Prior to completing this credentialing application, please read and observe the following:

**INSTRUCTIONS**

This form should be **legibly printed in black or blue ink**. If more space is needed than provided on the original, please attach additional sheets and reference the question(s) being answered. Modification to the wording or format of this application will invalidate the application.

- Please complete the application in its entirety
- Please sign and date the application
- Please attach the following, as applicable:
  - Completed Facility Self-Evaluation Form (enclosed, if applicable; *applies to non-accredited facilities only)
  - Copy of the organization’s licensure issued by the State *(if applicable)*
  - Copy of the organization’s malpractice face sheet, showing amounts of coverage and coverage dates
  - Copy(s) of all accreditation certificates and survey results *(if applicable)*
  - *(If not accredited)* Copy of most recent State Survey/Inspection Report, including Corrective Action Plan letter
  - Copy of the organization’s Medicare approval letter *(if applicable)*
  - Copy of the organization’s CLIA certification *(if applicable)*

**IMPORTANT**

In order to remain in compliance with DHP, each organization must be recredentialed every three (3) years. To allow DHP adequate time to process your application, please return all requested materials by their due date. Failure to provide credentialing information to DHP will delay the credentialing process and may affect your status as a plan provider.
### I. PROVIDER IDENTIFICATION

**A. Corporate Identification Information**

Please furnish the provider’s legal business name (as reported to the IRS), as well as the “doing business as” name (name generally known by to the public). In addition, please furnish the various operating dates and places of formal business registration and/or incorporation.

<table>
<thead>
<tr>
<th>Legal Business Name as reported to the IRS:</th>
<th>County where DBA name is registered (if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Doing Business As” (DBA) name (if applicable):</td>
<td>Address:</td>
</tr>
<tr>
<td>County where DBA name is registered (if applicable):</td>
<td></td>
</tr>
<tr>
<td>Primary Contact Name (Credentialing /Recredentialing):</td>
<td>Contact Title:</td>
</tr>
<tr>
<td>Phone: (          )</td>
<td>Fax: (          )</td>
</tr>
<tr>
<td>E-mail:</td>
<td></td>
</tr>
</tbody>
</table>

**B. Current Facility Location(s)**

*NOTE: Please provide a copy of your Medicare approval letter and CLIA certificate (if applicable)*

| Facility Location Name (primary location): | |
| Facility Location Address (primary location): | |
| City: | State: | Zip: | County: |
| Phone: (          ) | Fax: (          ) | E-mail: | |
| Medicare Number (Part A): | Medicare Number (Part B): | Medicaid Number: |

If the organizational provider does not have a Medicare Number, please submit an explanation:

| NPI(s): | CLIA: |
| Check box if the location is CLIA exempt |

| Facility Administrator (Full Name): | Phone: (          ) |
| Date facility opened and started operating (MM/YY): | |
### B. Current Facility Location(s) (continued)

*NOTE: Please provide a copy of your Medicare approval letter and CLIA certificate (if applicable)*

<table>
<thead>
<tr>
<th>Facility Location Name (branch location, if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Location Address (branch location, if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
<th>County:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone: ( )</th>
<th>Fax: ( )</th>
<th>E-mail:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Number (Part A):</th>
<th>Medicare Number (Part B):</th>
<th>Medicaid Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the organizational provider does not have a Medicare Number, please submit an explanation:

<table>
<thead>
<tr>
<th>NPI(s):</th>
<th>CLIA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Please check box if the location is CLIA exempt

<table>
<thead>
<tr>
<th>Facility Administrator (Full Name):</th>
<th>Phone: ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date facility opened and started operating (MM/YY):

<table>
<thead>
<tr>
<th>Facility Location Name (branch location, if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Facility Location Address (branch location, if applicable):</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
<th>County:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone: ( )</th>
<th>Fax: ( )</th>
<th>E-mail:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medicare Number (Part A):</th>
<th>Medicare Number (Part B):</th>
<th>Medicaid Number:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If the organizational provider does not have a Medicare Number, please submit an explanation:

<table>
<thead>
<tr>
<th>NPI(s):</th>
<th>CLIA:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

☐ Please check box if the location is CLIA exempt

<table>
<thead>
<tr>
<th>Facility Administrator (Full Name):</th>
<th>Phone: ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Date facility opened and started operating (MM/YY):
C. **Type of Provider** *(contracted services for DHP ONLY)*

Please check all boxes that apply:

- [ ] Ambulatory Surgical Center
- [ ] Comprehensive Outpatient Rehab
- [ ] End-stage Renal Dialysis Center
- [ ] Federally Qualified Health Care Center
- [ ] Home Health Agency
- [ ] Hospice Care
- [ ] Hospital – Number of beds: _________
- [ ] Outpatient Diabetes Management Training
- [ ] Outpatient Physical Therapy Facility
- [ ] Outpatient Speech Pathology
- [ ] Portable X-ray Supplier
- [ ] Rural Health Clinic
- [ ] Skilled Nursing Facility
- [ ] Other *(explain):* ____________
- [ ] Behavioral Health Facility
  - Mental Health:  
    - [ ] Ambulatory
    - [ ] Inpatient
    - [ ] Residential
  - Substance Abuse:  
    - [ ] Ambulatory
    - [ ] Inpatient
    - [ ] Residential
- [ ] Clinical Laboratory
  - [ ] Hospital
  - [ ] Physician Office
  - [ ] Ambulatory

D. **Scope of Services**

Please check all services provided at this facility:

- [ ] Acute Care
- [ ] Ambulatory Surgery
- [ ] Critical Access
- [ ] Dialysis Inpatient
- [ ] Emergency Department (Level I, II, III, IV, V)
- [ ] Home Health
- [ ] Hospice
- [ ] Imaging Department
- [ ] Infusion Therapy
- [ ] Laboratory/Pathology Department
- [ ] Outpatient Surgery
- [ ] PT, OT, Speech Therapy
- [ ] Skilled Nursing
- [ ] Other: ____________

II. **CERTIFICATION AND ACCREDITATION**

A. **Certification Information** – *Certification and report must have been completed within the last three (3) years to be applicable*

1. Is this facility participating in the Medicare program?  
   - [ ] Yes
   - [ ] No
   - [ ] Pending *(If Yes, please provide information below)*

2. Date of last full CMS survey *(MM/DD/YYYY)*: ________________________________

3. Date of most recent survey report *(MM/DD/YYYY)*: __________________________

*If the facility is accredited by a national accreditation organization that has been granted deeming authority by CMS, the site survey performed by the accredited organization meets this requirement.

** Survey and report must be completed within the last three (3) years to be applicable.
Dean Health Plan, Inc.
Organizational Provider
Credentialing/Recredentialing Application

A. Certification Information (continued)

Casper Report (Non-Accredited Facilities):
Dean Health Plan (DHP) will request a copy of your facility’s most recent Casper report from the Wisconsin Department of Health Services (DHS). In addition to DHP’s request from the DHS, your facility is responsible for submitting documentation so that we may fully verify compliance status (as applicable). All applicable documents must be returned to DHP with your completed application. Failure to provide credentialing information may delay the process and may affect your status as a plan provider.*

- Casper report documentation must be from a visit performed in the last three (3) years.
- Areas that were identified as requiring follow-up, improvements, corrections and/or identified deficiencies – please provide a letter of acknowledgement from the Wisconsin DHS indicating that the necessary corrections have been made and were deemed acceptable in each identified area.
- Substantiated complaints: please provide a listing of substantiated complaints, along with notification from the DHS of accepted Plan of Correction for each substantiated complaint.

*It is not necessary to submit your Plan of Correction in its entirety. State notification of accepted correction(s) or accepted plan of correction for each substantiated complaint is acceptable.

<table>
<thead>
<tr>
<th>Section N/A – Facility is accredited by a national accreditation organization (If N/A box is checked, please skip to section B: Accreditation Information)</th>
</tr>
</thead>
</table>

1. Current Compliance Status:
- Provider meets requirements
- Provider meets requirements based on an acceptable plan of correction
- Provider does not meet program requirements

- Were any deficiencies identified during the last full CMS/State survey? ☐ Yes ☐ No
- If yes, have all deficiencies been corrected?
  - ☐ Yes – Accepted Plan of Correction letter (please attach letter from State documenting acceptance)
  - ☐ No – Please attach written explanation of outstanding issues and how each issue is being addressed

2. Quality Issues:
Substandard quality of care citations (Life Safety and Health citations): ____________
(Total number)

3. Complaints:
Substantiated complaints in the last 36 months: ____________
(Total number)

*Note: if your facility does not meet program requirements and you are unable to provide documentation that the facility is in compliance with CMS, an on-site visit will be conducted by a Dean Health Plan credentialing staff member. You will be contacted to arrange a date and time for the visit.
B. Accreditation Information

1. Is this facility accredited by a national accreditation organization?  
   □ Yes  □ No  □ Pending

2. Please check one:  
   □ AAAASF  □ CHAP  □ CIHQ  
   □ AAAHC  □ DNV Healthcare  □ DNV Healthcare  
   □ ACHC  □ HFAP  □ HFAP  
   □ CAP  □ Joint Commission  □ Joint Commission  
   □ CARF  □ NIAHO  □ NIAHO  
   □ CHAP  □ Other:  

3. Date of last survey (MM/DD/YYYY):  ______________________________________

4. Has the accreditation organization been granted deeming authority by CMS for this provider type?  
   □ Yes  □ No

5. Has this facility ever been denied accreditation by any accrediting body?  
   □ Yes  □ No  (If Yes, please provide details on a separate sheet)

III. STATE LICENSURE, REGISTRATION, CERTIFICATE AND ID NUMBERS

*NOTE: Please provide a photocopy of your state licensure (if applicable)

<table>
<thead>
<tr>
<th>License #</th>
<th>Issue Date</th>
<th>Expiration Date</th>
<th>Licensing Agency</th>
</tr>
</thead>
<tbody>
<tr>
<td>State:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IV. LIABILITY INSURANCE

*NOTE: Please provide a photocopy of your current malpractice face sheet, showing amounts of coverage and coverage dates

The parties hereto represent and warrant that each facility shall obtain and maintain, at its sole cost and expense, such commercial general liability insurance coverage at a minimum of $1,000,000 per occurrence and $1,000,000 aggregate, unless a greater amount is required by applicable Federal and State laws and regulations. (NOTE*: Please attach liability coverage face sheet showing current coverage amounts and expiration dates)

A. Current Coverage

<table>
<thead>
<tr>
<th>Current Carrier Name:</th>
<th>Policy #:</th>
</tr>
</thead>
</table>

Carrier Address:

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip:</th>
</tr>
</thead>
</table>

Effective Date:  
Expiration Date:

Per Occurrence $:  
Per Aggregate $:
V. ADMINISTRATIVE (MEDICAL STAFFING PROGRAM)

<table>
<thead>
<tr>
<th>Contact Name:</th>
<th>Contact Title:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Phone: ( )</th>
<th>Fax: ( )</th>
<th>E-mail:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Is there a formal credentialing program/policy for health care professionals?  
☐ Yes  ☐ No

1. Does your facility have policies and procedures in place for the hiring of facility staffing?  
☐ Yes  ☐ No

2. Are facility staffing qualifications verified upon hiring?  
☐ Yes  ☐ No

VI. ATTACHMENTS

This section is a list of documents that, if applicable, should be submitted with the completed application.

**Please place a check next to each document that is being included with the completed application:**

- Completed Facility Self-Evaluation Form (enclosed, if applicable; *applies to non-accredited facilities only)
- Copy of the organization’s **licensure issued by the State** (if applicable)
- Copy of the organization’s **malpractice face sheet**, showing amounts of coverage and coverage dates
- Copy(s) of all **accreditation certificates and survey results** (if applicable)
- **(If not accredited)** Copy of most recent State Survey/Inspection Report, including Corrective Action Plan letter
- Copy of the organization’s **Medicare approval letter** (if applicable)
- Copy of the organization’s **CLIA certification** (if applicable)

VII. ATTESTATION QUESTIONS (PERTAINING TO THE LAST 36 MONTHS)

**NOTE:** *If your answer to any of the following questions is Yes, please provide written details on a separate sheet. Please sign and date each additional sheet.*

A. Liability:

1. Has the facility’s liability insurance been denied, suspended, cancelled or not renewed (in the last 36 months)?  
☐ Yes  ☐ No

2. Has any settlement been paid on behalf of the facility and/or any of its employees (in the last 36 months)?  
☐ Yes  ☐ No

3. Are there any pending legal actions or claims against the facility and/or any of its employees (in the last 36 months)?  
☐ Yes  ☐ No

B. Regulatory and Disciplinary Actions:

Please indicate whether any of the following have ever been, or are currently in the process of, being denied, revoked, suspended, reduced, reprimanded, sanctioned, limited, placed on probation, not renewed, or voluntarily relinquished:

1. State License  
☐ Yes  ☐ No

2. Medicare participation  
☐ Yes  ☐ No

3. Medicaid participation  
☐ Yes  ☐ No

4. Other third-party payer participation  
☐ Yes  ☐ No
5. Has this facility, under any current or former name or business identity, had any felony or misdemeanor convictions, under Federal or State law, related to: (a) the delivery of an item or service under Medicare or a 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 (in the last 36 months)?
   □ Yes □ No

6. Has this facility, under any current or former name or business identity, 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 (in the last 36 months)?
   □ Yes □ No

7. Has this facility, under any current or former name or business identity, had any felony or misdemeanor convictions, under Federal or State law, related to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance (in the last 36 months)?
   □ Yes □ No

8. Has this facility, under any current or former name or business identity, had accreditation revoked or suspended (in the last 36 months)?
   □ Yes □ No

9. Has this facility, under any current or former name or business identity, been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in any Federal Executive Branch procurement or non-procurement program (in the last 36 months)?
   □ Yes □ No

10. Is this facility, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?
    □ Yes □ No

C. Compliance:
1. Does this facility currently meet all State and Federal requirements?
   □ Yes □ No

2. Does this facility currently meet requirements set forth by the Centers for Medicare and Medicaid Services?
   □ Yes □ No

C. Attestation

I hereby grant permission for Dean Health Plan, Inc. (DHP) to conduct on-site and/or medical records reviews as necessary. I further agree that this facility and/or providers will participate in, and support DHP’s Credentialing, Quality Improvement and Utilization review programs.

In submitting this application and supporting documentation to DHP, I am attesting to and certifying that all information in this application is accurate and complete, and I also agree to provide additional information as may be requested by DHP in order to evaluate the qualifications of this facility to become or continue to be a DHP provider.

All of the information in this application is warranted to be true, correct and complete.

Signature: ___________________________ Date: ________/_______/______
Name (print): ___________________________ Title: ___________________________