UNM HOSPITALS
Veterans Affairs Patient-Centered Community Care (VAPC3)

FACILITY CREDENTIALING APPLICATION AND DOCUMENTATION CHECKLIST

For your facility's participation in the UNMH VAPC3/VCP Network, please complete the attached application. Please submit clear and legible copies of the application and documents requested.

	REQUIRED DOCUMENT CHECKLIST
	COPY OF CURRENT STATE OR LOCAL OPERATING LICENSE - REQUIRED
	COPY OF MEDICARE AND/OR MEDICAID CERTIFICATION & CMS LETTER FOR EACH OF FACILITIES BELOW, REQUIRED, IF APPLICABLE: ➢ **Hospital** ➢ **Freestanding Ambulatory Surgery Center** ➢ **Skilled Nursing Facility** ➢ **Swing Bed(s)** ➢ **Rehabilitation Unit** ➢ **Home Health Agency** ➢ **Behavioral Health Services** ➢ **Residential Treatment Facility** ➢ **Sleep Study Center**
	Current Liability Coverage (Malpractice Certificate) - REQUIRED
	W-9 IRS FORM – REQUIRED
	Copy of all Licensure/Accreditation/Certification - REQUIRED
	Maximus Certifications (If Applicable)

Please type or print legibly, ensure that the attestation and release form is signed and dated. Please do not use whiteout. If the application is incomplete, not signed/dated, or if whiteout is used, it will not be processed. Please use additional sheets if you need to provide additional information.

PLEASE RETURN THE COMPLETED APPLICATION VIA

EMAIL: VAPC3CREDENTIALING@SALUD.UNM.EDU

OR

VIA FAX – 505.272.3614.

UNM HOSPITALS

Veterans Affairs Patient-Centered Community Care (VAPC3)

INSTITUTIONAL/FACILITY CREDENTIALING APPLICATION

(Please complete a separate application for each location)

- **Complete this form in its entirety and attach all requested documentation and explanations.**
- If a question does not apply to your facility, answer with "Non-Applicable" or "NA".
- If additional space is necessary to provide answers, attach additional sheet(s) of paper.
- Incomplete applications will be returned.
- **This application must be signed and dated where indicated.**

FACILITY NAME: _____

PROVIDER INFORMATION (Choose all that apply):

***Type of Hospital Provider*:**

- ☐ Acute Care
- ☐ Cancer
- ☐ Critical Access
- ☐ Psychiatric
- ☐ Rehabilitation
- ☐ Sole Community
- ☐ Other (please specify) _____

Hospital Based Units/Services:

- ☐ Ambulatory Surgery
- ☐ Cardiac Catheterization Lab
- ☐ Cardiac Rehabilitation
- ☐ Home Health
- ☐ Psychiatric Unit
- ☐ Psychiatric Partial Hospitalization Program
- ☐ Rehabilitation Unit
- ☐ Residential Treatment Center
- ☐ Skilled Nursing Unit
- ☐ Substance Use Disorder Rehabilitation
- ☐ Swing Bed Unit

***Type of Ancillary or Freestanding Facility Provider*:**

- ☐ Ambulance
- ☐ Ambulatory Surgery Center
- ☐ Bone Marrow Transplant
- ☐ Cardiac Catheterization Lab
- ☐ Cardiac Rehabilitation Facility
- ☐ Clinical Medical Laboratory
- ☐ Comprehensive Outpatient Rehab Facility
- ☐ Durable Medical Equipment
- ☐ Home Health Agency
- ☐ Home Infusion
- ☐ Magnetic Resonance Imaging Center
- ☐ Orthotics/Prosthetics
- ☐ Outpatient Rehabilitation Clinic (OT, PT, ST)
- ☐ Pain Management Clinic
- ☐ PET Center
- ☐ Pharmacy (special)
- ☐ Pharmacy with DME
- ☐ Portable X-Ray
- ☐ Psychiatric Partial Hospitalization Program
- ☐ Radiation Therapy Clinic
- ☐ Radiology Center
- ☐ Residential Treatment Center
- ☐ Skilled Nursing Facility
- ☐ Sleep Study Center
- ☐ Substance Use Disorder Rehabilitation

UNM HOSPITALS
Veterans Affairs Patient-Centered Community Care (VAPC3)

DEMOGRAPHIC INFORMATION

Facility Name: _____

DBA Name (if applicable): _____

Street address: _____

City: _____ **County**: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax #:** _____ **Email:** _____

Contact Person (the person you wish us to contact regarding information on this application):

Contact Name: _____ **Title:** _____

Phone #: _____ **Fax #:** _____ **Email:** _____

Federal TIN # (include a copy of W-9): _____

PAYMENT/BILLING INFORMATION

Corporate/Pay to Name (if different than facility name): _____

Address: _____

City: _____ **County:** _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax #:** _____

Billing Contact Name: _____

Phone #: _____ **Fax #:** _____ **Email**: _____

OWNERSHIP/MANAGEMENT

President/CEO Name: _____ **Phone #:** _____ **Title:** _____

CFO Name: _____ **Phone #:** _____ **Title:** _____

Medical Director Name: _____ **Phone #:** _____ **Title:** _____

Facility Ownership Type: ☐Government ☐Non-Profit
☐For Profit ☐Other (indicate type): _____

Organizational Structure: ☐Corporation ☐Partnership ☐Single Owner
☐Public Agency ☐Professional Group

LICENSURE/ACCREDITATION/CERTIFICATION

- **Please provide a copy of all applicable documents**
- If not accredited or certified, please note where you are in the process of obtaining accreditation or certification and by what date you expect to complete the process

Agency	License, Certification or Accreditation Number (if applicable)	Last Review/ Renewal Date	Expiration Date
AAAHC – Accreditation Assoc. for Ambulatory Health Care, Inc.			
ACR - American College of Radiology			
CARF – Commission on Accreditation of			
Chemical Dependency Certification			
CLIA - Clinical Laboratory Improvement			
Commission on Cancer (CoC) of the American College of Surgeons			
DEA Registration			
FDA – Mammography Facility Certification			
Medicare Part A			
Medicare Part B			
Medicaid			
State License			
The Joint Commission			
Other (specify name)			

PLEASE ANSWER ALL QUESTIONS:

- **Facilities performing Cardiac Surgery report to the Society for Thoracic Surgery (STS) National Adult Cardiac Surgery Database.** ☐ Yes ☐ No ☐ N/A
- **Facilities performing Cardiac Catheterization and/or Percutaneous Coronary Intervention participate in the National Cardiovascular Data Registry (NCDR) CathPCI Registry.** ☐ Yes ☐ No ☐ N/A
- **Facilities implanting Cardioverter Defibrillators (ICDs) participate in the National Cardiovascular Data Registry (NCDR) ICD Registry.** ☐ Yes ☐ No ☐ N/A
- **Facility participates in the National Disaster Medical System (NDMS).** ☐ Yes ☐ No ☐ N/A

UNM HOSPITALS
Veterans Affairs Patient-Centered Community Care (VAPC3)

LIABILITY COVERAGE : Please provide a copy of a current Liability Insurance Face sheet

Current Carrier: _____

Agency Name: _____

City: _____ **ST:** _____ **Phone #:** _____

$ Amount per occurrence: _____ **$ Amount Aggregate**: _____

Dates of Coverage (mm/dd/year format): _____ to _____

Please answer all the questions and provide a concise summary on a separate sheet for any "Yes" answer. In the past five years:

- **Has the corporation, an officer or a board member ever been convicted of a felony?** ☐ **Yes** ☐ **No** ☐ **N/A**
- **Has your State License (if applicable) ever been denied, suspended or revoked for any reason?** ☐ **Yes** ☐ **No** ☐ **N/A**
- **Have you ever been subjected to sanctions by a Professional Review Organization, the Medicare/Medicaid Program, a Third Party Payor or a Regulatory agency?** ☐ **Yes** ☐ **No** ☐ **N/A**

MALPRACTICE HISTORY

Please answer all the questions and provide a concise summary on a separate sheet for any "Yes" answer. In the past five (5) years:

- **Has the facility's professional liability insurance coverage ever been denied or cancelled?** ☐ **Yes** ☐ **No**
- **Has the facility's current or previous professional liability ever made an out of court settle or paid a judgment of a professional liability claim on the facility/service behalf?** ☐ **Yes** ☐ **No**
- **Is or has the facility ever been involved in a malpractice suite(s), grievance(s) filed with a county or state medical society or licensing agency, or arbitration proceeding(s)?** ☐ **Yes** ☐ **No**
- **Have you ever had a liability case brought against you?** ☐ **Yes** ☐ **No**
- **Have any judgments been brought against you in a liability case?** ☐ **Yes** ☐ **No**
- **Have any settlements ever been made on your behalf?** ☐ **Yes** ☐ **No**
- **Are there any open claims or cases presently filed against you?** ☐ **Yes** ☐ **No**

****If you answered yes to a question above, provide a concise summary on a separate sheet.****

OTHER INFORMATION

List the days and hours your facility is open: Hours of Operation: _____

Mon ☐ Tues ☐ Wed ☐ Thur ☐ Fri ☐ Sat ☐ Sun ☐

Total licensed bed capacity: _____

Are you a teaching facility? ☐ Yes ☐ No

Do you have an intern or residency program? ☐ Yes ☐ No

What steps to you take to ensure that all individuals who provider services maintain a current license and provider services within the scope of their license? _____

ATTESTATION AND RELEASE OF INFORMATION

On behalf of the facility, I hereby certify and attest that information contained herein is true and correct and that any omission or misrepresentation may void this application or be cause for termination of this organization's participation as a TriWest network provider. Further, I give permission to TriWest and or its designee to verify the facility's credentials and by doing so hereby authorize release of the requested information concerning the facility's licensing, certification and accreditation. I attest that this facility ensures all individuals contracted or employed by the facility meet credentialing requirements, appropriate accreditation or certification and maintain Medicare approval for payment and unrestricted current state licensure to practice.

On behalf of the facility, I release all individuals and organizations from all liability for any damages which may result from issuing such information.

Type/Print Name: _____

Signature: _____

Title: _____

Date: _____

PLEASE INCLUDE A COPY OF YOUR W-9