



700 Main Street, #100
Alamosa, CO 81101
(719) 589-3696
fridayhealthplans.com

Ancillary & Facility Credentialing Application

This application will be used if you wish to become a participating ancillary or facility provider with Friday Health Plans. This application is not a contract.

To ensure accuracy, please type your information in this form and fax it 719-589-4901 or email to credentialing@fridayhealthplans.com. If you have any questions about completing this form, e-mail or call the Credentialing Department at 719-589-3696.

You may also mail the completed form to:
Credentialing Department
Friday Health Plans
700 Main St, #100
Alamosa, CO 81101

As a provider, you have the right to review your credentialing information. If you wish to obtain the status of your application, please contact the Credentialing Department at the e-mail or phone number listed above. Initial credentialed providers will be notified via letter of the credentialing decision. All providers may consider themselves recredentialed unless otherwise notified.

Complete a separate application for:

- Each site location
- Each organization with a unique Federal Tax Identification Number

APPLICATION TYPE

Initial Request Recredentialing

Is this application for the addition of a new site to your current contract? Yes No

Is this application due to physical address change or practice relocation? Yes No
If yes, please provide the old address and new address below

Old Address:

New Address:

Please return completed Application along with copies of the following or indicate "NA":

1. _____ Copy of State Facility License
2. _____ Most recent CMS or State Department of Health survey report; or Approval letter from CMS or State Department of Health stating facility's review date and inspection results
3. _____ Copy of JCAHO Accreditation Letter and Accreditation Decision Grid; or Copy of the most recent survey results from the State Department of Health if not currently accredited by JCAHO, AAAHC or AAAASF
4. _____ Copy of Professional Liability and General Liability Insurance Certification, which list amounts and coverage dates
5. _____ Entity W-9 or copy of IRS 540 or 941
6. _____ Lab Cert
7. _____ CLIA
8. _____ Pharmacy Permit
9. _____ FDA ACR Cert (Mammography)
10. _____ Bedding/Upholstery License

Please indicate type of organization (choose all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Ambulatory Surgical Clinic/Center | <input type="checkbox"/> Physical Therapy Clinic/Center |
| <input type="checkbox"/> Clinical Medical Laboratory | <input type="checkbox"/> Radiology, Mammography Clinic/Center |
| <input type="checkbox"/> DME & Medical Supplies | <input type="checkbox"/> Rehabilitation Clinic/Center |
| <input type="checkbox"/> General Acute Care Hospital | <input type="checkbox"/> Rehabilitation Hospital |
| <input type="checkbox"/> Hearing and Speech Clinic/Center | <input type="checkbox"/> Rural Health Clinic/Center |
| <input type="checkbox"/> Home Health Agencies | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Hospice, Inpatient | <input type="checkbox"/> Substance Abuse Rehabilitation Facility |
| <input type="checkbox"/> Long Term Care Hospital | <input type="checkbox"/> Urgent Care Clinic/Center |
| <input type="checkbox"/> Magnetic Resonance Imaging Clinic/Center | <input type="checkbox"/> Other_____ |
| | <input type="checkbox"/> Taxonomy Code _____ |

PROVIDER INFORMATION

Legal Name *(As it appears on W-9)*: _____
Entity Name *(DBA)*: _____
Physical Address: _____
City, State, Zip: _____
Web address: _____
Phone: _____ Fax: _____
NPI: _____ Tax ID: _____
State License #: _____ CLIA #: _____
Credentialing Contact Person: _____
E-mail: _____ Phone: _____
Remittance Address (if different): _____
Remittance City, State, Zip _____
Remit Phone: _____ Remit Fax: _____
Does your organization submit claims electronically? Yes No
Is your entity a Physician Owned facility? Yes No
If no, please describe ownership: _____

OTHER INFORMATION

- A. Has your organization's license to practice ever been limited, suspended, or revoked?
 Yes No
- B. Has your organization ever been sanctioned, expelled, or suspended from receiving payment under Medicare or Medicaid Programs?
 Yes No
- C. Has your organization been named in any malpractice actions in the last 5 years?
 Yes No

If you answered "YES" to any questions above, please attach an explanation, including the specific details of each incidence.

ATTESTATION

All information and documentation submitted here within is correct and complete to my best knowledge and belief. I acknowledge and understand that any material misstatements in or omissions from this application may constitute cause for denial of my application for participation in Friday Health Plans. A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

I authorize Friday Health Plans the right to obtain documents, recommendations, reports and statements relating to the Credentialing process of this entity and the associated entities that intend to contract with Friday Health Plans. In addition, I also authorize the right to verify my standing with State and Federal regulatory bodies relating to the Credential process.

Name: _____
Signature: _____
(Signing on behalf of entity)
Date: _____
Phone: _____
Fax: _____
E-mail: _____