

ORGANIZATIONAL PROVIDER REASSESSMENT UPDATE

INSTRUCTIONS

1. Type or print legibly in black or dark blue ink.
2. Complete Pages 1 – 4. All fields are required.
3. Sign and date Page 4.
4. See any further instructions in the shaded area of each section.
5. Attach current copies of the following documents:
 - Facility License(s)
 - Facility General Liability and Professional Liability Insurance Certificate(s)
 - Accreditation, CMS Certification, or State On-Site Survey Findings
 - Certified Laboratory Improvement Amendments (CLIA) Certification

Please fax the completed application along with all necessary attachments to 612-884-2184 or email to credentialinginfo@ucare.org. Or, mail to the following address:

UCare Credentialing Department
P.O. Box 52
Minneapolis, MN 55440-0052

6. If you have questions, please contact 612-676-3660.

IMPORTANT

Failure to legibly complete all sections of this Update form *and* submit current copies of all required documentation in a timely manner will be considered a request to withdraw from the recredentialing process and participation with UCare.

I. FACILITY IDENTIFICATION			
A. Business Identification Information			
Tax Identification Number:	Time in Business with this name and Tax ID: _____ Years _____ Months		
Business Name:			
Practice Location Name:			
Street Address:			
City:	State:	Zip Code:	County:
Medicaid Number: (Required)		National Provider Identifier: (Required)	
If facility does not have a Medicare number, submit an explanation:			

B. Credentialing Contact Information			
Primary Contact Name:		Contact Title:	
Phone:	Fax:	E-Mail:	
Administrator (Full Name):			
C. Mailing / Correspondence Address - <i>Must be an address where provider can be contacted directly.</i>			
<input type="checkbox"/> Check here if all correspondence can be directed to the practice location in Section A on Page 1.			
Mailing Address Line 1:			
Mailing Address Line 2:			
City:	State:	Zip:	County:
D. Provider Type - <i>Indicate type of provider.</i> <i>- A separate Update form is required for each provider type and - A separate Update for is required for each practice location.</i>			
<u>Medical</u>			
<input type="checkbox"/> Ambulatory Surgical Center (Free-standing only) <input type="checkbox"/> Home Health Agency (No PCA services) <input type="checkbox"/> Hospital (All types) <input type="checkbox"/> Skilled Nursing Facility <input type="checkbox"/> Nursing Home			
E. Certified Laboratory Improvement Amendments (CLIA) Certification • <i>A copy of the CLIA Certification must accompany this application.</i>			
CLIA Certification Number:	Effective Date:	Expiration Date:	

II. HEALTH CARE LICENSURE / REGISTRATION

- A copy of each facility license must accompany this application.
- Do not submit individual practitioner licenses.

	License Number	INITIAL Issue Date	Renew Date	Expiration Date	Licensing Agency
State of _____					
State of _____					
Other:					

III. CERTIFICATION / ACCREDITATION

A. Certification - Attach copy of most recent survey and Corrective Action Plan (if applicable).

1. Is this provider participating in the Medicare program? Yes No Pending
If Yes, provide the following: Date of last full CMS survey: _____ / _____ / _____
Month Day Year
2. Has provider had an on-site survey by a State agency? Yes No Pending
If Yes, provide the following: Date of last full State survey: _____ / _____ / _____
Month Day Year
3. Were any deficiencies identified during the last full CMS or State survey? Yes No
If Yes, have all deficiencies been corrected?
 Yes - Provide evidence that your CAP was accepted by CMS or the State agency
 No - Provide explanation and your plan to correct all deficiencies:

B. Accreditation - At least one box must be checked.

- If accredited, attach copy of current Accreditation certificate.

1. Specify:	<input type="checkbox"/> AAAAPSF/AAAASF <input type="checkbox"/> AAAHC <input type="checkbox"/> AASM* *Required for Sleep Centers	<input type="checkbox"/> ACHC <input type="checkbox"/> AOA <input type="checkbox"/> CARF <input type="checkbox"/> CHAP	<input type="checkbox"/> COA <input type="checkbox"/> JOINT COMMISSION <input type="checkbox"/> URAC <input type="checkbox"/> NOT ACCREDITED
-------------	--	---	--

2. Date of initial accreditation: _____ / _____ / _____
Month Day Year

3. Date of last survey: _____ / _____ / _____
Month Day Year

5. Has this provider been denied accreditation by any accrediting body in the last three years?
 Yes No

6. If Yes, provide details:

IV. INSURANCE - Attach copy of current coverage certificate(s) showing current coverage amounts and expiration dates.

- Both General and Professional Liability are required.

Minimum coverage requirements are \$1,000,000 per occurrence and \$3,000,000 per aggregate. Except for government providers subject to statutory limits. (showing coverage amounts and dates)..

A. General Liability Coverage

Current Carrier (Not Agency) Name:	Policy Number:
Effective Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____
Per Incident: \$ _____	Aggregate: \$ _____

B. Professional Liability (Malpractice) Coverage

Current Carrier (Not Agency) Name:	Policy Number:
Effective Date: _____ / _____ / _____	Expiration Date: _____ / _____ / _____
Per Incident: \$ _____	Aggregate: \$ _____

V. ATTESTATION QUESTIONS

- Answer each of the following questions "Yes" or "No".
- If you answer "Yes" to any of the following questions, provide details and reasons as specified in each question, on a separate sheet.
- Sign and date this and each additional sheet. **Modification to the wording or format will invalidate this attestation.**

<p>1. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under Federal or State law, related to:</p> <p>(a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with the delivery of a health care item or service?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>2. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>3. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under Federal or State law, related to the interference with or obstruction of any investigation into any criminal offense described in Title 42 - Code of Federal Regulations Section 1001.1001 or 1001.201?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>4. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> had any felony or misdemeanor convictions, under federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>6. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> had accreditation revoked or suspended?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>7. In the past three years, has this provider, under any current or former name or business identity, <u>ever</u> been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any disbarment from participation in any Federal Executive Branch procurement or non-procurement program?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>8. In the past three years, has this provider, under any current or former name or business identity, currently suspended from Medicare or Medicaid payment under any Medicare or Medicaid billing number?</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No

I, the undersigned authorized agent, hereby attest and certify that all statements on this Recredentialing Update form are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this form may be grounds for denial as a participating provider or cause for summary dismissal from UCare network participation. Further, I acknowledge that failure to communicate any relevant information or to release any and all required documentation in a timely manner (within two weeks) will be considered a request to withdraw from the recredentialing process and from participation with UCare.

Printed Name of Authorized Representative

Signature of Authorized Representative

Authorized Representative's Title

Date Signed