BEHAVIORAL HEALTH SYSTEMS

Behavioral Healthcare Programs for Business & Industry Since 1989

Two Metroplex Drive • Suite 500 • Birmingham, AL 35209 • (800) 245-1150 • Fax (205) 879-1178 • www.behavioralhealthsystems.com

Hospital and Facility Recredentialing Application

Instructions

Please complete all sections of this application. If a section is not applicable, mark it N/A. Please print or type information. If there are any questions, please contact the representative listed in the cover letter accompanying this application. Complete the attached Multiple Practice Location Form, if applicable.

Identifying Information

Hospital/Facility Name	Patient ages treated by facility

DBA Name (If your facility does business under a different name from the facility name listed)

Federal Tax ID Number	National Provider Identification Number	Administrator's/CEO's Name/Title

Facility Type *(Please check all that apply)* ❑ Hospital Unit ❑ Free-standing Psychiatric Hospital ❑ Substance Abuse Facility ❑ Partial Hospitalization Facility ❑ Intensive Outpatient Psychiatric Program ❑ Intensive Outpatient Substance Abuse Program ❑ Mental Health Center ❑ Home Health Agency ❑ Other _____

Physical Address			**Mailing Address**		
Street Address			Address		
City	State	Zip Code	City	State	Zip Code
County	Website		**Claims Address**		
Phone	Fax		Address		
Credentialing Contact:	Phone #		City	State	Zip Code

Mandatory Questionnaire

IMPORTANT: If any of the following questions are answered "Yes", please provide a summary below or attach an explanation for each answer. If any questions do not apply to your facility, please answer "No". **Failure to respond or provide explanations for "Yes" responses may result in delay of application processing.**

Licensure Information

In the last 5 years:

1. Has your facility been censured, reprimanded, or had disciplinary action taken by an ethical standards committee, licensing board, or other board of inquiry, or is any such action currently pending or under investigation? ❑ Yes ❑ No
2. Has your facility voluntarily surrendered its license, had its license revoked, suspended, or limited, or operated under a probationary license or consent agreement? ❑ Yes ❑ No
3. Has your facility been the subject of any investigation by any private, federal, or state health program or is any such action pending? ❑ Yes ❑ No
4. Has your facility's Federal DEA and/or State Controlled Dangerous Substance (CDS) Certificate(s) been voluntarily or involuntarily limited, suspended, revoked, surrendered, or not renewed, or is any such action currently pending? ❑ Yes ❑ No
5. Has your facility lost any accreditation? ❑ Yes ❑ No

Insurance Information

In the last 5 years:

1. Has your facility's professional liability insurance coverage been involuntarily terminated, or modified by action of any insurance company? ❑ Yes ❑ No
2. Has your facility been denied or refused renewal of professional liability coverage, rated in a higher-than-average risk class for its specialty, or had a surcharge relative to claims? ❑ Yes ❑ No
3. Has your facility filed a claim under professional liability insurance, have any suits, actions, or claims alleging malpractice been filed, or are there any pending against your facility? ❑ Yes ❑ No
4. Has your facility filed a claim under general liability insurance, have any suits, actions, or claims been filed, or are there any pending against your facility? ❑ Yes ❑ No
5. Have any judgments been made against your facility in professional liability cases or claims, or has your facility entered into any settlements? ❑ Yes ❑ No
6. To your knowledge, has information pertaining to your facility been reported to the National Practitioner Data Bank or the Healthcare Integrity and Protection Data Bank? ❑ Yes ❑ No

Criminal History		
In the last 5 years:		
1. Has your facility been indicted for, convicted of, or pleaded guilty to a crime, or is your facility presently under investigation for a crime?	❑ Yes ❑ No	
2. Has your facility entered into a consent agreement, entered a plea of guilty, or been found guilty of, fraud or abuse involving payment of health care claims by any health care payor or been sanctioned by any third party payor or health care claims or professional review organization, governmental entity or agency, or is any such action pending?	❑ Yes ❑ No	

Hospital /Facility Attestation and Release of Information

I hereby certify that the information contained herein is true and correct to the best of my knowledge, and acknowledge that any omission or misrepresentation may void this application or be cause for termination of my facility's participation in the Behavioral Health Systems, Inc. (BHS) Network. Further, I give permission to BHS and/or its designee to request information and verify the facility's credentials and by so doing, hereby authorize release of the requested information concerning the facility's licensure and accreditation.

I hereby release all individuals and organizations from any and all liability for providing the requested information.

Facility Officer's Name/Title (Please print or type) **Facility Officer's Signature** **Date**

Please sign and date this application and return with items listed below, if applicable.

- Current copy of applicable accreditation (JCAHO, CARF, etc.)
- Current copy of state license
- Current copy of general and professional liability insurance declarations page(s) (if self-funded, please provide a statement of reserves)