Colorado Choice Health Plans

700 Main Street, Suite 100
Alamosa, CO 81101
719-589-3696
Fax: 719-589-4901
www.cochoice.com

Ancillary & Facility Credentialing Application

This application is to be used if you wish to become a participating provider facility with Colorado Choice. This application is not a contract.

To ensure accuracy, please type your information onto this form and fax it 719-589-4901 or email to Credentialing@cochoice.com. If you have any questions about completing this form, e-mail or call the Credentialing Department at 719-589-3696.

You may also mail the completed form to:
Credentialing Department
Colorado Choice Health Plans
700 Main St, #100
Alamosa, CO 81101

As a provider, you have the right to review your credentialing information. If you wish to obtain the status of your application, please contact the Credentialing Department at the e-mail or phone number listed above. Initial credentialed providers will be notified via letter of the credentialing decision. All providers may consider themselves recredentialed unless otherwise notified.

Complete a separate application for:

- Each site location
- Each organization with a unique Federal Tax Identification Number

APPLICATION TYPE

☐ Initial Request ☐ Recredentialing

Is this application for the addition of a new site to your current contract? ☐ Yes ■ No

Is this application due to physical address change or practice relocation? ☐ Yes ☐ No
If yes, please provide the old address and new address below

Old Address: _____

New Address: _____

Please return completed Application along with copies of the following or indicate "NA":

1. _____ Copy of State Facility License
2. _____ Most recent CMS or State Department of Health survey report; or Approval letter from CMS or State Department of Health stating facility's review date and inspection results
3. _____ Copy of JCAHO Accreditation Letter and Accreditation Decision Grid; or Copy of the most recent survey results from the State Department of Health if not currently accredited by JCAHO, AAAHC or AAAASF
4. _____ Copy of Professional Liability and General Liability Insurance Certification, which list amounts and coverage dates
5. _____ Entity W-9 or copy of IRS 540 or 941
6. _____ Lab Cert
7. _____ CLIA
8. _____ Pharmacy Permit
9. _____ FDA ACR Cert (Mammography)
10. ____ Bedding/Upholstery License

Please indicate type of organization (choose all that apply):

- ☐ Ambulatory Surgical Clinic/Center
- ☐ Clinical Medical Laboratory
- ☐ DME & Medical Supplies
- ☐ General Acute Care Hospital
- ☐ Hearing and Speech Clinic/Center
- ☐ Home Health Agencies
- ☐ Hospice, Inpatient
- ☐ Long Term Care Hospital
- ☐ Magnetic Resonance Imaging Clinic/Center
- ☐ Physical Therapy Clinic/Center
- ☐ Radiology, Mammography Clinic/Center
- ☐ Rehabilitation Clinic/Center
- ☐ Rehabilitation Hospital
- ☐ Rural Health Clinic/Center
- ☐ Skilled Nursing Facility
- ☐ Substance Abuse Rehabilitation Facility
- ☐ Urgent Care Clinic/Center
- ☐ Other_____
- ☐ Taxonomy Code _____

PROVIDER INFORMATION

Legal Name *(As it appears on W-9)*: _____

Entity Name *(DBA)*: _____

Physical Address: _____

City, State, Zip: _____

Web address: _____

Phone: _____ Fax: _____

NPI: _____ Tax ID: _____

State License #: _____ CLIA #: _____

Credentialing Contact Person: _____

E-mail: _____ Phone: _____

Remittance Address (if different): _____

Remittance City, State, Zip _____

Remit Phone: _____ Remit Fax: _____

Does your organization submit claims electronically? ☐ Yes ☐ No

Is your entity a Physician Owned facility? ☐ Yes ☐ No

If no, please describe ownership: _____

OTHER INFORMATION

A. Has your organization's license to practice ever been limited, suspended, or revoked?
   ☐ Yes ☐ No

B. Has your organization ever been sanctioned, expelled, or suspended from receiving payment under Medicare or Medicaid Programs?
   ☐ Yes ☐ No

C. Has your organization been named in any malpractice actions in the last 5 years?
   ☐ Yes ☐ No

If you answered "YES" to any questions above, please attach an explanation, including the specific details of each incidence.

ATTESTATION

All information and documentation submitted here within is correct and complete to my best knowledge and belief. I acknowledge and understand that any material misstatements in or omissions from this application may constitute cause for denial of my application for participation in Colorado Choice Health Plans. A copy of this original statement as signed by me shall have all the same force and effect as the signed original.

I authorize Colorado Choice Health Plans the right to obtain documents, recommendations, reports and statements relating to the Credentialing process of this entity and the associated entities that intend to contract with Colorado Choice Health Plans. In addition, I also authorize the right to verify my standing with State and Federal regulatory bodies relating to the Credential process.

Name: _____

Signature: _____

(Signing on behalf of entity)

Date: _____

Phone: _____

Fax: _____

E-mail: _____