DeanHealthPlan
A member of SSM Health

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Health Care Credentialing Application
Organizational Supplier

☐Clinical Laboratories/ Independent Diagnostic Testing Facilities,
☐Portable X-Ray Suppliers
☐Durable Medical Equipment Suppliers

Section 1. Organization Information:

Entity Name: _____

DBA (if different than above) _____

Address: _____

Address cont._____

City, State, Zip _____ _____ _____

Phone: _____ Fax: _____

Email: _____

Credentialing Contact Name and Title:

_____ _____

Phone: _____ Email: _____

Medicare Number: (required) _____

- Organizational Suppliers are required to meet the conditions of participation for Medicare to be considered for credentialing

License Number(s): (if applicable) _____ _____ _____

CLIA Number: (clinical labs only) _____

Section 2. Accreditation

☐ AAACH ☐ ACHC ☐ CAP ☐ CARF ☐ CHAP ☐ HFAP ☐ JCAHO ☐ DMEPOS

☐ OTHER_____

Section 4. Required Documents: Please submit copies of the following documents:

- State License (if applicable)
- Accreditation Certificate
- Current malpractice insurance certificate (must show dates of coverage and amounts)
- CLIA Certification certificate (if applicable)

Section 3. Organizational Supplier Attestation:

In submitting this application for credentialing to Dean Health Plan, Inc. (DHP) I am agreeing to the following:

I certify that all information provided in or attached to this application is accurate and complete. I also agree to provide additional information and execute additional forms as may be requested by DHP in order to evaluate qualifications as an organizational supplier.

I certify that this supplier meets all state and federal conditions of participation requirements for participation in Medicare as specified by CMS in 42 CFR 498.2

As a representative for this organizational supplier credentialing with DHP, I have the right to review the information submitted in support of this credentialing application. I acknowledge that DHP will notify me of any information obtained during the credentialing process that varies substantially from the information provided to DHP on behalf of this organizational supplier. I have the right to correct any and all erroneous information supplied in this application. I have the right upon request to be informed of the status of the credentialing application by contacting the DHP Provider Relations Department or the Credentialing Department. DHP will reply within two working days as to what materials may be missing from the credentialing application and/or when the application may be expected to be completed for presentation to the Credentialing Committee. Credentialing and Recredentialing of organizational suppliers will be conducted in a manner that is non-discriminatory.

All information provided by me in this application is warranted to be true, correct and complete.

Dated	**Signature**
Title	**Printed Signature**