fax #:**
State License # : ***Please provide a copy of State License*** **Expiration Date:_____**	**CLIA #:** **Expiration Date:_____**

NPI #:
(Application cannot be processed without a valid 10-digit NPI)

Medicare Certified? ☐ **Yes** ☐ **No**
Please provide a copy of most recent (completed within the last 3 years) State Agency Site Review or CMS Certification approval letter

Medicare #:

Medicaid #:

Accreditation:
Does this site have the same accrediting agency as the primary address?

☐ **Yes**

☐ **No - Please specify accrediting agency or NONE:_____**

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Disclosure Questions

Please answer the following questions by checking the appropriate box. If the answer to any question is yes, please provide a complete description of the facts on a separate attached sheet.	
1. Has the facility license to do business in any applicable jurisdiction ever been denied, restricted, suspended, reduced or not renewed?	☐ Yes ☐ No
2. Has the facility been denied participation, suspended from or denied renewal from Medicare or Medicaid?	☐ Yes ☐ No
3. Has the facility ever had its professional liability coverage cancelled or not renewed?	☐ Yes ☐ No
4. Has the facility been denied accreditation by its selected accrediting body (e.g. TJC), or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?	☐ Yes ☐ No

Facility Attestation/Consent & Release Form

Any alteration or failure to sign and date this form will result in the delay of processing this application.

By signing below, I attest that I am the duly authorized representative of the Facility, that all information on the Application pertains to the above-named Facility, and that such information is current, complete and correct.

Your signature is required to complete this application.

Facility Name: _____

Name (Please Print): _____

Title: _____

Signature: _____ **Date:** _____

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Facility Credentialing and Recredentialing
Application Instructions

Please include with your completed/signed application the following items for each location:

- □ Copy of current State License (if applicable)
- □ Copy of Medicare Certification letter (if applicable)
- □ Copy of Certifications and/or Accreditation Certificates (e.g. TJC, CHAP, etc)
- □ Copy of Declaration Sheet and/or Certificate of Insurance for BOTH Current *Professional* Malpractice and Comprehensive *General* Liability Insurance Policies

If you have any questions, please contact our credentialing vendor, Aperture at 800-398-0335, option 4.

Please fax completed application, along with all required documentation to 520-874-7142.

Please Note:

Initial Credentialing – Failure to legibly complete all sections of this Application and submit current copies of all required documentation will result in processing delays.

Recredentialing – Submission of recredentialing information is a contractual obligation. Failure to complete all sections of this Application and submit current copies of all required documentation in a timely manner will be considered a request to terminate the facility's participation in our network.