CRESCENT
HEALTH SOLUTIONS

Provider Demographic Sheet

Please complete the information below so that we can list the specifics of your practice correctly on our website and in any employer directories that we may print.

Practice Name	
Tax Identification #	
Practice NPI # (if multiple locations, please include each applicable ID#.)	
Type of Practice	**Primary Care:** ☐ **Specialty:** ☐ **FQHC:** ☐ **Rural Healthcare Provider:** ☐
Physical Address **Include multiple locations. If separate tax id numbers, complete a separate form.**	
Remittance Address **Phone#** **Contact Name**	
Mailing Address	
Phone Number	
Fax Number	
Office Manager/ Contact Person **Address** **Phone Number** **E-Mail**	
Credentialing Contact **Address** **Phone Number** **E-Mail**	
Managed Care Negotiations Contact **Address** **Phone Number** **E-Mail**	

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Provider Demographic Sheet

Please list all providers that are included in your practice, their individual NPI and Medicare numbers, and the locations in which they provide service. Make a copy to use if more space is needed.

Practice Billing Name on Claims:

Provider Name and Location	Provider Name on Billed Claims	Individual NPI #	Medicare #

Crescent Health Solutions 1200 Ridgefield Blvd Ste 215 Asheville NC 28806-2292 Telephone 828-670-9145 Fax 828-670-9155

CRESCENT
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Facility Credentialing

Please complete all sections of this application. Print or type and save. Mark N/A if a section is not applicable.

Attach the following documents to the completed application. Mark N/A if a document is not applicable.

_____ List of Services Offered
_____ Copy of Current State license; license registration; license permit or Certificate of Compliance (including expiration date)
_____ Copy of Current DEA Registration Certificate or State CDS Registration Certificate (including expiration date)
_____ Copy of current facility liability insurance face sheet (including coverage amounts and expiration date)
_____ Copy of accreditation certificate(s) and/or accrediting organization's letter indicating facility's accreditation level
_____ Copy of letters/certificates indicating Medicaid or Medicare Provider numbers
_____ Copy of full CMS or State audit report for a non-accredited facility

FACILITY TYPE:

_____ Ambulatory Surgical Facility
_____ Behavioral Health
_____ Diagnostic Center (Mammography, Radiology, Urgent Care)
_____ Dialysis Center
_____ Durable Medical Equipment (DME)
_____ Home Health Agency/ Infusion Therapy
_____ Hospice
_____ Hospital
_____ Rehabililitation Facility (Inpatient/Outpatient PT, OT, or ST)
_____ Skilled Nursing Facility
_____ Other: _____

GENERAL INFORMATION:

Name of Facility _____

Address _____

City/State/Zip _____

Telephone _____ **Fax** _____ **Email** _____

Federal Tax ID Number _____ **Website** _____

Administrator Name/Title _____ **Telephone** _____

Managed Care Contact Name _____ **Telephone** _____

If you have multiple locations, please complete the following information for each on a separate sheet.

BILLING INFORMATION

Same as primary office? ☐ **Yes** ☐ **No** If No, please complete the following:

Contact Person_____ Telephone _____

Address_____ Fax _____

City/State/Zip _____ Email _____

CREDENTIALING OFFICE AND ADDRESS

Same as primary office? ☐ **Yes** ☐ **No** If No, please complete the following:

Contact Person_____ Telephone _____

Address_____ Fax _____

City/State/Zip _____ Email _____

OWNERSHIP AND CONTROL

Owned By _____

Address_____ Year Opened _____

City/State/Zip _____

Type of Ownership (Choose one)

_____ Independent	_____ Corporate Chain	_____ Joint Venture
_____ Limited Partnership	_____ Hospital-owned	_____ Investor-owned (for profit)
_____ Government (non-Federal)	_____ State-owned	_____ County-owned
_____ City-owned	_____ Non-Governmental (not for profit)	_____ Church-operated
	_____ Other: _____	

SERVICES

Total number of licensed beds _____ Do you offer 24/7 Emergency Department Services? ☐ **Yes** ☐ **No**

List foreign languages spoken at the facility _____

The Americans with Disabilities Act includes certain requirements for public accommodations to ensure effective communication. Is a sign language interpreter or teletype available in this facility for the hearing impaired patients? ☐ **Yes** ☐ **No**

List the hours of operation:

	Monday	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
From/To							

LICENSURE

State License Number _____ State _____ Exp. Date _____

State License Number _____ State _____ Exp. Date _____

DEA (Federal) Certificate _____ Exp. Date _____

Other applicable narcotic certificate:
Certificate Number (State CDS) _____ State _____ Exp. Date _____

Medicare Provider Number _____ Medicaid Provider Number _____

NPI Number _____

ACCREDITATION/CERTIFICATION

☐ AAAHC ☐ CAP ☐ CARF ☐ CHAP ☐ CLIA ☐ CMS (Medicare)

☐ HFAP ☐ JCAHO ☐ NCQA ☐ URAC ☐ Other _____

Please note that if the facility is not accredited, an on-site visit may also be required.

ADDITIONAL INFORMATION

1. Has the facility ever had any of the following items involuntarily denied, revoked, suspended, not renewed, placed under probation, subject to disciplinary action or otherwise limited or curtailed; or has the facility voluntarily relinquished any item in anticipation of any of these actions; or are any of these actions pending with respect to any of the following items? If Yes, please explain.

		Yes	No	NA
A.	State License	☐	☐	☐
B.	Medicare, Medicaid or other local, state and/or federal government program participation	☐	☐	☐
C.	HMO, PPO or other health plan participation	☐	☐	☐
D.	Other regulatory agency (OSHA, etc)	☐	☐	☐
E.	Accreditation organization (CLIA, JCAHO, etc)	☐	☐	☐
F.	Professional liability coverage	☐	☐	☐

2. Has the facility ever been placed under temporary government-ordered management? If Yes, please explain. ☐ ☐ ☐

3. Has the facility ever permitted the appointment of a receiver for its business or its assets? If Yes, please explain. ☐ ☐ ☐

4. Would the facility be willing, if needed, to sponsor or provide Educational programs for members of Crescent? ☐ ☐ ☐

5. Do you understand that subject to proper confidentiality restrictions and Authorizations, medical records might be subject to on-site review by Crescent representatives for peer review, utilization review and quality assurance purposes? ☐ ☐ ☐

MALPRACTICE HISTORY

1. Has this facility's current or any previous professional liability carrier ever made an out-of-court settlement or paid a judgment of professional liability carrier on the facility's behalf? ☐ **Yes** ☐ **No**

2. Is the facility, or has it ever been, involved in a malpractice suit, grievance filed with a county or state medical society or licensing agency, or arbitration proceeding? ☐ **Yes** ☐ **No**

If you answered "yes" to any of the questions in this section, please supply information regarding the case. If more than one case exists, please supply information for each case. The information that should be included is as follows:

- **Date claim was filed**
- **Date closed/settled**
- **Status of case (pending; dropped; settled out-of-court; or dismissed)**
- **Amount of settlement or court award**

Hospitals that are accredited by the Joint Commission for Accreditation of Healthcare Organizations will not be required to submit a detailed history of malpractice settlements.

ATTESTATION STATEMENT

The undersigned hereby certifies that the preceding information and all attachments provided to Crescent Health Solutions, Inc. is truthful, correct and complete in all respects and the undersigned further understands the intentional submission of false or misleading information or the withholding of relevant information are grounds for termination or disapproval as a participating provider with Crescent Health Solutions, Inc. The undersigned hereby agrees to notify Crescent Health Solutions, Inc. of any material changes in the preceding information in writing within 30 days of change.

_____

Signature Date

_____

Printed Name of above person

_____

Title of above person