

# MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

Initial Credentialing

Re-credentialing

## APPLICATION INSTRUCTIONS

- ALL fields must be completed unless otherwise directed
- Please do not use abbreviations when completing the application
- Submit completed application along with **all** required documentation
- Please E-mail or Fax Completed Application to

## APPLICATION NOTES

- For the purposes of this application, "facility" is defined as a hospital; home health agency; skilled nursing facility; ambulatory surgery center; and inpatient, residential, and ambulatory behavior health facility
- As required by the facility contract and accrediting agencies, one unique application is required for each facility type and location as listed on page three
- Failure to complete this application in its entirety, including submission of required documentation may delay or suspend network participation
- The Minnesota Uniform Facility Credentialing Application may be used by other organizations

## ATTACHMENTS

### THE PROCESSING OF YOUR APPLICATION WILL BE DELAYED IF ALL REQUIRED INFORMATION IS NOT SUBMITTED

	Copy of all current State and/or local licenses required to operate as a health care facility. If your State / provider type does not require a State / local license [Explanation Needed]
	Current copy of your onsite governmental agency site survey including facility's corrective action plan if deficiencies were cited, OR cover letter/e-mail from licensing agency stating facility is in substantial compliance with licensing standards
	Current copy of facility Commercial Liability Insurance Certificate
	Current copy of facility Professional Liability Insurance Certificate covering <u>all</u> facility employees
	Copy of current accreditation letter or certificate is required please note all CMS accrediting organizations are accepted
	Signed copy Medicare certification documents from CMS

# MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

## 1. FACILITY IDENTIFICATION

### CORPORATE IDENTIFICATION INFORMATION

<b>LEGAL BUSINESS NAME</b> <i>(as reflected on W-9)</i>	<b>FEDERAL TIN/TAX ID</b> <i>(application cannot be processed without valid 9 digit TIN)</i>
<b>BUSINESS ADDRESS</b> <i>(if different than facility address)</i>	<b>TYPE-2 NPI</b> <i>(application cannot be processed without valid 10-digit NPI)</i>
<b>ORGANIZATION CLASSIFIED AS:</b>  <div style="display: flex; justify-content: space-between;"> <span>Corporation</span> <span>Partnership</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Not-For-Profit Corp</span> <span>Sole Proprietorship</span> </div> <span>Other (Specify)</span>	<b>Is facility owned in whole or in part or managed by a hospital or health care system/facility?</b>  <div style="display: flex; justify-content: space-between;"> <span>Yes, owned in whole or in part by</span> </div> <div style="display: flex; justify-content: space-between;"> <span>Yes, managed by</span> </div> <div style="display: flex; justify-content: space-between;"> <span>No, not affiliated with a hospital or health care system/Facility</span> </div>

### FACILITY INFORMATION

<b>FACILITY DOING BUSINESS AS NAME</b> <i>(as reflected on W-9)</i>			
<b>STREET ADDRESS:</b>	<b>CITY:</b>	<b>STATE:</b>	<b>ZIP CODE:</b>
<b>COUNTY:</b>	<b>PHONE:</b>	<b>FAX:</b>	<b>WEBSITE:</b>

<b>OFFICE ADMINISTRATOR</b> <i>(Name, Title, Email, Phone, Fax)</i>
<b>APPLICATION CONTACT PERSON</b> <i>(Name, Title, Email, Phone, Fax)</i>

### MAILING/CORRESPONDENCE ADDRESS

Check here if all correspondence can be directed to the facility location directly above.  
Otherwise, complete the section below.

<b>FACILITY NAME</b>
<b>FACILITY ADDRESS</b>
<b>FACILITY COUNTY AND PHONE NUMBER</b>
<b>OFFICE ADMINISTRATOR</b> <i>(Name, Title, Email, Phone, Fax)</i>
<b>APPLICATION CONTACT PERSON</b> <i>(Name, Title, Email, Phone, Fax)</i>

## 2. MEDICAL DIRECTOR OR EQUIVALENT

**A specific physician Medical Director or equivalent must clearly be identified and must be licensed in good standing.**

Name: MD DO Other Specialty:

License Number: NPI Number:

Phone Number: Email Address:

## 3. FACILITY TYPE

**One box must be checked based on licensure status. If your provider type is not listed below, do NOT complete this application**

### MEDICAL

Ambulatory Surgery Center \_ Free Standing

Home Health Care Agency – Providing skilled nursing services

Hospital – All Types including Psychiatric (# of Medicare certified beds: )

Skilled Nursing Facility / Nursing Home (# of Medicare certified beds: )

Birth Center

### BEHAVIORAL HEALTH

Adult Licensed Residential Crisis

Children’s Residential Facility – Mental Health Treatment

Children’s Residential Facility – Substance Abuse Treatment

Eating Disorders Residential Facility

Mental Health Residential Treatment, IRTS, or Residential Crisis

Partial Psych/Partial Hospitalization – Free standing only

Substance Abuse Treatment – Outpatient and / or Residential / Inpatient

Outpatient Treatment Program

### \*FOR HOSPITALS ONLY\*

#### Does your Facility provide any of the following services?

Critical Access Hospital	Yes	No	Cardiac Surgery Program	Yes	No
Outpatient Dialysis	Yes	No	Physical Therapy	Yes	No
Critical Care Services - Intensive Care Unit (ICU)	Yes	No	Occupational Therapy	Yes	No
Diagnostic Radiology	Yes	No	Outpatient Infusion / Chemotherapy	Yes	No
Mammography	Yes	No	Speech Therapy	Yes	No
Genetic Counseling and Testing	Yes	No	Laboratory Services	Yes	No
Cardiac Catheterization Services	Yes	No			



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## 7. NON ACCREDITED FACILITY

*Complete this section if facility is not accredited.*

**Medical Facility: Has your State completed an onsite licensing review or has CMS certification survey within the past 36 months?**

**YES - Date of most recent onsite survey:**

*Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.*

**NO - Successful completion of a health plan onsite visit will be required to complete re/credentialing. You will be contacted by health plan to schedule the visit.**

**If your State has not had a Services Site survey within the past 36 months, please note when your next site survey is scheduled:**

**Behavioral Health Facility: Has your State completed an onsite licensing site review within the past 36 months?**

**YES- Date of most recent onsite survey:**

*Attach copy of the most recent onsite licensing/certification survey along with your Corrective Action Plan (CAP), if deficiencies were cited; OR attach a letter or email from the licensing/certification agency stating that the facility is in substantial compliance with the most recent survey standards.*

**NO – Successful completion of a health plan onsite visit will be required to complete re/credentialing. You will be contacted by health plan to schedule the visit.**

**If you have not had a State site survey within the past 36 months, please note when your next site survey is scheduled:**

## 8. HEALTH PLAN SITE VISIT:

**Does your branch or satellite location(s) follow the same policies and procedures as your main facility?**

Yes - Fill out the attached Policy and Procedure Attestation on the page 7.

No - When the health plan contacts you to schedule the health plan site visit, it will be determined if site visits are required for the branch/satellite locations.

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## POLICY ATTESTATION

Please list any other facilities under the same name and/or tax id number as name of facility, specialty and location listed on this application.

If your facility follows the same policies and procedures as your main facility, the **Health Plan** may limit a site visit.

### Attestation:

I, the undersigned authorized agent, hereby attest and certify that (name of facility, specialty and location) shares the same policies and procedures as: (list all facilities, specialty and locations)

Facility Name	Specialty	Location	TIN	NPI

\_\_\_\_\_  
Signature of Authorized Representative

\_\_\_\_/\_\_\_\_/\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Title

# MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

## 9. CREDENTIALING PROGRAM

Indicate how credentialing is ensured for all health care professionals employed or contracted at the facility:

Credentialing procedures are performed internally

Credentialing procedures are outsourced/delegated to:

Name :

Phone Number:

## 10. INSURANCE COVERAGE

1. This facility is covered by **Commercial General** liability insurance in the minimum amount of

\$                    per occurrence and \$                    aggregate? (Excess liability/Umbrella coverage can count toward the  
\$                    aggregate amount.)

YES - Attach copy of insurance certificate. We prefer the Acord® Certificate of Liability Coverage

Facility is covered by Government insurance. – Attach documentation detailing coverage.

2. Is this facility covered by **Professional** liability insurance in the minimum amount of \$1 million per

occurrence and \$3 million aggregate? Policy must state it covers all facility employees.  
(Excess liability/Umbrella coverage can count toward the \$3 million aggregate amount.)

YES - Attach copy of insurance certificate. We prefer the Acord® Certificate of Liability Coverage form.

Facility is covered by Government insurance - Attach documentation detailing coverage.

*NOTE: Hospitals may be required to have additional insurance cover amounts*

## MINNESOTA UNIFORM FACILITY CREDENTIALING APPLICATION

### FACILITY CREDENTIALING APPLICATION LANGUAGES

● *Check all languages spoken by facility/agency/program staff fluently enough to treat patients/clients who speak only that language.*

● *Indicate if Sign Language and/or an Interpreter Service is available at your facility*

	AFRIKAANS		HILIGAYNON		OROMO
	AKAN		HINDI		PAKASTANI
	ARABIC		HINDU		PERSIAN
	ARABIC NORTH LEVAN		HMONG		POLISH
	ARMENIAN		IBO OF NEGERIA		PORTUGUESE
	ASSAMESE		ICELANDIC		ROMANIAN
	BENGA		INDONESIAN		RUSSIAN
	BENGALI		IOLCANO		SERBIAN
	BOSNIAN		ITALIAN		SINDHI
	BULGARIAN		KANNADA		SINHALA
	BURMESE		KAREN		SLAVIC
	CAMBODIAN		KASHMIRI		SLOVENIAN
	CANTONESE		KISII		SOMALI
	CHILEAN		KISWAHILI		SPANISH
	CHINESE		KONKANI		SWAHILI
	CHINESE MANDARIN		KOREAN		SWEDISH
	CROATIAN		KUNIAN		TAGALOG
	CZECH		KURDISH		TAIWANESE
	DANISH		LATIAN		TAMIL
	DUTCH		LAOTIAN		TELUGU
	EGYPTIAN		LATVIAN		THAI
	ESAN		LIINGALA		TIGRIGNA
	EATONIAN		LITHUANIAN		TSWANA
	FARSI		LUGANDA		TURKISH
	FILIPINO		LUO		TURKMEN
	FINNISH		MALAY		UKRANIAN
	FLEMISH		MALATALAM		URDU
	FRENCH		MANDARI		VIETNAMESE
	GERMAN		MANDINKA		WELSH
	GREEK		MARATHI		WOLOF
	GUJARATI		NEPALI		YIDDISH
	HAITIAN CREOLE FRENCH		NORWEGIAN		YORUBA
OTHER:					
	AMERICAN SIGN LANGUAGE			INTERPRETER SERVICE UTILIZED BY FACILITY	



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## 11. NON -MEDICARE CERTIFIED HOME CARE AGENCY SECTION

**Complete this section ONLY if the facility is a Home Care Agency that is not Medicare (CMS) certified. Answer ALL questions.**

1. Indicate the age range of clients accepted. \_\_\_\_\_ to \_\_\_\_\_
2. Number of agency employees in each category:
  - Registered Nurses (RN): \_\_\_\_\_
  - Licensed Practical Nurses (LPN): \_\_\_\_\_
  - Home Health Aide: \_\_\_\_\_
  - Other \_\_\_\_\_
3. Give reason(s) this home care agency has not pursued/been granted Medicare certification.

## 12. PROVIDER INTEGRITY ATTESTATION OR ELECTRONIC SIGNATURE

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a participating provider.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

**Signature of Authorized Representative**

**Printed Name of Authorized Representative**

**Date Signed**

**Authorized Representative's Title**