PreferredOne
Facility Information Sheet

Identifying Information

Corporate Name _____ Tax ID _____
(if applicable) ***Please attach W9 form***

Facility Name _____ Phone _____

Primary Address _____ Fax _____

_____ E-mail _____
(For multiple facilities, please use attached "Supplemental Site Sheet")
Billing Address (if different) _____ Billing Phone (if different) _____

_____

Administrator Name and Phone Number: _____

Billing Contact Name and Phone Number: _____

Utilization Review Contact Name and Phone Number: _____

Licensure and Accreditation

State License #: _____ Expires: _____ Number of licensed Beds: _____
JCAHO Cert #: _____ Expires: _____ Number of Operating Beds: _____
Medicare Number: _____
Medicaid Number: _____
Other Accreditation? (Please specify type and renewal date) _____

Please attach copies of the facility's current State license and Accreditation certificates

Disclosure and Attestation - Please attach an explanation and documentation for each affirmative answer

1. **Yes** □ **No** Has the facility's license, certification, or accreditation ever been terminated, stipulated, restricted, limited, conditioned, suspended, revoked, refused, voluntarily relinquished, or not renewed by any licensing board, Medicare, Medicaid, or any other health accreditation organization, or is there a review pending?

2. **Yes** □ **No** Has the facility's license, certification, or accreditation ever been or is it currently being investigated?

3. **Yes** □ **No** Has the facility ever been reprimanded, censored, or otherwise disciplined by, or subject to a corrective action plan with any licensing board, peer review organization, third party payor, Medicare, Medicaid, or any other health accreditation organization, or is there a review pending?

4. **Yes** □ **No** Has the facility's certificate or participation in any private, federal, or state health insurance program ever been revoked or otherwise limited or restricted, or is any investigation or proceeding presently underway?

5. **Yes** □ **No** Has the facility's liability carrier ever refused, revoked, cancelled, or excluded services from the facility's insurance coverage?

Please complete page 2 on reverse

Services Provided

Ancillary Services:

□ Yes □ No **Ambulatory Surgery Center** (free-standing from hospital)
□ Yes □ No **Durable Medical Equipment**
□ Yes □ No **Home Health/Infusion Services**
□ Yes □ No **Hospice**
□ Yes □ No **Orthotics & Prosthetics**
□ Yes □ No **Skilled Nursing Facility** (# of Beds: _____)
□ Yes □ No **Transportation Services**

Behavioral Health Services:

□ Yes □ No **Mental Health – Inpatient – Adult** (# of Beds: _____)
□ Yes □ No **Mental Health – Outpatient – Adult**
□ Yes □ No **Mental Health – Inpatient – Child/Adolescent** (# of Beds: _____)
□ Yes □ No **Mental Health – Outpatient – Child/Adolescent**

Chemical Dependency Services:

□ Yes □ No **Alcohol and Drug Abuse – Inpatient – Adult** (# of Beds: _____)
□ Yes □ No **Alcohol and Drug Abuse – Outpatient - Adult**
□ Yes □ No **Alcohol and Drug Abuse – Inpatient – Child/Adolescent** (# of Beds: _____)
□ Yes □ No **Alcohol and Drug Abuse – Outpatient – Child/Adolescent**

Other Inpatient Specialty Services:

□ Yes □ No **Acute Rehabilitation** (# of Beds: _____)
□ Yes □ No **Pediatric Intensive Care** (# of beds: _____)
□ Yes □ No **Private Rooms Available**
□ Yes □ No **Neonatal Intensive Care** (# of Beds: _____)
□ Yes □ No **Semi-Private Rooms Available**
□ Yes □ No **Transplantation** (Specify type(s): _____

Professional Services Billed by Hospital:

□ Yes □ No **Anesthesia** □ CRNA's □ MD's
□ Hospital Employed? If no, practice name_____
□ Yes □ No **Clinic(s) owned by hospital.** ***If yes, please complete attached New Clinic Information Form.***
□ Yes □ No **Emergency Room**
□ Hospital Employed? If no, practice name_____
□ Yes □ No **Pathology**
□ Hospital Employed? If no, practice name_____
□ Yes □ No **Radiology Services**
□ Hospital Employed? If no, practice name_____
□ Yes □ No **Urgent Care** Hours: _____ Location(s): _____
□ Yes □ No **Other services provided**? *Please specify*_____

Please submit this form along with copies of facility's current W9, State license, Certifications, insurance certificate with limits of general and aggregate liability identified, and Supplemental Site Sheet if applicable.

I hereby certify that all the information on this form is complete and accurate. I further agree to notify PreferredOne with any material updates to this information.

Signature _____ Date _____

Print Name and Title _____