Credentialed Ancillary Facility Data Form

PLEASE ATTACH:

1. A COPY OF YOUR OPERATING CERTIFICATE/LICENSE (if applicable)
2. A COMPLETED AND SIGNED W-9
3. PROOF OF PROFESSIONAL LIABILITY INSURANCE
4. PROOF OF PARTICIPATION WITH MEDICAID/MEDICARE
5. CURRENT DEPARTMENT OF HEALTH SURVEY (and any applicable associated documents)

GENERAL INFORMATION

FACILITY NAME: _____
ADDRESS: _____
CITY: _____ COUNTY: _____
STATE: _____ ZIP: _____
PHONE: _____ FAX: _____
FEDERAL TAX ID # _____ (attach completed W-9)
NPI NUMBER: _____
TAXONOMY CODE: _____ OTHER TAXONOMY CODE: _____
Are you licensed under NYS Article 28? _____ If yes, are you subject to HCRA Surcharge? _____

CONTACT INFORMATION

OFFICE CONTACT:
NAME: _____ TITLE: _____
PHONE: _____ FAX: _____ EMAIL: _____

CREDENTIALING CONTACT:
NAME: _____ TITLE: _____
PHONE: _____ FAX: _____ EMAIL: _____

BILLING CONTACT:
NAME: _____ TITLE: _____
PHONE: _____ FAX: _____ EMAIL: _____

BILLING ADDRESS (If different from address above)
ADDRESS:_____
CITY:_____COUNTY: _____
STATE:_____ZIP: _____
PHONE:_____FAX: _____

REMIT TO ADDRESS (If different from billing address above)
ADDRESS: _____
CITY:_____COUNTY: _____
STATE:_____ZIP:_____
PHONE:_____FAX: _____

GOVERNANCE AND SPONSORSHIP

OWNERSHIP

- ☐ For Profit Entity
- ☐ Private Corporation
- ☐ Subsidiary of the Above
- ☐ Public Entity
- ☐ Non-Profit

PLEASE LIST ALL PARENT OR SPONSORING ORGANIZATIONS, INCLUDING FULL ADDRESS:

_____
_____
_____
_____
_____

GEOGRAPHIC COVERAGE

(*Please list all counties covered*)

_____
_____
_____
_____

LICENSE/OPERATING CERTIFICATE

(*Please attach copies of all documents*)

STATE LICENSING AGENCY: _____

LICENSE #:_____RENEWAL DATE: _____

MEDICARE #:_____MEDICAID #: _____

ACCREDITATION

(*Please attach copies of all certification(s)*)

ACCREDITING BODY

- ☐ JCAHO
- ☐ ASPEN
- ☐ MEDICARE CERTIFICATION
- ☐ CLIA
- ☐ CARF
- ☐ MEDICAID CERTIFICATION
- ☐ OMH
- ☐ OASAS
- ☐ AAAHC

Additional certifications or accreditation (please specify): _____

_____

_____

_____

_____

ACCESSIBILITY

Is the facility handicapped accessible? ☐YES ☐NO

Is there 24 hour coverage (if applicable)? ☐YES ☐NO

If 24 hour coverage is not available and is applicable, where are patients treated? _____

_____

monroe plan FOR MEDICAL CARE

YourCare A MONROE PLAN COMPANY

ADDITIONAL OFFICE LOCATIONS

FACILITY NAME: _____
ADDRESS: _____
CITY: _____ COUNTY: _____ STATE: _____
ZIP: _____
PHONE: _____ FAX: _____

FACILITY NAME: _____
ADDRESS: _____
CITY: _____ COUNTY: _____ STATE: _____
ZIP: _____
PHONE: _____ FAX: _____

SERVICES PROVIDED
(*check all that apply*)

- ☐ Adult Day Health Program
- ☐ Audiology
- ☐ Institutional Long Term Care
  - ☐ AIDS Specialty (RHCF)
  - ☐ Behavioral Intervention Specialty (RHCF)
  - ☐ Pediatric Specialty (RHCF)
  - ☐ TBI Specialty (RHCF)
  - ☐ Ventilator Unit
- ☐ Institutional Short Term Care
- ☐ Memory Unit
- ☐ Occupational Therapy
- ☐ Physical Therapy
- ☐ Speech Therapy
- ☐ Other: _____

_____
_____
_____