Bright HealthCare™

Bright HealthCare Facility Application

Please complete the entire form and use the required attachment checklist below as a cover sheet to ensure you include all necessary documents. Current copies of all items listed below are required to participate with Bright HealthCare.

Return instructions

Return this form and all applicable items on the checklist via encrypted email to the Credentialing team at facilitycredentialing@brighthealthgroup.com and your Bright HealthCare contact, if applicable.

General facility information

Legal business name:
Primary facility DBA:
Credentialing contact name:
Contact email:
Contact phone:
Associated TIN*:

*Bright HealthCare collects facility credentialing applications on an individual TIN level

☐ Initial Credentialing ☐ Re-credentialing

Required attachments

Note: You only need to submit one copy of each required attachment for all locations that use the associated TIN **unless** one of the locations differs (i.e. one location has a separate insurance from the other locations). Please include a separate copy of each unique element below. For instance, if there are multiple facility types, include all unique accreditation materials.

☐ Copy of current state license

☐ Copy of certifications and accreditations

Note: If unaccredited, include a copy of the most recent CMS survey or state survey and corrective action plan and approval letter, if applicable.

☐ Copy of declaration sheet and certificate of insurance

- Current professional malpractice
- Comprehensive general liability insurance policies

☐ Medicare Provider Number/CMS Certification Number (CCN)

☐ Signed and dated complete attestation

Failure to include all items listed above per location will delay the credentialing process.

Component Initial and Recredentialing Application

Note: Do not leave any fields blank. Blank fields will delay processing. Enter N/A where necessary.

1. General information

Facility name:
Corporate name (if different from facility name):

2. Type of facility, as listed on license or accreditation (Check all that apply)

- ☐ Hospital type_____
- ☐ Ambulatory surgery center
- ☐ Behavioral healthcare facility providing mental health or substance abuse services in an inpatient, residential, or ambulatory setting
- ☐ Birthing center
- ☐ Dialysis center
- ☐ Endoscopy center
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Hospice care
- ☐ Home health agency
- ☐ Imaging center
- ☐ Infusion center
- ☐ Long term acute care
- ☐ Rural health center
- ☐ Skilled nursing facility
- ☐ Urgent care center
- ☐ Other (please specify)_____

3. Primary facility physical address

Street address:		**City:**	
State:	**ZIP code:**	**Phone:**	**Fax:**
NPI:	**Taxonomy code:**	**Medicare CCN/PTAN:**	

Billing address (If different from primary facility address)

Street address:		**City:**	
State:	**ZIP code:**	**Phone:**	**Fax:**

4. Corporate/System owner:

Name:		**DBA name:**	
Street Address:		**City:**	
State:	**ZIP code:**	**Phone:**	**Fax:**
Facility Application Contact Name:		**Phone:**	**Fax:**

Please list other practice locations and addresses. If additional space is needed, please attach a separate page.

5. Practice locations

Include state license, accreditation, and malpractice insurance for each location, if different from primary facility's associated TIN.

Facility name/DBA:		Phone:	Fax:
Practice address:		City:	State:
NPI:	Taxonomy code:	Medicare CCN/PTAN:	ZIP code:

Facility name/DBA:		Phone:	Fax:
Practice address:		City:	State:
NPI:	Taxonomy code:	Medicare CCN/PTAN:	ZIP code:

Facility name/DBA:		Phone:	Fax:
Practice address:		City:	State:
NPI:	Taxonomy code:	Medicare CCN/PTAN:	ZIP code:

Facility name/DBA:		Phone:	Fax:
Practice address:		City:	State:
NPI:	Taxonomy code:	Medicare CCN/PTAN:	ZIP code:

If additional space is needed, please attach a separate page.

6. Licensure/Certification

Medicare certified? ☐ **Yes** ☐ No
(If Medicare certified – attach a copy of letter from CMS indicating Medicare Participation Number & effective date)

# **Medicaid Provider Number:**	
License from the state Department of Health (if applicable)	
State:	License number:
Expiration date:	Expiration date:
CLIA number:	
Other license/certificate:	Type:
Number:	Expiration date:

7. Professional liability and malpractice liability

Name of corporate entity on declaration sheet and/or certificate of insurance:		
Carrier name:	Effective date:	Expiration date:
Coverage per occurrence amount:	Coverage aggregate amount:	
Comprehensive general liability insurance		
Carrier name:	Effective date:	Expiration date:
Coverage per occurrence amount:	Coverage aggregate amount:	

8. Accreditation

Failure to check an answer and include an accreditation copy will delay application processing.

Has the facility been reviewed by any of the accrediting authorities listed below?

☐ Yes ☐ No

If yes, what were the results of the review?

☐ Approved ☐ Denied ☐ Provisional

Date of last approval:	**Year of next scheduled site visit :**

If you checked denied or provisional above, explain the circumstances on a separate sheet. Please provide the new accreditation or state survey authority describing the issue and all approved remediation efforts, such as actions taken to resolve issues per the state or accrediting authority.

Bright HealthCare Facility Accreditations Accepted	**Included**
Accreditation Commission for Health Care, Inc. (ACHC)	☐
American Academy of Sleep Medicine (AASMNET)	☐
American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)	☐
American Association of Ambulatory Health Centers (AAAHC)	☐
American College of Radiology (ACR)	☐
American Osteopathic Association (AOA)	☐
Board of Certification/Accreditation International (BOC)	☐
Center for Improvement in Healthcare Quality (CIHQ)	☐
College of American Pathologists (CAP)	☐
Commission on Accreditation of Rehabilitation Facilities (CARF)	☐
Community Health Accreditation Program (CHAP)	☐
Continuing Care Accreditation Commission (CCAC)	☐
Council On Accreditation (COA)	☐
Det Norske Veritas (DNV)	☐
DNV Healthcare Inc. (NIAHO Hospital Accreditation Program)	☐
Facilities accreditation Program (HFaP)	☐
Health and Human Services (HHS)	☐
Healthcare Facilities Accreditation Program (HFAP)	☐
Healthcare Quality Association on Accreditation (HQAA)	☐
International Planned Parenthood Federation (IPPF)	☐
Intersocietal Accreditation Commission (IAC)	☐
National Abortion Federation (PPFS)	☐
National Dialysis Accreditation Commission (NDAC).	☐
RadSite	☐
State Department of Health Survey (SDOH)	☐
The Compliance Team (TCT)	☐
The Joint Commission (TJC)	☐
Urgent Care Association of America (UCAoA)	☐

9. Unaccredited facilities

Failure to check an answer and include a survey copy will delay application processing.

If the facility is unaccredited but CMS or a state-appointed agency has performed an onsite survey in the last 36 months, please check applicable boxes below (note a letter is required if a Corrective Action Plan was initiated):

- ☐ I have attached a copy of the most recent onsite survey conducted by CMS or a state-appointed agency along with any Corrective Action Plan if deficiencies were identified
- ☐ I have attached a letter or email from the licensing agency stating the facility is in substantial compliance with the most recent survey

If the facility is unaccredited and CMS or a state-appointed agency has NOT performed an onsite survey in the last 36 months, indicate below so a Bright HealthCare representative can contact you to schedule an onsite survey:

- ☐ I need to plan an onsite survey

Please answer all questions. You must provide an explanation for all bold answers.

Failure to fully complete an answer and include a survey copy will delay application processing.

1. Has the facility license to do business in any applicable jurisdiction ever been denied, restricted, sanctioned, suspended, reduced, or not renewed?

- ☐ Yes If yes, please explain:_____
- ☐ No

2. Has the facility been denied participation, suspended from, or denied renewal from Medicare or Medicaid?

- ☐ Yes If yes, please explain:_____
- ☐ No

3. Has the facility ever had its professional liability coverage canceled but not renewed?

- ☐ Yes If yes, please explain:_____
- ☐ No

4. Has the facility been denied accreditation by its selected accrediting body (i.e. JCAHO) or had its accreditation status reduced, suspended, revoked, or in any way revised by the accrediting body?

- ☐ Yes If yes, please explain:_____
- ☐ No

5. Are all professional providers employed in these facilities credentialed under industry-standard credentialing guidelines?

- ☐ Yes
- ☐ No If no, please explain:_____

Component Attestation/Consent & Release Form

By signing below, I attest that I am the duly authorized representative of the Component, that all information on the application pertains to the above-named Component, and that such information is current, complete, and correct. I authorize Bright HealthCare to collect any information necessary to verify the information in the application.

Background Investigations

The Component's duly authorized representative must sign the following attestation:

I attest that this organization conducts background investigations on all employees, interns, volunteers, and contract agents having contact with clients, consisting of at least the following, prior to hire:

- A name search through the appropriate state Bureau of Investigation
- A reference from the licensing board (for licensed persons)
- A check of the Central Registry of Child Abuse (for persons having unsupervised contact with clients under the age of 18)
- A check of references of former employers (for clinical staff)

The organization has written criteria for evaluating which felony and misdemeanor convictions or complaints make an applicant unacceptable for hire, or a person unacceptable for retention.

Your signature is required to complete this application. Stamped signatures are NOT acceptable.

Component name:
Name (print or type):
Title:
Signature:
Date:

Please return this form along with all required documentation from the checklist below:

- ☐ Copy of state facility licenses, if applicable
- ☐ Medicare Participation Certificate/Number
- ☐ Copy of certifications and/or accreditation certificates (e.g. JCAHO, CARF, etc.)
- ☐ If unaccredited, copy of most recent CMS survey or state survey (include Corrective Action Plan and Approval Letter, if applicable)
- ☐ Copy of declaration sheet and/or certificate of insurance for BOTH current professional malpractice and comprehensive general liability insurance policies
- ☐ Signed and dated attestations