Health Plan of Nevada
A UnitedHealthcare Company

Sierra Health and Life
A UnitedHealthcare Company

Facility Credentialing Application Instructions

Thank you for your interest in joining our network. Before contracting can be completed, all practitioners must complete our credentialing process.

To begin, please complete the attached Credentialing Application (please make sure to use this new NDOI-901B Rev. 02-25 form) and submit it along with the required documentation. Incomplete applications will cause a delay in the process, so make sure to complete this form in its entirety.

Initial Credentialing Submissions or Provider Adds
Submit to:

- Contracting@uhc.com (Medical and Dental)
- ProviderRelations@bhoptions.com (Behavioral Health)

Recredentialing
Have there been any changes to the Uniform Credentialing Form since it was originally filled out?

- If YES, just fill out the portion of NDOI-901 which has changed.
  - Submit to:
    - NVSierraCred@uhc.com (Medical, Dental, and Behavioral)
- If NO, please attest to this in the separate ADDENDUM only

For any questions regarding the credentialing process, feel free to contact us at:

- Email nvsierracred@uhc.com (preferred)
- 702-242-7758

We appreciate your cooperation and look forward to working with you.

INSTRUCTIONS

Please complete all sections of this application. Separate applications are required for each facility location. If a section is not applicable, mark "N/A". Please print legibly or type the information. Include any additional information on a separate sheet.

IDENTIFICATION			
FACILITY PROFILE INFORMATION			
Facility Name		Facility Tax Identification Number (TIN):	
Facility DBA (Alternative Name):		Facility NPI:	
Corporate Address:		Hospital or Health System Affiliation: ☐ Not affiliated with any hospital/health system	
City:	State:		Zip:
Facility Owner:		Legal Type: Nonprofit Corporation ☐ Wholly Owned Subsidiary☐ Professional Corporation Subsidiary ☐ Limited Liability Corporation ☐	
FACILITY PHYSICAL LOCATION			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Facility Phone: ( ) -	Fax: ( ) -	Website: www.	
Facility Administrator:		Email:	
Languages Spoken at Location:			
Interpreter Services Available at Location? Yes ☐ No ☐			
Does the facility have a separate billing address? Yes ☐ No ☐			
FACILITY BILLING LOCATION			
Address Line 1:			

Address Line 2:			
City:	State:	Zip:	County:
FACILITY MAILING LOCATION			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
CREDENTIALING CONTACT INFORMATION			
Name:		Email:	
Phone:		Fax:	

FACILITY TYPE
Check ONE box only per Application.

☐ Ambulatory Surgery Center - Free standing only
☐ Pregnancy/Birth Center - Free standing only
☐ Home Health Care Agency that provides skilled nursing services (not a PCA-only agency)
☐ Hospital (type: _____)
☐ Skilled Nursing Facility/Nursing Home
☐ Sleep Disorders Center - Free standing only (not a Sleep Lab)
☐ Hospice
☐ Outpatient PT/OT/SLT
☐ Behavioral Health (type: _____)
☐ Long Term Care Facility
☐ Dialysis Center
☐ LTACH
☐ Urgent Care
☐ Rural Health Clinic
☐ Lab
☐ Other: _____

Facility Licensure ***Attach a copy of each license for this facility***					
License Number	**State or City**	**Licensing Agency**	**Initial Issue Date**	**Renewal Date**	**Expiration Date**
			/ /	/ /	/ /
			/ /	/ /	/ /
			/ /	/ /	/ /

Do you have a laboratory on premises? Yes ☐ No ☐	
If yes, CLIA Certificate Number:	Expiration Date:
Facility Medicare Number (N/A if not registered with Medicare):	
Facility Medicaid Number (N/A if not registered with Medicaid):	
Liability Insurance – complete this section attach a copy of the facility's insurance certificate(s)	
Issuing Insurance Agency:	
Policy Number:	
Single Occurrence Amount:	Aggregate Amount:
Issue Date:	Expiration Date:

ACCREDITED FACILITIES ***Complete this section and attach copies of current Accreditation certificate or letter. Certificate/letter should list this facility location as being included in the accreditation.***	
Is this facility Accredited by a National Accrediting Organization, such as JCAHO, CARF, AAAHC, ETC? Yes ☐ No ☐	
Accrediting Body:	
Date of Last Accreditation:	Accreditation Expiration Date:
NON-ACCREDITED FACILITIES ***Complete this section and attach copy of most recent onsite government agency survey along with your Corrective Action Plan(s), if deficiencies were cited, OR attach letter from government agency stating facility is in substantial compliance with most recent survey standards.***	
Has this facility had an onsite licensing survey by the Department of Health or CMS <u>within the past 36 months</u>?	

ATTESTATION ***Answer every question YES or NO.*** ***Provide a detailed explanation on a separate sheet, including dates, for any questions answered YES.*** ***Sign and date the Attestation.***	
□ YES □ NO	1. Has this facility had or currently has pending any legal actions in the last ten years?
□ YES □ NO	2. Has this facility been convicted of a crime in the last ten years?
□ YES □ NO	3a. In the last ten years, has the facility ever been named in a complaint based on allegations of professional negligence or professional misconduct or has this facility ever received notice of an intent to commence litigation of that type? *Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.*
□ YES □ NO	3b. With regard to any suit in the last ten years, has it resulted in a judgment, a settlement, or other final disposition, or is it still pending? *Note: Make copies of the attached Malpractice Claim Information Worksheet and complete for each case.*
□ YES □ NO	4. In the last ten years, has a government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business?
□ YES □ NO	5. In the last ten years, has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now underway?
□ YES □ NO	6. In the last ten years, has this facility/organization been assessed a penalty or fined by a government agency or is the facility currently under investigation by the Medicaid or Medicare programs or any other government agency?
□ YES □ NO	7. In the last ten years, have any third-party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management, quality of care issues, or for any other reason?
□ YES □ NO	8. Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?
□ YES □ NO	9. Has this facility, under any current or former name or business identity, in the last ten years had its accreditation revoked or suspended, or placed conditions upon?
□ YES □ NO	10. Has this facility's Commercial General or Professional liability insurance been denied, cancelled, non-renewed, or initially refused upon application, for any reason, in the last ten years?
□ YES □ NO	11. Have there been any Medicare/Medicaid sanctions in the last ten years?

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from the Application may be ground for denial of the Application as a Health Plan participating provider or cause for summary dismissal from the Health Plan.

As an authorized agent, I grant the Health Plan authorization to collect any and all information necessary to verify the information needed for credentialing.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

_____ _____

Printed Name of Authorized Representative | Title of Authorized Representative

_____ _____

Signature of Authorized Representative | Date Signed

MALPRACTICE CLAIM INFORMATION WORKSHEET

Form must be completed and signed even if there were no claims
Complete a separate sheet for each claim

Facility Name:
1. Patient Name:
2. Diagnosis:
3. Facility Involvement in case:
4. Allegation(s):
5. Case Summary (include additional pages if necessary):
6. Patient outcome:
7. Other Pertinent Details:
8. Date of Incident: **Date Filed:** **Date Closed:**
9. Resolution of Case (dismissed, settled, etc.) ***Note: Attach all relevant legal documentation:***
10. Settlement amount paid on your behalf, if any:
11. Professional liability insurer involved: **Name of Insurer:** **Policy #:**
Address of Insurer:
Name:
Signature: **Date:**

□ No claims to report