



PacifiCare of Texas
HEALTH DELIVERY ORGANIZATION APPLICATION

PLEASE TYPE OR PRINT LEGIBLY. APPLICATION MUST BE FILLED OUT COMPLETELY.

GENERAL INFORMATION

1. Applicant Information:

Organization Name: _____

Facility Name (DBA): _____

Facility Type: _____

Physical Address: _____ Mailing Address: _____

City: _____ State: ____ Zip: _____

Phone: (____) _____ 24 Hour Phone: (____) _____ Fax: (____) _____

Federal Tax Identification No.: _____ **(Please attach W-9 Form.)**

Medicare Provider No: _____

2. Executive Staff of the Applicant Organization:

Chief Executive Officer (or equivalent) Name: _____ Title: _____

Medical Director (or equivalent) Name: _____ Title: _____

Administrator Name: _____

Director of Nursing Services Name: _____ Title: _____

3. Primary Contact:

Person responsible for the completion of this application:

Name: _____ Title: _____ Phone: (____) _____

Administrative Address (if different): _____
Street (or PO Box) City State/Zip

Fax #: _____ Email: _____

4. Secondary Contact:

Name: _____ Title: _____ Phone: (____) _____

Fax #: _____ Email: _____

MEDICAL LIABILITY INSURANCE INFORMATION

Current Insurance Carrier's Name: _____

Policy Period: _____ Policy No.: _____

Amount of Coverage: Per Occurrence _____ Aggregate: _____

Attach copy of current insurance policy face sheet.

LICENSURE—REQUIRED FOR HOSPITALS, SKILLED NURSING FACILITIES, HOME HEALTH, HOSPICE, AMBULATORY SURGICAL CENTERS, PHARMACIES, REHABILITATION

State License Number _____ Expiration Date _____

If the location provides pharmacy services please provide license

Pharmacy State License Number _____ Expiration Date _____

Attach a copy of your state license.

CERTIFICATIONS—PLEASE COMPLETE ALL YES/NO QUESTIONS AND OTHERS IF APPLICABLE

LABORATORY SERVICES: Is there a laboratory on-site at this location? Yes No

If YES, please **attach** a copy of the **CLIA** certificate

CLIA Identification No: _____ Expiration Date: _____

RADIOLOGY SERVICES: Are radiology services performed at this location? ? Yes No

If YES, please **attach** a copy of the **BRC** certificate

BRC Identification No: _____ Expiration Date: _____

MAMMOGRAPHY SERVICES: Are mammograms performed at this location? Yes No

If YES, please **attach** a copy of the **Certificate of Mammography Systems**

PHARMACY SERVICES: Are pharmaceuticals mixed/dispensed at this location? Yes No

If YES, please **attach** a copy of the **DEA Registration**

DEA No: _____ **DEA Expiration:** _____

If YES, please attach **DPS Registration** for **Texas**

DPS No: _____ **DPS Expiration:** _____

ACCREDITATION

Check any of the following that apply to your organization:

- Accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)
- Accredited by The Rehabilitation Accreditation Commission (CARF)
- Accredited by Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
- Accredited by the Continuing Care Accreditation Commission (CCAC)
- Accredited by The Community Health Accreditation Program, Inc. (CHAP)
- Accredited by the American College of Radiology (ACR)
- Accredited by the College of American Pathologist (CAP)

CMS APPROVAL

If the facility is not accredited by one of the above, please provide the following:

Date of most recent CMS Audit _____ **Please attach a copy of the site visit report**

FACILITY CAPACITY

Check the following services that are provided by your organization:

- | | | |
|--------------------------|--------------------------|-----------------|
| Medical | <input type="checkbox"/> | # of Beds _____ |
| Surgical | <input type="checkbox"/> | # of Beds _____ |
| Psychiatric | <input type="checkbox"/> | # of Beds _____ |
| Skilled Nursing Facility | <input type="checkbox"/> | # of Beds _____ |
| OB/GYN | <input type="checkbox"/> | # of Beds _____ |
| Pediatrics | <input type="checkbox"/> | # of Beds _____ |
| Medical | <input type="checkbox"/> | # of Beds _____ |
| Surgical | <input type="checkbox"/> | # of Beds _____ |
| Neonatal Nursery | <input type="checkbox"/> | # of Beds _____ |
| Intensive Care Unit | <input type="checkbox"/> | # of Beds _____ |
| Rehabilitation | <input type="checkbox"/> | # of Beds _____ |
| Cardiovascular Surgery | <input type="checkbox"/> | # of Beds _____ |
| Transplants | <input type="checkbox"/> | Types: _____ |

Please indicate your Trauma level: _____ Trauma Expiration Date: _____

DISCLOSURES

1. Is your state license subject to any restrictions by the State? Yes No
2. Has your organization or any party owning or controlling 10% or more of your company been subject to:
 - Government disciplinary action such as, but not limited to, revocation, suspension or restriction of its license or Medicare/Medicaid Provider Status? Yes No

- Criminal or ethical investigations or convictions? Yes No
 - Bankruptcy, insolvency or assignment for the benefit of creditor proceedings? Yes No
3. Does your organization have knowledge of any action, current investigation which might reasonably result in such revocation, suspension, or restriction of its state licensure, Medicare/Medicaid provider status or accreditation status? Yes No

If YES to any of the above, please attach a brief explanation

The undersigned hereby certifies that the above information requested by PacifiCare of Texas is truthful, correct and complete in all respects, and the undersigned further understands that intentional submission of false or misleading information or the withholding of relevant information are grounds for termination as a participating provider with PacifiCare of Texas. The undersigned hereby agrees to notify PacifiCare of Texas of any changes in the above information.

Signature

Date

Title

**PLEASE INCLUDE THE FOLLOWING ATTACHMENTS
AS PART OF YOUR APPLICATION:**

Photocopy of Current:

- Texas State License, unless legally exempt from licensure
- Medicare correspondence (EX. Official correspondence from CMS - formally HCFA, TX Dept of Health, OK Dept of Health fiscal intermediary, or provider enrollment which offers verification of Medicare participation)
- CLIA certificate for on-site laboratories
- Applicable certificates/licenses from the Bureau of Radiation Control DEA and DPS if providing pharmaceutical services
- Medical Liability Insurance Face Sheet
- W-9 Form (Taxpayer Identification)
- Sample Claim Form with the facility billing information on the form
- Explanation to any "yes" answer in Disclosure section

ACCREDITED organizations, please also attach:

- Appropriate accreditation approval letter (with expiration date)

NON-ACCREDITED organizations, please also attach:

- The most recent inspection review by CMS - formally HCFA

MAIL APPLICATION AND ATTACHMENTS TO:

PacifiCare of Texas
Network Management
5001 LBJ Frwy Ste 600
Dallas, TX 75244