AULTCARE

AULTCARE'S PRIMETIME HEALTH PLAN

FACILITY INFORMATION FORM INSTRUCTIONS

- This form is a request for a facility application. Completing this form does not constitute approval of membership. All requests will go before our committee.
- This form may also be used to update provider information, including, but not limited to, the following:
  - » Facility name
  - » Telephone number
  - » Fax number
  - » Credentialing correspondence information of person to contact for provider updates
  - » Office Manager information update
  - » Facility address change
  - » Facility office hours
  - » Facility ownership
- Legibly complete both pages of this form in its entirety to begin the process.
- Complete all of the form for each location in which you operate.
- Outdated forms will not be accepted.
- Once your request is received, we will review the application to ensure it is complete and includes all required documentation. **All portions of this form are required**.
- If any portion of this form is missing information, we will attempt to contact you once per week for three weeks. As soon as we receive the outstanding information, we will send the application to the next committee meeting. If we are unable to reach out, you would need to re-request again if interested in the future.
- Once the committee has reviewed your request, you will be notified in writing of their decision.
- If approved for application, the credentialing process takes 60-90 days. (Your expediency will streamline this process.)
- Please make sure you include all required documentation, as we will not process requests that are missing required information.
- Once Credentialing is complete, a peer review is conducted.
- If approved through peer review, you will go before a committee for approval of contracts.
- If approved for final membership, note that your panel provider effective date will be after we receive your signed contract. Therefore, you should not be scheduling or seeing AultCare patients until that time.
- Per the Centers for Medicare and Medicaid Services (CMS), we are now required to verify the information contained in our provider files quarterly. This includes verification of information, such as your address, phone number, office hours, email, and affiliated physicians.
- Please submit this form and supporting documentation to one of the following:
  - » Email: credentialing@aultcare.com
  - » Fax: 330-363-6421
  - » Mail: AultCare | Attn: Network Analysis, Credentialing, and Contracting | PO Box 6910 | Canton, OH 44709
- Please submit a copy of your W-9 to providermaintenance@aultcare.com
- If you have additional questions, you may contact the AultCare and PrimeTime Network Analysis, Credentialing, and Contracting Department at 330-363-1400 between the hours of 8:00 am – 4:30 pm EST, Monday – Friday.

OVERALL REASON FOR REQUEST (Check all that apply)

☐ New facility	Effective Date	☐ Add location	Effective Date
☐ Facility Address Change	Effective Date	☐ Billing Address Change	Effective Date
☐ Deleting Facility	Effective Date	☐ Deleting Location	Effective Date
☐ Correspondence Change	Effective Date	☐ Update Information	Effective Date
☐ Other, please explain			

PRACTITIONER INFORMATION

Legal Name of Applicant		
Facility Type		Doing Business As (DBA)
NPI Group Number	Medicare Number or UPIN	Medicaid Number
OH License Number		Accreditations
Additional Comments		

OFFICE INFORMATION (please make additional copies and complete information for each location)

☐ Add location ☐ Delete Location Effective date with this location Location _____ of _____

Does this location take walk-ins? ☐ YES ☐ NO		Does this location provide extended hours? ☐ YES ☐ NO	
Tax ID	Office Name		
Street Address		Suite Number	
City	State	County	Zip Code
Telephone Number		Fax Number	

Business Hours for Location

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Start							
End							
Closed							

Please specify which of the following accessibility options you have for individuals with physical disabilities
☐ ALL ☐ NONE

Handicap accessible parking spaces, curb ramps, or loading zones at building entrance ☐ YES ☐ NO

ASL signage and raised tactile text characters at office, elevator, and restroom doors ☐ YES ☐ NO

Doorways wide enough to ensure safe passage by individuals using mobility aids ☐ YES ☐ NO

Medical equipment accessible to patients using mobility aids ☐ YES ☐ NO

Wheelchair accessible restrooms with grab bars and accessible lavatories ☐ YES ☐ NO

Exam rooms accessible to patients using mobility aids ☐ YES ☐ NO

LOCATION DETAIL INFORMATION

Is this location on an accessible transportation route? ☐ YES ☐ NO	Are you accepting new patients at this location? ☐ YES ☐ NO
If approved, would you like this location to be listed in the directory? ☐ YES ☐ NO	Do you supply translation services for written materials? ☐ YES ☐ NO
Are you a FHQC provider? ☐ YES ☐ NO	Are you an Acute Inpatient Hospital? ☐ YES ☐ NO
Are you a Skilled Nursing Facility? ☐ YES ☐ NO	Do you offer mammography services? ☐ YES ☐ NO
Do you offer Psychiatric Facility Services? ☐ YES ☐ NO ☐ Mental Health ☐ Substance Use Disorder ☐ Eating Disorder	Do you offer PHP? ☐ YES ☐ NO ☐ Mental Health ☐ Substance Use Disorder ☐ Eating Disorder
Do you offer IOP? ☐ YES ☐ NO ☐ Mental Health ☐ Substance Use Disorder ☐ Eating Disorder	Do you offer Residential Behavioral Health Services? ☐ YES ☐ NO ☐ Mental Health ☐ Substance Use Disorder ☐ Eating Disorder
Do you offer orthotics and prosthetics? ☐ YES ☐ NO	Do you offer Durable Medical Equipment? ☐ YES ☐ NO
Do you have a Cardiac Surgery Program? ☐ YES ☐ NO	Do you offer Cardiac Catherization Services? ☐ YES ☐ NO
Do you perform Outpatient Dialysis? ☐ YES ☐ NO	Do you offer Home Health? ☐ YES ☐ NO
Do you offer Lab Services? ☐ YES ☐ NO	Are you a Ryan White HIV provider? ☐ YES ☐ NO
Are you an Indian provider? ☐ YES ☐ NO	Are you a family planning provider? ☐ YES ☐ NO
Other ECP? (explain) _____	Do you have Critical Care Services – Intensive Care Units (ICU)? ☐ YES ☐ NO
Do you offer Outpatient Infusion/Chemotherapy? ☐ YES ☐ NO	Do you perform Diagnostic Radiology? ☐ YES ☐ NO
Do you offer Inpatient Physical Therapy? ☐YES ☐NO (For outpatient physical therapy, please complete a Practitioner Information Form for therapists)	Do you offer Inpatient Occupational Therapy? ☐ YES ☐ NO (For outpatient occupational therapy, please complete a Practitioner Information Form for therapists)
Do you offer Inpatient Speech Therapy? ☐ YES ☐ NO (For outpatient speech therapy, please complete a Practitioner Information Form for therapists)	Do you perform surgical services (outpatient or ASC)? ☐ YES (list surgeries performed below) ☐ NO _____ _____ _____
Do you perform heart/lung transplants? ☐ YES ☐ NO	Do you have a liver transplant program? ☐ YES ☐ NO
Do you have a pancreas transplant program? ☐ YES ☐ NO	Do you have a heart transplant program? ☐ YES ☐ NO
Do you have a kidney transplant program? ☐ YES ☐ NO	Do you have a lung transplant program? ☐ YES ☐ NO
Do you offer inpatient hospice care? ☐ YES ☐ NO	Do you offer outpatient hospice care? ☐ YES ☐ NO
What type of form do you bill on?	
Other services (please describe) ☐ YES ☐ NO	

CONTACTS (Submission of email addresses and signing of this form authorizes us to contact you via email)

Correspondence Contact		
Phone Number	Email Address	
Practice Administrator		
Phone Number	Email Address	
Correspondence address for mailing purposes ☐ Same as office location		
Street Address		Suite Number
City	State	Zip Code
Billing address for remit purposes ☐ Same as office location ☐ Same as correspondence address		
Street Address		Suite Number
City	State	Zip Code

Printed name of person completing this form _____

Signature of person completing this form _____ Date _____