

Progressive Care Network

Provider Re-Credentialing Application

Organization Name: _____

THE FOLLOWING ITEMS SHOULD BE RETURNED WITH YOUR APPLICATION:

A CURRENT COPY OF:

1. The organization's Indiana or Illinois state license to provide health services.
2. The organization's professional and comprehensive general liability insurance certificate.
3. JCAHO/AAAHC/URAC or applicable accrediting body certificate.
4. If not accredited a copy of the last annual state survey and corrective action plan, and any subsequent visits and plans.
5. Copy of W-9
6. Listing of Insurance contracts (Anthem, Aetna, etc...)
7. Copy of Quality Assurance program and its related policies and procedure.

Section 1: Organization Data

Director _____
(Last) (First) (MI) (Title)

Organization Address: _____
(Street)

(City) (State) (Zip)

Organization Phone Number: _____

Organization Fax Number: _____

Web address _____

Date of Incorporation: _____ Tax Identification Number: _____

Is the organization a participating provider in the Medicare Program: Yes No

Medicare Number: _____ Medicaid Number: _____

NPI # _____

Section 2: General Information

1. Have any disciplinary actions ever been initiated and/or are any pending now against your organization by any state licensure board? Yes No
2. Has your organization's license to provide health care ever been denied, limited, Suspended, revoked, or voluntarily relinquished? Yes No
3. Has your organization ever been suspended, sanctioned, or otherwise restricted from participating in any private, federal, or state health insurance program (e.g. Medicare, Medicaid, or any Managed care company)? Yes No
4. Has your organization ever been the subject of an investigation, by any state, federal, or private agency concerning your participation in any state, federal, or private health insurance program? Yes No
5. Subject to proper confidentiality restrictions, authorizations, state and federal requirements, your organization's medical records may be subject to review by a representative of PCN for peer review and utilization analysis purposes. Does this requirement preclude your participation? Yes No
6. Does your organization qualify as a health care provider under the Indiana Medical Malpractice Act: Yes No

If answers to questions 1-5 are yes, Please attach detailed information.

Signature and Title: _____

Printed Name: _____

Date: _____