ANCILLARY CARE SERVICES

American CareSource Holdings, Inc.
dba Ancillary Care Services
Provider Application

PLEASE TYPE OR PRINT LEGIBLY. APPLICATION MUST BE COMPLETE FOR CONSIDERATION.

GENERAL INFORMATION

PROVIDER IDENTIFICATION:

Provider Name____

Facility Address:____
Street City State Zip

Billing Address: ____
Street/P.O. Box City State Zip

Corporate Address: ____
Street/P.O. Box City State Zip

Contact Name:____

Phone Number(s):____
Facility Phone Billing Phone Corporate Phone

Fax Number(s):____
Facility Fax Billing Fax Corporate Fax

Contact E-Mail:____

E-Mail for Billing:____

Web Site:____

Number of employees:____

OWNERSHIP INFORMATION:

Check the box that best describes your organization:

☐ Professional Corporation ☐ Partnership ☐ Limited Liability Company

☐ Other____

Ownership (List Owners, if applicable)____

Physician Owned: ☐ Yes ☐ No Names:____

____

Directly Responsible Administrators:____

____

Tax ID Number: Corporate-wide ____________ **Please attach W-9 Form**

By location ____________ **Please attach W-9 Form**

Owner name of Tax ID Number: Corporate-wide ____________

By location ____________

Check the box that best describes the ownership of your organization:

☐ For profit ☐ Non-profit

National Provider Identifier (NPI): ___________________________ **(REQUIRED)**

LICENSURE/CERTIFICATION

Are you a Medicare provider? ☐ Yes ☐ No

If yes, please provide Medicare ID#: ____________

Please attach copy of certification.

Are you a Medicaid provider? ☐ Yes ☐ No

If yes, please provide Medicaid #: ____________

Please attach copy of certification.

Are you licensed to practice in your state? ☐ Yes ☐ No

Please attach copy of certification.

If required, are you certified to practice in your state? ☐ Yes ☐ No

Please attach copy of certification.

If you operate in multiple states, please list all applicable states and **attach** a current license copy for each state.

Please attach copies of all the following Information:

- **Copy of State License to Practice (**all professionals)**
- **Copy of Accreditations (**all professionals)**
- **Curriculum Vitae (**all professionals)**
- **Malpractice Insurance**
- **Listing of all Facilities**
- **DPS copy (if applicable)**
- **DEA copy (if applicable)**
- **Bureau of Radiation (if applicable)**

*** If multiple sites, please attach a spreadsheet with facility name, address, Tax Id #, City, State, Zip, Medicare #, Medicaid #, fax, phone, billing address, corporate address and contact name for each**
**** All professionals include all PT, OT, ST, chiropractors, podiatrists and message therapists**

ACCREDITATION

Are you accredited by JCAHO, URAC, CARF, CLIA, NCQA or other organizations? ☐ Yes ☐ No

If yes, please list all that apply and attach a current copy of each: ____________

____

____

____

Do you currently use a clearinghouse to submit claims? ☐ Yes ☐ No

If yes, please list the clearinghouse(s): ____________

MEDICAL LIABILITY INSURANCE INFORMATION

Do you carry general liability insurance? ☐ Yes ☐ No

If yes, please attach a current copy of Proof of Insurance.

Name of general liability insurer: ______________________________

Amount of coverage: ______________________________

Do you carry professional liability insurance? ☐ Yes ☐ No

If yes, please attach a current copy of Proof of Insurance.

Name of professional liability insurer:______________________________

Amount of coverage: ______________________________

SERVICES

PRODUCTS OR SERVICES AVAILABLE:

Please fill in your **primary** product/service type from the categories listed below: ______________________

Please check ALL service types that your facility offers.

If multiple facilities are involved, please e-mail an Excel spreadsheet to **ProviderRelations@anci-care.com** which includes the following for each facility: facility address, billing address, telephone number, fax number, e-mail address and the services available at each individual facility.

- ☐ Acupuncture
- ☐ Behavioral Health (See next page for sub-specialties)
- ☐ Cardiac Monitoring
- ☐ Chiropractic
- ☐ Diagnostic Imaging – Full Services
- ☐ Diagnostic Imaging – CT Scan
- ☐ Diagnostic Imaging – Mammography
- ☐ Diagnostic Imaging – MRI
- ☐ Diagnostic Imaging – Open Bore MRI
- ☐ Diagnostic Imaging – Open MRI
- ☐ Diagnostic Imaging – Other Services
- ☐ Diagnostic Imaging – P.E.T.
- ☐ Dialysis
- ☐ Durable Medical Equipment – General
- ☐ DME – Burn Garments
- ☐ DME – CPM
- ☐ DME – Diabetic Supplies
- ☐ DME – Hospital Beds and Accessories
- ☐ DME – Infusion Pumps and Supplies
- ☐ DME – Ostomy Supplies
- ☐ DME – Oxygen and Respiratory Equipment
- ☐ DME – TENS, Bone Stims
- ☐ DME – Wound Care Equipment & Supplies
- ☐ DME – Other
- ☐ Endoscopy
- ☐ Genetic Testing
- ☐ Hearing Aids
- ☐ Home Health
- ☐ Home Health – Cardiac
- ☐ Home Health – Companion
- ☐ Home Health – Pediatric Only
- ☐ Hospice
- ☐ Infusion Services
- ☐ Lab
- ☐ Lithotripsy
- ☐ Long Term Acute Care
- ☐ Massage Therapy
- ☐ Orthotics & Prosthetics
- ☐ Pain Management
- ☐ Podiatry
- ☐ Rehabilitation
- ☐ Rehabilitation – Aquatic Therapy
- ☐ Rehabilitation Equipment – Custom
- ☐ Rehabilitation – Inpatient
- ☐ Rehabilitation – Physical, Occupational, Speech
- ☐ Rehabilitation – Respiratory
- ☐ Skilled Nursing Facilities
- ☐ Sleep Diagnostic
- ☐ Surgery Center
- ☐ Transportation
- ☐ Urgent Care Center
- ☐ Vision

LANGUAGES SPOKEN

Please indicate all foreign languages spoken at your facility: ______________________________

____

Or, do you contract with a service that provides interpretation support? ☐ Yes ☐ No

BUSINESS HOURS

What are your hours of operation?

AM: Mon ____ - ____ Tues ____ - _____ Wed ____- _____Thurs _____ -____ Fri____ - ____Sat ____ - ____ Sun ___

PM: Mon ____ - ____ Tues ____ - _____ Wed ____- _____Thurs _____ -____ Fri____ - ____Sat ____ - ____ Sun ___

Please describe your after-hours delivery and service policy:______________________________

____

____

QUALITY ASSURANCE AND PATIENT SATISFACTION

Describe your quality assurance program/activities. Please **attach** additional pages if necessary.

____

____

____

What credentialing criteria do you use to evaluate your providers/licensed professionals:________________________

____

____

____

Do you measure clinical outcomes? ☐ Yes ☐ No

If yes, please explain method. ____

____

Do you use patient satisfaction surveys? ☐ Yes ☐ No **If yes, please attach a copy.**

CONFIDENTIAL INFORMATION

PROVIDER NAME:	TIN:	DATE:

INSTRUCTIONS

The information requested on this form will be used in the American CareSource Holdings, Inc. dba Ancillary Care Services credentialing process. The questions are worded to solicit as much information as possible for review and consideration. It is important that the information you provide be as complete and accurate as possible because any misstatement or omission of relevant information will constitute grounds for rejection of your application or summary dismissal as a participating provider. Thus, it is better to err on the side of inclusion with appropriate explanation, rather than exclusion. In addition, you will be held responsible for all statements written in the application, regardless of whether such statements were prepared by you or by an employee, agent, or representative.

Yes	No	NA		
			1.	Have you ever had any adverse action taken or is any adverse action pending with respect to any of the following items?
				▪ State License/Certificate/Registration
				▪ Medicare, Medicaid, or other government health program participants.
				▪ HMO, PPO, PHO, IPA or any prepaid health plan or managed care participation.
			2.	Do you have a medical condition that in any way impairs or limits your ability to practice medicine with reasonable skill and safety? If yes, please **attach** explanation.
			3.	Do you have any chronic communicable disease or other medical conditions that would pose a risk to the safety or well being of your patients?
			4.	If you use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
			5.	Are you currently engaged in illegal use of controlled or dangerous substances?
			6.	Are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you?
			7.	Are you now or have you been involved in any malpractice action(s), including litigation, arbitration or mediation, regardless of the method or amount of the outcome that resulted?
			8.	Has payment to resolve or avoid any allegation(s) concerning your competence, conduct or quality of care (not involving litigation, arbitration or mediation) ever been paid by or on your behalf? If yes, please attach a detailed explanation for each allegation, claim, suit, action, or settlement, whether open or closed, regardless of whether payment was made. Please be sure to include: ▪ Date of the incident(s) leading to the allegation, claim suit, action or settlement ▪ Dates of filing and resolution and outcome ▪ Professional liability insurer involved ▪ Your status
			9.	Has your general liability insurance or coverage been denied, suspended, canceled, lapsed, not renewed, special rated or experienced gaps?
			10.	Has your professional liability insurance or coverage been denied, suspended, canceled, lapsed, not renewed, special rated or experienced gaps?
			11.	Have you been convicted of a crime or are you under indictment for an alleged crime?
			12.	Have you been the subject of an administrative, civil or criminal complaint or investigation regarding sexual misconduct or child abuse? **If yes, please attach an explanation with full details** (including the plaintiff and court caption of any pending lawsuit).
			13.	Are you presently a defendant in a malpractice, discrimination or professional liability lawsuit or proceeding or have you been placed on notice of such a potential lawsuit or proceeding yet to be filed?

If you answered "Yes" to any of the above questions, please attach explanation. Information protected by applicable law from disclosure is not subject to disclosure.

RELEASE AND AUTHORIZATION

The undersigned provider authorizes American CareSource Holdings, Inc. dba Ancillary Care Services to confer with professional liability carriers, managed care organizations and other persons or entities to obtain information concerning my qualifications, including without limitation, my professional competence and conduct. I consent to the release to ACS of any and all information that may be relevant to an evaluation of credentials and qualifications, including information about disciplinary actions and information that might other wise be considered confidential or privileged. I authorize ACS to release this information, as well as quality assurance data relating to me. I release ACS and any and all persons or entities providing information about me to ACS from any and all liability connected with or arising from the release of such information, provided that they were acting in good faith and without malice. Further, I release ACS from any and all liability for its acts performed in good faith and without malice in evaluating my application and any decisions related to my application or credentialing status.

I understand that I need to provide adequate information to ACS to demonstrate my qualifications. I understand that any misstatement or omission of information in this application will constitute grounds for rejection of my application or dismissal as a participating provider in the ACS provider network. If any information I have provided in this application making such information no longer correct and complete or affecting my professional status, I understand and agree that it is my obligation to notify ACS within 15 days of said occurrence. Failure to comply with this obligation may result in termination of my participation in ACS' provider network.

I attest that the information contained in this application is correct and complete.

Name of Company (Please Print):

____

By:______________________________Title:________________________________Date: _________________

Name of attesting individual

MAIL APPLICATION AND ATTACHMENTS TO:

American CareSource Holdings, Inc.
dba Ancillary Care Services
Attention: Provider Relations
5429 Lyndon B. Johnson Freeway
Suite 700
Dallas, TX 75240

ATTACHMENTS MUST BE RECEIVED

TO BE CONSIDERED FOR PARTICIPATION IN THE AMERICAN CARESOURCE NETWORK

CHECKLIST

________ W-9

________ Medicare Certification

________ Medicaid Certification

________ State License

________ State Certification

________ Accreditation

________ General Liability Insurance

________ Professional Liability Insurance

________ Curriculum Vitae

Dear Provider,

Please note we have a new address and phone numbers effective 9/25/06.
If you should have any questions or concerns please feel free to use the listed contact numbers below to direct your calls.

Address:
Ancillary Care Services
5429 LBJ Freeway, Suite 700
Dallas, TX 75240

Contact Numbers:
972-308-6828 Main
800-370-5994 Toll Free

Provider Relations:
972-308-6838
800-370-5994 option # 4

Claims Resolutions:
972-308-6834
800-370-5994 option