



1001 Brinton Road  
Pittsburgh, PA 15221

**CREDENTIALING APPLICATION  
FOR ANCILLARY PROVIDERS**

**Any application that does not include the necessary items will cause a delay in the credentialing process until all items have been received**

Type of Health Care Facility/Provider \_\_\_\_\_ Date of Application: \_\_\_\_\_

Agency/Organization Name \_\_\_\_\_ Federal Tax ID # \_\_\_\_\_

Does your agency/organization do business under another name? \_\_\_\_\_

(IF YES, WHAT NAME?) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County \_\_\_\_\_

Telephone Number ( ) \_\_\_\_\_ Fax Number ( ) \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

Mailing/Correspondence Address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**KEY MANAGEMENT STAFF AND PHONE NUMBERS**

Contact Person \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

President/CEO \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Administrator/Executive Director \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Director of Nursing \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Medical Director \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

Business Manager \_\_\_\_\_ Telephone ( ) \_\_\_\_\_

**PAYMENT OFFICE LOCATION**

Address: \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Contact Person(s): \_\_\_\_\_

**LICENSURE/CERTIFICATION---Please include copies of all Licenses and Certificates for your Facility**

State License/Registration # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_  
TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

Business/Vendor License# SC: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

Medicaid Provider # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_  
TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

Medicare Provider # \_\_\_\_\_ Medicare Certification: \_\_\_\_Yes \_\_\_\_No

NPI Number (if any): \_\_\_\_\_ NCPDP#: \_\_\_\_\_

Pharmacy Permit/License # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_  
TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

CLIA Accreditation: Registration # \_\_\_\_\_ Waiver # \_\_\_\_\_

State Laboratory Permit: Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Bedding/Upholstery License (**DME providers only**): \_\_\_\_ Yes \_\_\_\_ No Expiration Date: \_\_\_\_\_

Mammography: FDA Certification for Mammography/MRI \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ None performed

ACR Certification for Mammography/MRI \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ None performed

State Inspection Certificates for all X-ray equipment: \_\_\_\_ Yes \_\_\_\_ No If no, explain: \_\_\_\_\_

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**ACCREDITATION – If Applicable**

**Indicate all Organizations and attach a copy of each certificate of accreditation and report from last survey.**

Accrediting Body \_\_\_\_\_ Accrediting Status \_\_\_\_\_ Expiration Date \_\_\_\_\_

If conditions exist on accreditation, specify \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey, if known \_\_\_\_\_

Accrediting Body \_\_\_\_\_ Accrediting Status \_\_\_\_\_ Expiration Date \_\_\_\_\_

If conditions exist on accreditation, specify \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey, if known \_\_\_\_\_

**ADDITIONAL SITE INFORMATION (For those facilities with more than one location)**

**Duplicate this page for each location operated by your Facility.**

Agency/Organization Name: \_\_\_\_\_ TIN # \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ County: \_\_\_\_\_

Telephone Number: ( ) \_\_\_\_\_ Fax Number: ( ) \_\_\_\_\_ Hours of Operation: \_\_\_\_\_

Mailing Address (if different) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**LICENSURE/CERTIFICATION**

**Complete information as applicable and submit a copy of each certificate as applicable.**

State License/Registration # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_

TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

Medicaid Provider # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_

TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

Medicare Provider # \_\_\_\_\_ Medicare Certification: \_\_\_\_ Yes \_\_\_\_ No

Pharmacy Permit/License # PA: \_\_\_\_\_ SC: \_\_\_\_\_ NJ: \_\_\_\_\_

TN: \_\_\_\_\_ OH: \_\_\_\_\_ Other: \_\_\_\_\_

Laboratories: CLIA Status: Registration # \_\_\_\_\_ Waiver # \_\_\_\_\_

Bedding/Upholstery License (**DME providers only**): \_\_\_\_ Yes \_\_\_\_ No Expiration Date: \_\_\_\_\_

Mammography: FDA Certification for Mammography/MRI \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ None performed

ACR Certification for Mammography/MRI \_\_\_\_ Yes \_\_\_\_ No \_\_\_\_ None performed

State Inspection Certificates for all X-ray equipment: \_\_\_\_ Yes \_\_\_\_ No If no, explain: \_\_\_\_\_

**ACCREDITATION**

**Attach a copy of each certificate of accreditation and report from last survey.**

Accrediting Body \_\_\_\_\_ Accrediting Status \_\_\_\_\_ Expiration Date \_\_\_\_\_

If conditions exist on accreditation, specify \_\_\_\_\_

Date of most recent survey \_\_\_\_\_ Date of next survey, if known \_\_\_\_\_

**COVERED SERVICES**

Identify specific service categories to be provided (e.g. skilled nursing, home health aid, speech therapy) \_\_\_\_\_  
\_\_\_\_\_

Provide a listing and description of each service and/or items being provided. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SERVICE AREAS AND OFFICE LOCATIONS OF PROVIDER ORGANIZATION**

Geographic Service Area (**list counties served**): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does your organization use a telephone answering service after hours? \_\_\_\_\_ Who? \_\_\_\_\_

Describe your agency's/organization's after-hours coverage policy and procedure \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIABILITY INFORMATION --- Attach separate sheet with explanation to all questions answered "Yes"**

1. Has your Facility ever been disciplined by any state licensing or other authorizing agency or have you ever been reprimanded, or fined by any state agency that disciplines healthcare facilities?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
2. Has your Facility ever been reprimanded, censured, excluded, suspended, or disqualified by the Medicare, Medicaid, or CLIA Program?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
3. Has the pharmacy license ever been suspended or otherwise limited for your Facility?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
4. Has your Facility ever been canceled, non-renewed, or restricted by insurance carrier?  
\_\_\_\_\_ YES \_\_\_\_\_ NO
  
5. Has your Facility ever had membership in a professional organization revoked, reduced, denied, or suspended?  
\_\_\_\_\_ YES \_\_\_\_\_ NO

**PLEASE ATTACH THE FOLLOWING TO THE APPLICATION (If Applicable)**

**\*\*\*Must be included for all provider types**

- 1. Copy of W-9 Form\*\*\***
- 2. Copies of Current Professional/Liability Facesheets of each insurance policy\*\*\***
- 3. Copy of Current State License(s) and other certifications**
- 4. Copy of Pharmacy Permit**
- 5. Copy of Current X-ray equipment inspection certificates/reports**
- 6. Copy of Current FDA and ACR Certificate for Mammography, MRI, CT or Ultrasound**
- 7. Copy of Current CLIA Lab Certificate**
- 8. Copy of Accreditation Certificates (JCAHO, AOA, CHAP, ABC or AAAHC)**
- 9. Detailed explanation to any questions answered “Yes” in LIABILITY INFORMATION section**
- 10. Current Medical Staff Listing**
- 11. Brochures and other literature about your organization**
- 12. Credentialing Criteria for professional staff and independent contractors**

**Note: If you are a Home Health Agency, Hospice, Skilled Nursing Facility or Ambulatory Surgical Center and your facility is not accredited the following must also be included:**

- 1. Copy of HCFA/CMS State Licensure Survey and Revisit (if deficiencies on licensure survey)**
- 2. Copy of Corrective Action Plan**
- 3. Copy of Current QI/UM Program with appropriate signature pages, QI/UM policies and procedures, including the QI Workplan, QI Activities Annual Report, Outcomes based studies, Patient Bill of Rights including QA Committee, organizational chart, patient satisfaction surveys, and Risk Management Plan.**

**ATTESTATION OF TRUTH and RELEASE OF LIABILITY**

This Health Care Facility certifies that all the information in this questionnaire is true. Any information in this questionnaire, which is later determined to be false, may result in contract termination. This Health Care Facility is aware that review of the information in this questionnaire will form the basis for the Unison Administrative Services credentialing assessment process regarding Health Care Facility continued participation in the Unison Administrative Services network.

This Health Care Facility authorizes Unison Administrative Services to consult with any appropriate person who has been associated with the Facility and who may have information about the Facility's practice. The Health Care Facility consents to the review of records and documents that may be material to any evaluation of the Facility's competence. Health Care Facility releases from liability individuals and organizations who provide information, including otherwise privileged or confidential information to Unison Administrative Services, representatives in good faith and without malice concerning the Facility's competence. The Health Care Facility authorizes and consents to Unison Administrative Services representatives providing other organizations, facilities, and licensing boards concerned with provider performance and the quality and efficiency of patient care with any information relevant to such matters that Unison Administrative Services may have concerning the Facility and releases Unison Administrative Services, representatives from liability for doing so provided that such furnishing of information is done in good faith and without malice. Health Care Facility consents to the release of information from the liability insurance carrier regarding its coverage and present and prior claims.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Title

**Original 1/6/06**