

# Facility Credentialing Application

PO Box 91110  
Sioux Falls, SD 57109  
(605) 328-6800 | (800) 752-5863  
Fax: (605) 328-6840  
sanfordhealthplan.com



Thank you for your interest in Sanford Health Plan. This application will need to accompany a signed and dated Participating Provider Agreement (not required for re-credentialing). Please follow the instructions to ensure you have all the necessary items to avoid processing delays.

## In order for your application to be considered complete:

1. All information must be legible. Please print or type all information.
2. A separate application must be completed for each legal entity/Tax ID
3. The application must be signed and dated. Signature dates must not be more than 60 days old upon receipt for application to be accepted.
4. NPI matches NPPES and NPI's used on the app are consistent throughout.
5. If necessary, use a separate sheet of paper to provide additional information.

## Documents you will need to provide:

- Copy of State Facility License
- Copy of Professional Liability and General Liability Insurance Certification, which list amounts and coverage dates
- 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
- Copy of Joint Commission 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 Joint Commission, AAAHC, or AAAASF

*If these documents cannot be provided please explain:*

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- Initial Credentialing/Rec credentialing
- Addition of new site to current contract

### Initial and Addition of New Site to Current Contract Applications

Return to Sanford Health Plan Provider Contracting  
Email: sanfordhealthplanprovidercontracting@sanfordhealth.org  
Fax: (605) 328-7224  
Mail: PO Box 91110, Sioux Falls SD 57109-1110  
For Questions Call: (855) 263-3544

### Rec credentialing Applications

Return to Sanford Credentialing Services  
Email: credentialing@sanfordhealth.org  
Fax: (605) 312-9801  
Mail: 900 E 54th St N, Sioux Falls SD 57104  
For Questions Call: (605) 312-7600

**Important Notice:** Failure to legibly complete all sections of this Application and submit current copies of ALL required documentation will result in processing delays. Initial credentialing applications WILL be discontinued if requested information is NOT provided within 30 days of Sanford's receipt of an application. Sanford Credentialing will obtain information from various outside sources (e.g., state licensing agencies, accreditation sources) to evaluate your application. You have the right to review any primary source information the Plan collects during this process. However, this does not include references or recommendations or other information that is peer review protected

**CONTACT INFORMATION: If questions about this application, contact:**

Contact Name: \_\_\_\_\_ Email address: \_\_\_\_\_  
Phone number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

**LEGAL ENTITY INFORMATION (Name on income tax return)**

Tax ID Holder/Facility Name: \_\_\_\_\_  
Federal Tax ID Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_  
Legal Tax Address (where you want the 1099 sent): \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Ownership: \_\_\_\_\_  
Legal type:  Nonprofit Corporation  Professional Corporation  Subsidiary

**BILLING INFORMATION same as Legal Entity**

Pay To Name (issues check to ): Note: may be different than name on the 1099.  
Federal Tax ID Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_\_ NPI(s): \_\_\_\_\_  
Pay to Address (send remittance to): \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Billing Contact Person: \_\_\_\_\_  
Billing Contact email address: \_\_\_\_\_

Complete for each service location that is part of this application.

**Service Location 1 of \_\_\_\_\_ (Must be a street address, not a post office box)**

Facility Name (to be displayed in the directory): \_\_\_\_\_

Federal Tax ID Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Same as Legal Entity NPI(s):  \_\_\_\_\_

State License Number: \_\_\_\_\_ Medicaid Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Service Location Address:  Same as Legal Entity \_\_\_\_\_

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

County: \_\_\_\_\_

Main Switchboard Phone Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Service Location Fax Number: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Web address: \_\_\_\_\_

Service Location Handicap Access?  Yes  No

Service Location Accepting new patients  Yes  No

ADA Compliant (including offices, exam rooms and equipment)  Yes  No

Is American Sign Language or other auxiliary aid services available  Yes  No

Please list any foreign languages spoken at this location: \_\_\_\_\_

Number of Beds \_\_\_\_\_

### **ECP PROVIDERS (EXCHANGE/COMMERCIAL ONLY)**

Are you considered an Essential Community Provider as defined by CMS?  Yes  No

### **SITE VISIT REQUIREMENT**

1. Has the Department of Human Services (DHS) or a government agency delegated by DHS

completed a post-licensing onsite survey within the past 36 months?

(YES) Date of most recent full survey \_\_\_\_/\_\_\_\_/\_\_\_\_

(NO) Successful completion of a health plan onsite visit will be required to complete credentialing.

2. Were any deficiencies cited during the last survey?  (YES)  (NO)  (N/A) (no recent survey)

If (NO), submit verification of no deficiencies.

If (YES), have all deficiencies been corrected?

YES - Provide evidence of acceptance letter by DHS.

**Please indicate type of organization (Choose all that apply):**

- |  |  |
|--|--|
| <input type="checkbox"/> Ambulatory Surgical Clinic/Center (261QA1903X)      | <input type="checkbox"/> Long Term Care Hospital (282E00000X)                  |
| <input type="checkbox"/> Ambulance, Air Transport (3416A0800X)               | <input type="checkbox"/> Magnetic Resonance Imaging Clinic/Center (261QM1200X) |
| <input type="checkbox"/> Ambulance, Land Transport (341600000X)              | <input type="checkbox"/> Opioid (Methodone) Treatment Program                  |
| <input type="checkbox"/> Chronic Disease Hospital (281P00000X)               | <input type="checkbox"/> Ophthalmologic Surgery Clinic/Center (261QS0132X)     |
| <input type="checkbox"/> Clinical Medical Laboratory (219U00000X)            | <input type="checkbox"/> Physical Therapy Clinic/Center (261QP2000X)           |
| <input type="checkbox"/> Critical Access Hospital (261QC0050X)               | <input type="checkbox"/> Radiology, Mammography Clinic/Center (261QR0206X)     |
| <input type="checkbox"/> DME & Medical Supplies (332B00000X)                 | <input type="checkbox"/> Rehabilitation Clinic/Center (261QR0400X)             |
| <input type="checkbox"/> Federal Qualified Health Center (FQHC) (261QF0400X) | <input type="checkbox"/> Rehabilitation Hospital (283X00000X)                  |
| <input type="checkbox"/> General Acute Care Hospital (282N00000X)            | <input type="checkbox"/> Skilled Nursing Facility (314000000X)                 |
| <input type="checkbox"/> Hearing and Speech Clinic/Center (261QH0700X)       | <input type="checkbox"/> Substance Abuse Rehabilitation Facility (324500000X)  |
| <input type="checkbox"/> Home Health Agencies (251E00000X)                   | <input type="checkbox"/> Urgent Care Clinic/Center (261QU0200X)                |
| <input type="checkbox"/> Hospice, Inpatient (315D00000X)                     | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Hospice Care, Community Based Agencies (251G00000X) | Taxonomy Code _____  |
| <input type="checkbox"/> Indian Health Service Facility                      |  |

Please reference the NPPES website to find your specialty/taxonomy: <https://nppes.cms.hhs.gov/NPPES/Welcome.do>

**Services offered**

Please indicate all programs or services provided by your institution. If these programs or services are billed for under a different name and address, please indicate. If these services have been accredited or licensed by an agency which is different from those above, please provide the name of the accrediting agency and the date of accreditation.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Alzheimer Unit                       | <input type="checkbox"/> Child Diagnosis              | <input type="checkbox"/> Geriatric Acute Care  |
| <input type="checkbox"/> Ambulance Service (Air)              | <input type="checkbox"/> Child Treatment              | <input type="checkbox"/> Hematological Service   |
| <input type="checkbox"/> Ambulance Service (Ground)           | <input type="checkbox"/> Communicable Disease         | <input type="checkbox"/> Home Health Care  |
| <input type="checkbox"/> Anesthesia Service Given byCRNA      | <input type="checkbox"/> Coronary Intensive Care      | <input type="checkbox"/> Home Health Care with (LTSS) Services:<br><input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST |
| <input type="checkbox"/> Anesthesia Service Given byPhysician | <input type="checkbox"/> CT Scanner                   | <input type="checkbox"/> Home Infusion   |
| <input type="checkbox"/> Assisted Living                      | <input type="checkbox"/> Ct Scanner (Mobile)          | <input type="checkbox"/> Home Dialysis Training  |
| <input type="checkbox"/> Blood Bank - Collection & Process    | <input type="checkbox"/> Dental                       | <input type="checkbox"/> Home Nursing Care   |
| <input type="checkbox"/> Burn Intensive Care                  | <input type="checkbox"/> Dental Surgery               | <input type="checkbox"/> Hospice Care  |
| <input type="checkbox"/> Cardiac Rehabilitation               | <input type="checkbox"/> Dermatology                  | <input type="checkbox"/> Intensive Care Unit   |
| <input type="checkbox"/> Cardiology                           | <input type="checkbox"/> Diabetes                     | <input type="checkbox"/> Long Term Service and Support (LTSS)  |
| <input type="checkbox"/> Chemical Dependency Program          | <input type="checkbox"/> Diabetes Training Class      | <input type="checkbox"/> Mammography   |
| <input type="checkbox"/> Chemotherapy                         | <input type="checkbox"/> Diabetic Counseling          | <input type="checkbox"/> Meals on Wheels Program   |
|   | <input type="checkbox"/> Emergency Helicopter Service | <input type="checkbox"/> Medical Intensive Care  |
|   | <input type="checkbox"/> Emergency Service (24 hrs)   |  |
|   | <input type="checkbox"/> Family Planning              |  |
|   | <input type="checkbox"/> Family Therapy               |  |

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Medical Research                      | <input type="checkbox"/> Pediatric Intensive Care         | <input type="checkbox"/> Renal Dialysis Training Class     |
| <input type="checkbox"/> MRI Services                          | <input type="checkbox"/> Pharmacy                         | <input type="checkbox"/> Skilled Nursing/<br>Extended Care |
| <input type="checkbox"/> Neonatal Acute Care                   | <input type="checkbox"/> Physical Therapy                 | <input type="checkbox"/> Social Worker                     |
| <input type="checkbox"/> Obstetrics                            | <input type="checkbox"/> Plastic Surgery                  | <input type="checkbox"/> Speech Therapy                    |
| <input type="checkbox"/> Occupational Therapy                  | <input type="checkbox"/> Podiatry                         | <input type="checkbox"/> Surgical Acute Care               |
| <input type="checkbox"/> On Site Medical/<br>Surgical Services | <input type="checkbox"/> Post Partum Care                 | <input type="checkbox"/> Surgical Intensive Care           |
| <input type="checkbox"/> Open Heart Surgery Services           | <input type="checkbox"/> Premature Nursery Care           | <input type="checkbox"/> Telemedicine Services             |
| <input type="checkbox"/> Ophthalmology                         | <input type="checkbox"/> Psychiatric                      | <input type="checkbox"/> Telemonitoring Services           |
| <input type="checkbox"/> Organ Bank                            | <input type="checkbox"/> Psychiatric Long Term Care       | <input type="checkbox"/> Urgent Care Center                |
| <input type="checkbox"/> Orthopedic Surgery                    | <input type="checkbox"/> Pulmonary Intensive Care         | <input type="checkbox"/> Urinalysis Service                |
| <input type="checkbox"/> Otolaryngology                        | <input type="checkbox"/> Pulmonary Laboratory<br>Services | <input type="checkbox"/> X-Ray Exam                        |
| <input type="checkbox"/> Parent Training Class                 | <input type="checkbox"/> Radiologist                      | <input type="checkbox"/> Other: _____                      |
| <input type="checkbox"/> Pediatric                             | <input type="checkbox"/> Renal Dialysis Services          |  |

**Long Term Service & Support Provider**

**Please select service type:**

**LTSS Service**

- |   |  |
|---|--|
| <input type="checkbox"/> Adult Day Care (X1)                        | <input type="checkbox"/> Adaptive Aides/Medical Equipment (X9) |
| <input type="checkbox"/> Primary Home Care/PAS (X2)                 | <input type="checkbox"/> Minor Home Modifications (XA)         |
| <input type="checkbox"/> TAS (Transitional Assistant Services) (XY) | <input type="checkbox"/> Physical Therapy (XB)                 |
| <input type="checkbox"/> FMS (Financial Management Services) (XU)   | <input type="checkbox"/> Occupational Therapy (XC)             |
| <input type="checkbox"/> Value Added (X3)                           | <input type="checkbox"/> Speech Therapy (XD)                   |
| <input type="checkbox"/> Assisted Living/Respite Care (X4)          | <input type="checkbox"/> Employment Assistance Services (XE)   |
| <input type="checkbox"/> Adult Foster Care (X5)                     | <input type="checkbox"/> Habilitation (XH)                     |
| <input type="checkbox"/> Emergency Response System (X6)             | <input type="checkbox"/> PAS for CFC only (XN)                 |
| <input type="checkbox"/> Nursing Facility (X7)                      | <input type="checkbox"/> Supported Employment (XS)             |
| <input type="checkbox"/> Home Delivered Meals (X8)                  |  |

**LICENSURE \* Provide copy of licensure**

Is the facility licensed by the state? (Please check one)  Yes  No

If yes, please provide the following information:

Name (as it appears on the license): \_\_\_\_\_

License number: \_\_\_\_\_ Expiration date: \_\_\_\_\_

Date of most recent CMS Survey: \_\_\_\_\_

## Accreditation/Certification Type

Please provide a copy of these documents; including the Survey Results and a report that shows the effective or survey date of accreditation or certification, deficiencies and approved corrective action plan.

**Agency Name** \_\_\_\_\_

- Accreditation Commission for Health Care (AHCH)
- American Association of Ambulatory Health Centers (AAAHC)
- American Board for Certification in Orthotics & Prosthetics, Inc. (ABCOP)
- American College of Radiology (ACR)
- American Osteopathic Hospital Association (AOHA)
- Board of Orthotist / Prosthetist Certification (BOCUSA)
- Clinical Laboratory Improvement Act (CLIA)
- College of American Pathologists (CAP)
- Commission on Accreditation for Rehab Facilities (CARF)
- Community Health Accreditation Program (CHAP)
- Healthcare Quality Association on Accreditation (HQAA)
- The Joint Commission (TJC (aka JCAHO))
- Det Norske Veritas/National Integrated Accreditation for Healthcare Organizations (DNV/NIAHO)
- National Association of Boards of Pharmacy (NABP)
- National Committee for Quality Assurance (NCQA)
- State Facility Operating License
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc. (URAC)
- Other (please list) \_\_\_\_\_

## Disclosure Questions & Sanctions

If yes, to any question below, please explain on a separate sheet of paper.

1. Have there been any settled malpractice claims, suites, settlements or proceedings involving your Organization within the past five years?  
 Yes  No
2. Has your Organization ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state government health care plans or programs?  
 Yes  No
3. Has an officer of your Organization ever been convicted of, pled guilty to, or pled "no lo contendere" to any felony including an act of violence, child abuse, or a sexual offense?  
 Yes  No
4. Has your Organization license ever been restricted, conditioned, suspended or terminated?  
 Yes  No
5. Does your Organization have any current state or federal sanctions or limitations?  
 Yes  No

**LIABILITY INSURANCE COVERAGE: Sanford Health Plan requires  
1,000,000/3,000,000 or 2,000,000/2,000,000.**

**Please provide your liability insurance coverage information below:**

Carrier Name: \_\_\_\_\_

Single Occurrence Amount: \_\_\_\_\_ Aggregate Amount: \_\_\_\_\_

Beginning Date (Mo/Day/Yr): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ End Date (Mo/Day/Yr): \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

**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 or omissions may constitute cause for denial of participation in the health plan. A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

I authorize Sanford Health Plan the right to obtain documents, recommendations, reports and statements relating to the Credentialing process of this facility and the associated facilities that intend to contract with the Sanford Health Plan. In addition, I also authorize the right to verify my standing with state & federal regulatory bodies relating to the Credentialing process.

\_\_\_\_\_  
Printed Name of Authorized Representative

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Authorized Representative's Title

\_\_\_\_\_  
Date signed