



# Facility & Ancillary Application

The original application with attachments should be returned to  
Sunshine State Health Plan  
400 Sawgrass Corporate Parkway, Suite 100  
Sunrise, FL 33325  
Phone: 1-866-290-9689

- Initial Credentialing
- Recredentialing
- Addition of a new site to current contract

Legal Name: \_\_\_\_\_  
*(Please type full name of facility)*

d/b/a Name: \_\_\_\_\_  
*(Please type full name of facility)*

- ✓ A separate application must be completed for each facility with a unique Federal Tax ID and/or site address.
- ✓ Complete this form in its entirety and attach all requested documentation and explanation.
- ✓ This application must be signed and dated where indicated.
- ✓ Facility credentialing is required for the following facility types – Choose all that apply:

- Hospital
- Skilled Nursing Facilities
- Diagnostic Imaging Centers
- Surgical Centers
- Rehabilitation Centers
- Adult Living Facilities
- Assisted Long-Term Care Facilities
- Home Health Agencies
- Durable Medical Equipment (DME)



# Facility & Ancillary Application

## I. Ownership/Management

President/CEO Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Vice President Name: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

CFO Name: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Medical Director: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

*Include copy of ME License and DEA*

## II. Facility Information

Facility Name: \_\_\_\_\_

Federal Tax ID #: \_\_\_\_\_ National Provider ID # (NPI): \_\_\_\_\_

Medicare Provider #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Medicaid Provider #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: FL Zip: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_ E-mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Title: \_\_\_\_\_

Billing address (if different): \_\_\_\_\_

*Street or PO Box*

Language(s) spoken at this location (*other than English*): \_\_\_\_\_

Is the facility open at least five (5) days per week? Yes \_\_\_\_\_ No \_\_\_\_\_

### Hours of Operation

Mon	Tue	Wed	Thurs	Fri	Sat	Sun
_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____	_____ to _____

Age Groups Treated  0 -12 yrs  13-17 yrs  18-64 yrs  65 +  all ages  Other \_\_\_\_\_

Are PAs, CNMs and/or Nurse Practitioners used? Yes \_\_\_\_\_ No \_\_\_\_\_

Is facility handicapped accessible? Yes \_\_\_\_\_ No \_\_\_\_\_

Identify the percentage of your practice dedicated to the following patient population:



# Facility & Ancillary Application

Business Lines

Percent of Practice

- |                           |            |
|---------------------------|------------|
| 1. Medicare FFS           | 1. _____ % |
| 2. Medicare Managed Care  | 2. _____ % |
| 3. Medicaid FFS           | 3. _____ % |
| 4. Medicaid Managed Care  | 4. _____ % |
| 5. Commercial HMO/PPO/POS | 3. _____ % |
| 6. Self Pay               | 4. _____ % |

Is your facility affiliated with any other health care organization(s) through corporate linkage or other formal arrangement? If so, please provide the following information (*List additional affiliations on a separate page.*)

Facility Name: \_\_\_\_\_ TIN: \_\_\_\_\_

Address: \_\_\_\_\_

Services Provided (IP/OP): \_\_\_\_\_

III. Accreditation and/or Certification

Agency Name	Acronym	Applied Date	Expiration Date
Accreditation Commission for Health Care, Inc.	ACHC		
American Association of Ambulatory Health Centers	AAAHC		
American Board for Certification in Orthotics & Prosthetics, Inc	ABCOP		
American College of Radiology	ACR		
American Osteopathic Hospital Association	AOHA		
Board of Orthotist/Prosthetist Certification	BOCUSA		
Commission on Accreditation for Rehab Facilities	CARF		
Clinical Laboratory Improvement Act	CLIA		
Community Health Accreditation Program	CHAP		
Healthcare Quality Association on Accreditation	HQAA		
Joint Commission on Accreditation of Healthcare Organizations	JCAHO		
National Association of Boards of Pharmacy	NABP		
National Committee for Quality Assurance	NCQA		
Utilization Review Accreditation Commission/Accreditation HealthCare Commission, Inc	URAC		
State Facility Operating License	N/A		
The National Board of Accreditation for Orthotic Suppliers	NBAOS		
Others (please list)			

*Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective date of accreditation or certification, deficiencies and approved plan for corrective action.*



# Facility & Ancillary Application

## IV. Insurance Coverage – Attach copy of declaration pages

1. Current Professional Carrier: \_\_\_\_\_

\$ Amount per Occurrence: \_\_\_\_\_ \$ Amount per Aggregate: \_\_\_\_\_

Dates of Coverage: From \_\_\_\_\_ To \_\_\_\_\_

2. Current Liability Carrier: \_\_\_\_\_

\$ Amount per Occurrence: \_\_\_\_\_ \$ Amount per Aggregate: \_\_\_\_\_

Dates of Coverage: From \_\_\_\_\_ To \_\_\_\_\_

3. Current Worker’s Compensation Carrier: \_\_\_\_\_

Dates of Coverage: From \_\_\_\_\_ To \_\_\_\_\_

## V. Sanctions – If yes to any question below, please explain on a separate sheet

1. Have there been or are there currently pending any malpractice claims, suits, settlements or proceedings involving your professional practice? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have you ever been disciplined, fined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental health care plans or programs? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you ever voluntarily relinquished or withdrawn, or failed to proceed with an application in order to avoid an adverse action, or to preclude an investigation or while under investigation relating to professional conduct? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Have you ever been subjected to sanctions by a Professional Review Organization (PSRO or PRO), a Third Party Payor, or a Regulatory Agency (CLIA, OSHA, etc.)? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Has your DEA Registration or State Controlled Substance Certificate (if applicable) ever been denied, suspended, or revoked for any reason? Yes \_\_\_\_\_ No \_\_\_\_\_
6. Has an officer ever been convicted of, pled guilty to, or pled nolo contendere to any felony including an act of violence, child abuse or a sexual offense? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Has the corporation, an officer or a board member ever been convicted of a felony? Yes \_\_\_\_\_ No \_\_\_\_\_

## VI. Provider Responsibility Form



## Facility & Ancillary Application

I hereby understand that as a prospective/current Sunshine Health provider, I am solely responsible for ensuring that any licensed practitioners under my employment or working in association with my clinical practice are fully qualified and have all necessary licenses required by all relevant laws to legally perform the assigned functions within my practice. Further, I agree that each such individual must be fully presented to Sunshine Health Credentials Committee for their review and approval, and, absent such affirmative approval, Sunshine Health members assigned to my care may not be treated or assisted by such individuals under my employment or associated to my practice without prior approval from Sunshine Health. Further, from time to time, such licensed practitioners may change, as my practice associates. In all such cases, I accept responsibility for notifying Sunshine Health in a timely manner about these new arrangements and will be responsible for fully cooperating in the submission of completed application forms and providing any other information as may be required to satisfy Sunshine Health credentials/recredentials requirements for all such individuals associated with my practice.

By applying for participation to the Plan, I hereby fully understand that the information submitted in this application shall be held confidential by the Plan and provided only to individuals connected with the Plan on a need to know basis. Notwithstanding the foregoing, I agree to the following:

- ✓ Participation in the credentialing review functions of the Plan.
- ✓ Authorize the Plan and its representatives to consult with prior or current associates and others who may have information bearing on our professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and other qualifications needed for verification of credentials. This includes such primary source verifications as accreditation bodies, professional liability carriers, State and Federal agencies or any other verification entities required by the Plan's accrediting bodies, CMS, AHCA, or other State or Federal regulatory agencies.
- ✓ Consent to an inspection by the Plan and its representatives of all documents that may be material to an evaluation of qualifications and competence. This is applicable if the applicant is not accredited by a nationally recognized accrediting body.
- ✓ Consent to the release of such information for credentialing purposes.
- ✓ Release from liability all representatives of the Plan for their acts performed and statements made, in good faith and without malice, in connection with evaluating the application, credentials and qualification for determination of credentialing status.
- ✓ Acknowledge that I, the Applicant, have the burden of producing adequate information for a proper evaluation of our professional, ethical and other qualifications for credentialing purpose and for resolving any doubts about such qualifications.
- ✓ Acknowledge that any material misstatement in, or omissions from, this application constitute cause for denial of credentialing status or cause for summary for revocation or suspension of privileges and/or dismissal from the participating network.

In order to evaluate this application for participation in and/or continued participation in the Plan, the Facility hereby gives permission to the Plan to request from other entities information regarding the Facility's credentials and qualifications. This includes consent to contact the Facility's accreditation agencies, State



## Facility & Ancillary Application

Regulatory and Licensing Departments, professional liability and workers compensation insurance carriers. The Facility understands that the Plan will use this information in a confidential manner on its own behalf and, if applicable, as an agent for one of its affiliated networks in connection with the administration of the Plan.

The Facility certifies that the information provided and the answers to the questions on this application are accurate and complete. While this application is being evaluated, and if this Facility/Subcontractor is selected or retained, after such selection or retention, the Facility agrees to inform the Plan in writing within 15 days of any changes in the information provided and the answers to questions on the application as a result of developments subsequent to the execution of this application.

The Facility agrees that submission of this application does not constitute selection or retention by the Plan on its own behalf or, if applicable, as an agent for one of its affiliated Plans and if the Facility is initially applying for participation, grants this Facility no rights or privileges in any Plan programs or any program or one of its affiliated Plans until such time as this Facility receives notice of selection.

All information submitted in this application is true and complete to the best of my/our knowledge and belief. A photo copy of this original constitutes our written authorization and requests to release any and all documentation relevant to this application. Said photo copy shall have the same force and effect as the signed original.

Name of Provider: \_\_\_\_\_ Date: \_\_\_\_\_  
*Print or type name*

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Signature of Provider or Authorizing Representative \_\_\_\_\_ Title \_\_\_\_\_  
*A stamp signature is not acceptable*