

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
- Please complete both pages of this form in its **entirety** and legibly to begin the process.
- Please fill out all of the form for each location in which you operate.
- Outdated forms will not be accepted.
- Once your request is received, we review the application to make sure 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 you, 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's 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 mail, fax (330) 363-6421 or email, credentialing@aultcare.com this form and supporting documentation to:
AultCare
Attn: Network Analysis, Credentialing, & Contracting
PO Box 6910
Canton, OH 44709
- Please submit a copy of your W9 to ProviderMaintenance@aultcare.com
- If you have additional questions, you may contact the AultCare and PrimeTime Network Analysis, Credentialing, & Contracting department at 330-363-1400 between the hours of 8:00 am to 4:30 pm EST, Monday through Friday.

Overall Reason for Request (check all that apply)			
<input type="checkbox"/> New Facility	Eff Date:	<input type="checkbox"/> Deleting Facility	Eff Date:
<input type="checkbox"/> Add Location	Eff Date:	<input type="checkbox"/> Deleting Location	Eff Date:
<input type="checkbox"/> Facility Address Change	Eff Date:	<input type="checkbox"/> Correspondence Change	Eff Date:
<input type="checkbox"/> Billing Address Change	Eff Date:	<input type="checkbox"/> Update Information	Eff Date:
<input type="checkbox"/> Other	Explanation:		

Practitioner Information	
Legal Name of Applicant	Facility Type
Doing Business As (DBA)	
NPI group Number	
Medicare # or UPIN	Medicaid #
OH License #	Accreditations
Additional Comments:	

Office Information (please make additional copies and complete information for each location)																							
<input type="checkbox"/> ADD Location		<input type="checkbox"/> DELETE Location		Effective date with this location					Location ____ of ____														
Does this location take walk-ins? <input type="checkbox"/> YES <input type="checkbox"/> NO						Does this location provide extended hours? <input type="checkbox"/> YES <input type="checkbox"/> NO																	
Tax ID			Office Name																				
Street Address										Suite #													
City			State			County			Zip														
Telephone #			Fax #																				
BUSINESS HOURS FOR LOCATION (List start & end times)		Monday	Start	End	Tuesday	Start	End	Wednesday	Start	End	Thursday	Start	End	Friday	Start	End	Saturday	Start	End	Sunday	Start	End	
			Closed <input type="checkbox"/>			Closed <input type="checkbox"/>			Closed <input type="checkbox"/>			Closed <input type="checkbox"/>			Closed <input type="checkbox"/>			Closed <input type="checkbox"/>			Closed <input type="checkbox"/>		
Please specify which of the following accessibility options you have for individuals with physical disabilities All <input type="checkbox"/> None <input type="checkbox"/>																							
Handicap accessible parking spaces, curb ramps, or loading zones at building entrance <input type="checkbox"/> YES <input type="checkbox"/> NO						Doorways wide enough to ensure safe passage by individuals using mobility aids <input type="checkbox"/> YES <input type="checkbox"/> NO						Wheelchair accessible restrooms with grab bars and accessible lavatories <input type="checkbox"/> YES <input type="checkbox"/> NO											
ASL signage and raised tactile text characters at office, elevator, and restroom doors <input type="checkbox"/> YES <input type="checkbox"/> NO						Medical equipment accessible to patients using mobility aids <input type="checkbox"/> YES <input type="checkbox"/> NO						Exam rooms accessible to patients using mobility aids <input type="checkbox"/> YES <input type="checkbox"/> NO											

Location Detail Information	YES	NO		YES	NO
Is this location on an accessible transportation route?	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
Are you accepting new patients at this location?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a Ryan White HIV provider?	<input type="checkbox"/>	<input type="checkbox"/>
If approved, would you like this location to be listed in the directory?	<input type="checkbox"/>	<input type="checkbox"/>	Are you an Indian provider?	<input type="checkbox"/>	<input type="checkbox"/>
Do you supply translation services for written material?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a family planning provider?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a FHQC provider?	<input type="checkbox"/>	<input type="checkbox"/>	Other ECP? (explain)	<input type="checkbox"/>	<input type="checkbox"/>
Are you an Acute Inpatient Hospital?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have Critical Care Services – Intensive Care Units (ICU)?	<input type="checkbox"/>	<input type="checkbox"/>
Are you a Skilled Nursing Facility?	<input type="checkbox"/>	<input type="checkbox"/>	Do you offer Outpatient Infusion/Chemotherapy?	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer Mammography services?	<input type="checkbox"/>	<input type="checkbox"/>	Do you perform Diagnostic Radiology?	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer Psychiatric Facility Services?	<input type="checkbox"/>	<input type="checkbox"/>	Do you offer Inpatient Physical Therapy?	<input type="checkbox"/>	<input type="checkbox"/>
• Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	(For Outpatient Physical Therapy, please complete a Practitioner Information Form for therapists)		
• Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
• Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Do you offer PHP?	<input type="checkbox"/>	<input type="checkbox"/>	Do you offer Inpatient Occupational Therapy?	<input type="checkbox"/>	<input type="checkbox"/>
• Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	(For Outpatient Occupational Therapy, please complete a Practitioner Information Form for therapists)		
• Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
• Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Do you offer IOP?	<input type="checkbox"/>	<input type="checkbox"/>	Do you offer Inpatient Speech Therapy?	<input type="checkbox"/>	<input type="checkbox"/>
• Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	(For Outpatient Speech Therapy, please complete a Practitioner Information Form for therapists)		
• Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
• Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Do you offer Residential Behavioral Health Services?	<input type="checkbox"/>	<input type="checkbox"/>	Do you perform surgical services (Outpatient or ASC)?	<input type="checkbox"/>	<input type="checkbox"/>
• Mental Health	<input type="checkbox"/>	<input type="checkbox"/>	List Surgeries Performed		
• Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>			
• Eating Disorders	<input type="checkbox"/>	<input type="checkbox"/>			
Do you offer Orthotics and Prosthetics?	<input type="checkbox"/>	<input type="checkbox"/>	Do you perform Heart/Lung Transplants?	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer Durable Medical Equipment?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Liver Transplant Program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have a Cardiac Surgery Program?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Pancreas Transplant Program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer Cardiac Catheterization Services?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Heart Transplant Program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you perform Outpatient Dialysis?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Kidney Transplant Program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer Home Health?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a Lung Transplant Program?	<input type="checkbox"/>	<input type="checkbox"/>
Do you offer Lab Services?	<input type="checkbox"/>	<input type="checkbox"/>	Do you offer Inpatient Hospice Care?	<input type="checkbox"/>	<input type="checkbox"/>
Other Services (please describe)	<input type="checkbox"/>	<input type="checkbox"/>	Do you offer Outpatient Hospice Care?	<input type="checkbox"/>	<input type="checkbox"/>

Contacts *submission of e-mail addresses and signing of this form authorizes us to contact you via e-mail					
Credentialing Contact	Phone #	Email Address			
Practice Administrator	Phone #	Email Address			
Correspondence address for mailing purposes: <input type="checkbox"/> Same as office location					
Street Address	Suite #	City	State	Zip	
Billing address for remit purposes: <input type="checkbox"/> Same as office location <input type="checkbox"/> Same as correspondence address					
Street Address	Suite #	City	State	Zip	

Printed Name of Person completing this form _____

Signature of Person completing this form _____ Date _____