

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:

- 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 by CRNA | <input type="checkbox"/> Coronary Intensive Care | <input type="checkbox"/> Home Health Care with (LTSS) Services: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST |
| <input type="checkbox"/> Anesthesia Service Given by Physician | <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/ 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/ 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 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, suits, 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