Care to Care

RADIOLOGY CREDENTIALING APPLICATION

CREDENTIALING CHECKLIST

FACILITY INFORMATION

- ❑ Facility application completed in its entirety and signed/dated by Authorized signatory
- ❑ Copy of all current facility licenses/certifications for each site
- ❑ W-9 Form
- ❑ Copy of Organization's Commercial General Liability Insurance and Professional Liability Insurance Face Sheets covering all sites
- ❑ All current equipment ACR, FDA, JCAHO or Other Accreditation Certificates by site, as applicable

RADIOLOGIST INFORMATION

- ❑ Roster of all reading physician radiologists and copies of the following documents:
- ❑ Current CV indicating current practice locations (in month/year format)
- ❑ Medical School Diploma
- ❑ ECFMG Certificate or Fifth Pathway Certificate (if applicable)
- ❑ Copy of current DEA License and/or State Narcotics License (if applicable)
- ❑ Copy of current State Medical License
- ❑ Copy of current Board Certification(s)
- ❑ Copy of current Malpractice Coverage

PLEASE SUBMIT APPLICATION AND ALL SUPPORTING DOCUMENTS TO:

Credentialing Department
Care to Care
755 Second Avenue
New York, NY 10017
(888) 246-5553

For Office Use Only

Present to Credentialing Committee	☐ **Yes** ☐ **No**
Date Submitted	
Date Approved	

Signature____

755 Second Avenue – 2nd Floor
New York, NY 10017
Phone : (212) 931 – 9090 / Fax : (212) 659 - 0142

CORPORATE ORGANIZATION LOCATION INFORMATION

CORPORATE ORGANIZATION INFORMATION

Corporation Name (As Filed With The IRS):	
DBA:	
Corporate Federal Tax ID#:	
Corporate Address:	
Corporate Zip Code:	
Corporate County:	
Corporate: Telephone #:	
Fax #:	
Corporate Office Contact Name & Title:	
Corporate Contact E-Mail Address:	

BILLING/REMITTANCE INFORMATION

If billing/remittance address and contact information is different from above, please complete the following:

Billing Company Name:	
Address, State Zip:	
Telephone #:	
Fax #:	
Contact Name & Title:	
Corporate: Telephone #:	
Fax #:	
Group Medicare #:	
Group Medicaid #:	
Group NPI#:	

CORRESPONDENCE LOCATION INFORMATION

Location Name:	
Complete Address:	
Telephone #:	
Fax #:	
Credentialing Contact & Telephone Number	
Credentialing Contact E-Mail Address:	

Please note: For Organizations/Groups of 12 or more radiologists we will consider delegated credentialing for entities meeting Care to Care credentialing criteria as well as NCQA recredentialing frequency. For further information please call (877) 931 - 2227.

PART I

INDIVIDUAL CENTER/FACILITY INFORMATION
(Site must complete all information below, make additional copies as needed for each site)

Facility Tracking Number__________________

CENTER/FACILITY INFORMATION *(as you would like it to appear in a directory)*

Center/Facility Name:	
Address & Zip Code:	
County:	
Telephone #:	
Fax #:	
Areas Served By Center/Facility (County/Zip Codes):	
Group Medicare #:	
Group Medicaid #:	
Group NPI #:	

CENTER/FACILITY CONTACT INFORMATION

Center/Facility Scheduling Contact Name and Title:	
Contact E-mail Address:	
Medical Director:	
Website:	

TYPE OF FACILITY

☐ **Free Standing Imaging Center** ☐ **Physician's Office** ☐ **Hospital-based Facility**
☐ **Mobile Services Unit** ☐ **Other____________________**

FACILITY/CENTER LICENSURE

Is your facility licensed by the state? ☐ Yes ☐ No ☐ N/A
If yes, please give the following information for each license type:

Facility Licensure/Certification *(Attach copies of all licensures and certificates)*

State	Type of License	License Number	Expiration Date

FACILITY INFORMATION

Hours of Operation

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

What is the average waiting time (days) to obtain a routine appointment in your office?

CT		MR		PET		Screening Mammo	

What is the average waiting time to obtain an urgent appointment?

CT		MR		PET		Diagnostic Mammo	

Do you offer sedation?	☐ Yes	☐ No
Do you accept worker's compensation cases?	☐ Yes	☐ No
Handicapped accessible?	☐ Yes	☐ No
Hearing impaired accommodations? TTY/TDD	☐ Yes	☐ No
Hearing impaired accommodations? ASL	☐ Yes	☐ No
Languages spoken by staff at this location:		

FACILITY INSURANCE

Please complete the information below with the liability insurance information for the facility. ***(Attach copies of all policy certificates.)***

Type Of Insurance	**Carrier Name**	**Policy Number**	**Policy Terms**		**Limits of Liability**	
			From Date	**To Date**	**Occurrence**	**Aggregate**
General Liability Insurance						
Professional Liability Insurance						
Facility Other Liability Insurance						

RADIOLOG TECHNICIAN INFORMATION

Please list all technicians that provide services at your facility. If additional space is needed, please copy this page.

What professional and experience requirements must a technician meet to practice at your facility?

FACILITY EQUIPMENT

Equipment Summary: Please check all services you provide at your facility and complete all equipment specifications.

Services Facility Provides: *(Check all that apply)*

☐ CT
☐ EMG
☐ MRI
☐ Myelography
☐ PET
☐ Arthrography
☐ Bone Densitometry
☐ Breast MRI & MR Guided Breast Biopsy
☐ Fluoroscopy
☐ IVP
☐ Mammography
☐ Ultrasound
☐ X-ray
☐ CTA
☐ Doppler Studies
☐ PET-CT
☐ Echocardiography
☐ EKG
☐ Holter Monitoring
☐ MRA
☐ Nuclear Cardiography
☐ Nuclear Medicine
☐ Other
☐ CCTA

Equipment Specifications: If more than one unit for any above modality, please add and number each piece of equipment. (Attach copies of current accreditation certificates.)

MRI

Manufacturer /Model:		Year manufactured:		Field strength:	
Table weight Limits:			Software:		
ACR Accreditation #:			Date of last upgrade:		
Coils:					
Frequency of Routine Maintenance:					
Choose one:	☐ Open	☐ Close			
Do you perform MRA?	☐ Yes	☐ No	Mobile Unit Only?	☐ Yes	☐ No

COMPUTERIZED TOMOGRAPHY (CT)

Manufacturer /Model:		Year manufactured:		Slices per Rotation:	
Capabilities:					
ACR Accreditation #:			Date of last upgrade:		
Frequency of Routine Maintenance:					
Mobile Unit Only?	☐ Yes	☐ No			
Do you perform CTA?	☐ Yes	☐ No			
If yes: CTA of Lower Extremities	☐ Yes	☐ No	or	Coronary CTA ☐ Yes	☐ No

MAMMOGRAPHY

Manufacturer/Model:		Year manufactured:			
Capabilities:					
ACR Accreditation #:		Date of last upgrade:			
Frequency of Routine Maintenance:					
FDA Accreditation #		Mobile Unit Only?	☐ Yes	☐ No	

ULTRASOUND

Manufacturer/Model:		Year manufactured:	
Transducers:			
ACR Accreditation #:		Date of last upgrade:	
Frequency of Routine Maintenance:		Mobile Unit Only?	☐ Yes ☐ No

NUCLEAR MEDICINE

ACR or ICANL Accreditation #:		Capabilities:	
Is this equipment utilized primarily for cardiac nuclear imaging?			☐ Yes ☐ No
Manufacturer/Model:		Year manufactured:	
Current NRC License #:		Current State Materials License #:	
Date of Last Upgrade:		Frequency of Routine Maintenance:	
SPECT Capable	☐ Yes ☐ No	If Yes, # of Heads:	☐ Yes ☐ No
Mobile Unit Only?	☐ Yes ☐ No		

RADIOLOGRAPHY/FLUOROSCOPY

Manufacturer/Model:		Year manufactured:	
Capabilities:			
Date of Last Upgrade:		Frequency of Routine Maintenance:	
Mobile Unit Only?	☐ Yes ☐ No		

PET OR PET-CT

Scanner Type:		Year manufactured:	
Capabilities:			
Date of Last Upgrade:		Frequency of Routine Maintenance:	
ACR Accreditation #:		Mobile Unit Only?	☐ Yes ☐ No

BONE DENSITOMETRY

Manufacturer/Model:		Year manufactured:	
Capabilities:			
Date of Last Upgrade:		Frequency of Routine Maintenance:	
DEXA?	☐ Yes ☐ No	Fan Beam?	☐ Yes ☐ No

DECLARATION OF FACILITY AND NON-PHYSICIAN PROFESSIONAL INFORMATION

(Please complete one for each facility location.)

CENTER/FACILITY NAME: ______________________________

1) Have there ever been, or are there currently, any claims, settlements, or judgments against your Facility, even if not resulting in monetary damages, or have you received any notice of "Intent to File"? If yes, attach explanation.

   ☐ Yes ☐ No

2) Has your facility ever had any general or professional liability insurance coverage canceled, declined or modified (i.e. reduced limits, restricted coverage), or has any renewal ever been refused, or has your facility voluntarily given up coverage? If yes, attach explanation.

   ☐ Yes ☐ No

3) Has your facility ever been denied membership or renewal of membership, or been subject to any disciplinary action in any hospital, IPA, HMO, PHO, PPO, managed care organization, with the exception of “no network need” or professional society, or is such action pending? If yes, attach explanation.

   ☐ Yes ☐ No

4) Has any Professional Conduct Board or any State Board of Medical Examiners disciplined any of your facility staff or has any Staff member been reprimanded, or disciplined by any state or federal agency that disciplines physicians or allied health professionals? If yes, attach explanation.

   ☐ Yes ☐ No

5) Has your facility ever been reprimanded, censured, excluded, suspended, or disqualified from Federal or State Programs? If yes, attach explanation.

   ☐ Yes ☐ No

6) Has your facility state license ever been revoked, suspended, or subject to probation or any conditions or limitations in any state? If yes, attach explanation.

   ☐ Yes ☐ No

7) Have any of your licensed non-physician professional staff licenses ever been revoked, suspended, or subject to probation or any conditions or limitations in any state? If yes, attach explanation.

   ☐ Yes ☐ No

FACILITY ATTESTATION

I _________________________ (name) on behalf of ________________ (facility name), herinafter Facility, hereby authorize Care to Care, LLC and its agencies to consult with administrators and members of medical staffs of hospitals, facilities, malpractice carriers and organizations with which Facility or its licensed professional staff has been associated, who may have bearing on the Facility's qualifications. Facility further consents to inspection of all records and documents that may be material to facility's evaluation. Facility agrees to abide by the terms of the Agreement with Care to Care, LLC, as well as the policies that may be adopted by Care to Care, LLC concerning the conditions, criteria, and standards of participation in the provider panel.

Facility shall provide immediate notice to Care to Care, LLC of any circumstance that limits any of the facility's ability to provide the Radiological services as outlined in the application.

All physicians providing services at facility are duly licensed in the state in which they practice, and are Board Certified or eligible to sit for board certification in their specialty. All technologists and other non-physician medical personnel are duly licensed and/or certified. As employer of Facility non-Physician staff, I confirm that none of my employed professionals have been sanctioned by State or Federal Licensing authorities and that no employees of Facility have a criminal background. By the signature below I hereby attest that all information contained herein is complete and accurate, and I agree to provide information as requested to support this application.

X____

Medical Director or Facility Administrator

______________________________ ______________________

Print Name/Title Date

PART II: PHYSICIAN INFORMATION

Center/Facility Name: ____

RADIOLOGIST INFORMATION

Please list all physicians rendering services at this location.

1. ______________________________ Medical Director
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________
11. ______________________________
12. ______________________________
13. ______________________________
14. ______________________________
15. ______________________________
16. ______________________________

What professional training and experience requirements must a physician meet to practice at your facility?

Each physician <u>must</u> complete:
a) Physician Fact Sheet
b) Physician Mandatory Questionnaire

Please copy for each physician practicing at the Facility/Center.

PHYSICIAN FACT SHEET

Center/Facility:					
Physician Name:				Check One:	☐ MD ☐ DO
Gender:		Date of Birth:		Social Security #:	
Place of Birth: (State and Country)					
Current NYS Medical License Number:				Expiration Date (mm/yy)	
Current Other Medical License # & State:				Exp. Date:	
Current Other Medical License # & State:				Exp. Date:	
Individual NPI#:					
Current DEA Number: (if applicable)				Exp. Date:	
State-specific narcotic/controlled substance license # (if applicable) & State				Exp. Date:	
Medical School & Graduation Date:					
ECFMG Certificate Number (if applicable)					
Fellowship training (if applicable)					
Board Certification 1: Specialty				Exp:	
Board Certification 2: Specialty				Exp:	
Board Certification Other: Specialty				Exp:	
Current Malpractice Policy Carrier:					
Limits of Liability:			Policy Coverage Dates:		
Hospital Affiliations					
Hospital Name:				Status: _	
From (mm/yy):			To (mm/yy)		
Hospital Name:				Status: _	
From (mm/yy):			To (mm/yy)		
Hospital Name:				Status: _	
From (mm/yy):			To (mm/yy)		

PHYSICIAN MANDATORY QUESTIONNAIRE (PART 1)

Center/Facility Name: ____

Physician Name: ____

EDUCATION AND TRAINING	
During your education, internship, residency, fellowship preceptorship or additional training (as applicable) were you ever disciplined, suspended, placed on probation, formally reprimanded, or asked to resign?	☐ Yes ☐ No
BOARD CERTIFICATION	
Has your Specialty Board certification or eligibility ever been denied, revoked, relinquished, not renewed, suspended, or reduced – or have any proceedings toward those ends been instituted?	☐ Yes ☐ No
LICENSE INFORMATION *(FOR THE PURPOSE OF THIS QUESTIONNAIRE, "STATE" ALSO INCLUDES ANY DISTRICT, TERRITORY OR PROVINCE.)*	
1. Have you ever been disciplined, reprimanded, or fined by any state board of medical examiners, professional conduct board, or state or federal agency that disciplines physicians or allied health professionals?	☐ Yes ☐ No
2. Has your license to practice, in your profession, ever been denied, limited, suspended, revoked, or subject to probation or any conditions or limitations in any state?	☐ Yes ☐ No
3. Have you ever been disciplined, suspended, sanctioned, or otherwise restricted from participating in any private, federal or state health program (for example, Medicare, Medicaid), professional society or managed care organization – or is any such action pending?	☐ Yes ☐ No
4. Have you ever been the subject of an investigation by any private, federal, or state health program – or is any such action pending?	☐ Yes ☐ No
5. Have your federal DEA and/or State Controlled Dangerous Substances (CDS) Certificate(s) ever been voluntarily or involuntarily limited, suspended, revoked, relinquished, or not renewed – or are proceedings currently pending?	☐ Yes ☐ No

INSURANCE INFORMATION	
1. How long have you been insured with your current professional liability insurance carrier? ➢ If under five (5) years, provide name/address and length of coverage for previous carrier to include a five (5) year period:_______________________________	______YEARS ______YEARS
2. Has your professional liability insurance coverage ever been terminated or modified by action of an insurance company?	☐ Yes ☐ No
3. Have you ever been denied professional liability insurance coverage or rated in a higher-than-average risk class for your specialty?	☐ Yes ☐ No
4. Have any professional liability suits, actions or claims alleging malpractice ever been filed against you?	☐ Yes ☐ No
5. Are any professional liability suits, actions or claims currently pending against you?	☐ Yes ☐ No
6. Have any judgments ever been made against you in professional liability cases or claims, or have you ever entered into any settlements?	☐ Yes ☐ No
7. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank?	☐ Yes ☐ No
8. Are you currently uninsured for professional liability (malpractice insurance) coverage?	☐ Yes ☐ No

PHYSICIAN MANDATORY QUESTIONNAIRE (PART 2)

Center/Facility Name: ____

Physician Name: ____

HOSPITALS AND OTHER AFFILIATIONS		
1. Have your clinical privileges at any hospital or healthcare institution or organization ever been limited, suspended, revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings toward any of these ends been instituted or recommended by any hospital or healthcare institution, medical staff or committee, or governing board?	YES ☐	NO ☐
2. Has your request for any specific clinical privileges been denied or granted with stated limitations (aside from ordinary or initial requirements of proctorship), or has a medical staff or peer review committee recommended to a governing board such a denial or limitation?	YES ☐	NO ☐
3. Have you ever had any challenges to, or voluntarily or involuntarily relinquished any medical staff membership clinical privilege(s), as a result of any investigation or disciplinary action?	YES ☐	NO ☐
4. Have you ever been court-martialed, sanctioned, reprimanded, or cautioned by a hospital or any other healthcare facility or military agency,; been involuntarily terminated or forced to resign; or have you resigned voluntarily while under investigation or threat of sanction from a hospital or healthcare facility or military agency?	YES ☐	NO ☐
HEALTH STATUS		
1. Are you currently using any illegal drugs?	YES ☐	NO ☐
2. During the last three years have you ever been under the influence of alcohol during working hours, or have you used drugs illegally?	YES ☐	NO ☐
3. Are you unable, with or without reasonable accommodation, to practice to the fullest extent of your license, qualification, and privileges without in any way posing a risk of harm to your patients?	YES ☐	NO ☐
CRIMINAL HISTORY		
1. Have you ever been arrested for, or charged with, a crime involving children? ➢ If "Yes," include the disposition of the arrest or charge on a separate sheet. This statement is being answered under penalty of perjury, subject to applicable Federal punishment for perjury.	YES ☐	NO ☐
2. Have you ever been convicted of a felony or are you presently under investigation or have you ever been indicted for a felony?	YES ☐	NO ☐

If you have answered "Yes" to any of the questions above, please attach an explanation for each answer including for each claim, please complete the attached Professional Claims History Form providing an explanation of liability actions, or settlements made on your behalf. Please note that you are encouraged to report all claims regardless of status (i.e. pending, dismissed/discontinued, settled, etc) as any omissions may delay the processing of your application as well as complicate routine recredentialing process in the future.

PHYSICIAN ATTESTATION STATEMENT

Center/Facility Name: ____

Physician Name: ____

I hereby authorize Care to Care, LLC and its agencies to consult with administrators and members of medical staffs of hospitals, malpractice carriers and organizations with which I have been associated, who may have bearing on my qualifications. I further consent to inspection of all records and documents that may be material to my evaluation. I agree to abide by the terms of the Agreement with Care to Care, LLC, as well as the policies that may be adopted by Care to Care, LLC concerning the conditions, criteria, and standards of participation in the provider panel.

I shall provide immediate notice to Care to Care, LLC of any circumstance that limits any of my abilities to provide the Radiological services as outlined in the application.

I___________________ (print name) am a_________________________ (indicate specialty) providing services at _____________________ (facility name) at ____________________(facility address). I am duly licensed in the state in which I practice. I am Board Certified/Board Eligible in my specialty. By the signature below I hereby attest that all information contained herein is complete and accurate, and I agree to provide information as requested to support this application.

X____

Signature of MD

____ ________________________________

Title Date