Rehab Provider Network

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Facility Application

INSTRUCTIONS: This form should be typed or legibly printed in black or blue ink. If more space is needed than provided below, please attach additional sheets & reference the question being answered. One form *per location* must be completed.

FACILITY INFORMATION

Facility Legal Name:			Federal TIN:
Business Name if different from above:			
Physical Street Address:			
City:	State:	Zip:	County:
Phone:	Fax:		Facility NPI:

Type of Organization: ☐ Professional Corp. ☐ Partnership ☐ Limited Liability Co. ☐ Sole Proprietorship ☐ Corporation State:

Practice Owners name(s) and title(s):

Practice Setting: ☐ Free Standing ☐ Hospital-Based Outpatient ☐ Other

CONTRACT ADMINSTRATOR

Administrator's Name:		Title:
Phone:	Email Address:	
Mailing Address:		

BILLING / REMIT INFORMATION

Billing / Remit Street Address:			
City:	State:	Zip:	County:
Billing Contact:	Contact's Phone:		Contact's Fax:
Contact's Email :			
Billing Method: ☐ Manual ☐ Electronic (EDI) EDI Vendor:			

CREDENTIALING INFORMATION

Credentialing Contact:		
Phone:	Fax:	Email:
Credentialing Mailing Address:		

PROFESSIONAL STAFF (PT, OT, SLP *ONLY*) (Please add Additional Sheets of Needed)

Name	Credentials	Individual NPI #	Status
			☐ Full Time ☐ Part Time ☐ Pool
			☐ Full Time ☐ Part Time ☐ Pool
			☐ Full Time ☐ Part Time ☐ Pool
			☐ Full Time ☐ Part Time ☐ Pool
			☐ Full Time ☐ Part Time ☐ Pool
			☐ Full Time ☐ Part Time ☐ Pool

Please list foreign languages spoken by staff:

FACILITY APPLICATION PG. 2

Facility Name: Federal TIN:

PRACTICE INFORMATION
(Please attach copies of all certifications/accreditations/licenses etc.)

Is this facility an approved Medicare provider? ☐ Yes ☐ No *If yes, Medicare #:*	Is this facility an approved Medicaid provider? ☐ Yes ☐ No *If yes, Medicaid #:*
Is this facility JCAHO accredited? ☐ Yes ☐ No *If yes, date of accreditation:*	Is this facility accredited by any other agency? ☐ Yes ☐ No *Please specify:*
Is this facility Handicap accessible? ☐Yes ☐ No	Ratio of professional staff to 'extenders' or 'assistants':
How many new patients can you accept per day?	Current # of patients seen at this location per day?
What is the average wait time in your office?	What is your current wait time for new evals?
What is the average length of a patient's appointment?	

OFFICE HOURS

Mon:	Tues:	Wed:	Thurs:	Fri:	Sat:	Sun:

CLINICAL SERVICES

☐Adult Neuro Rehab
☐AfterCare Program
☐Aquatic Therapy
☐Certified Athletic Training
☐Certified Hand Therapy
☐Fitness Program
☐Isokinetic Testing/Rehab
☐Lymphedema
☐Massage Therapy

☐McKenzie Approach-Certified? ☐Yes☐No
☐Occupational Therapy
☐Oncological Rehab
☐Orthotics ☐ UE ☐LE
☐Pain Management
☐Pediatrics
☐Physical Therapy
☐Social Worker/Vocational Rehab Counselor
☐Speech/Language Therapy

☐Spine Dysfunction Program
☐Sports Medicine Program
☐TMJ
☐Vestibular Rehab
☐Women's Therapy Services
Types:_____
☐Wound Care
☐Others not listed above: _____

INDUSTRIAL SERVICES

☐ Ergonomic & Injury Prevention Training
☐ Function Restoration Program
☐ Functional Capacity Evaluation
☐*Select Med* ☐*BTE*
☐*ErgoScience* ☐*Isernhagen*
☐*Other*
☐ Job Demands Analysis

☐ Office Workstation Evaluation
☐ On-Site Rehabilitation
☐ Procedure and Policy Development
☐ Pre Placement/Post Offer Screens
☐*WorkSTEPS* ☐*BTE*
☐*AEI* ☐*Other*
☐ Program Evaluation & Outcomes Tracking

☐ Return to Work Program
☐ Work Conditioning
☐ Work Hardening
☐*CARF Certified* ☐Yes ☐No
☐ Work Risk Analysis
☐Others not listed above: _____

PROFESSIONAL LIABILITY INFORMATION (Please attach copy of facesheet)

Does the facility carry a professional liability insurance policy? ☐ Yes ☐ No (If no, please provide explanation)

Name of Carrier: Policy Number: Expiration Date:

Mailing Address:

Amount Aggregate: Amount Per Occurrence:

Does this policy cover all professional and support staff? ☐ Yes ☐ No

GENERAL LIABILITY INFORMATION (Please attach copy of facesheet)

Does the facility carry a general liability insurance policy? ☐ Yes ☐ No (If no, please provide explanation)

Name of Carrier: Policy Number: Expiration Date:

Mailing Address:

Amount Aggregate: Amount Per Occurrence:

Facility Name: Federal TIN:

ATTESTATION QUESTIONS/LIABILITY QUESTIONS

***A *"Yes"* ANSWER ON THE FOLLOWING QUESTIONS *REQUIRES AN EXPLANATION ON A SEPARATE PAGE* ***

1. Have there ever been or are there now any state licensing investigations or actions against the facility - or is such action pending?	☐ Yes	☐ No
2. Has the facility ever been denied membership of renewal or been subject to disciplinary action or review proceedings or been reprimanded by any administrative agency, state board, peer review, insurance carrier, professional association, third party administrative company, or network - or is such action pending?	☐ Yes	☐ No
3. Are there any past or currently pending legal actions or decisions against the facility?	☐ Yes	☐ No
4. Have there ever been, or are there now, any claims, judgments pending or paid or suits brought against the facility or a member of the corporation or employees for alleged malpractices, error or omission?	☐ Yes	☐ No
5. Has an insurance company ever canceled, declined coverage or refused to renew the facility's malpractice coverage?	☐ Yes	☐ No

OTHER QUESTIONS

6. Do any practitioners, assistants or other professional caregivers practice or bill from any other location? *If yes, please indicate the location.* _____	☐ Yes	☐ No
7. Does this organization or its owners possess any subsidiaries? *If yes, please list subsidiaries.* _____	☐ Yes	☐ No
8. Do any other businesses use the same Federal Tax ID Number? *If yes, please list businesses.* _____	☐ Yes	☐ No
9. Does any other entity bill for services rendered at this facility? *If yes, please indicate entity.* _____	☐ Yes	☐ No
10. Does this facility include equipment requiring county or state permits (e.g., swimming pool, etc.)? *If yes, please indicate equipment.* _____	☐ Yes	☐ No
11. Are any professionals administering care NOT licensed in the state where employed?	☐ Yes	☐ No
12. Do you sub-contract with any clinical providers? *If yes, please describe.* _____	☐ Yes	☐ No

INFORMATION RELEASE / ACKNOWLEDGEMENT/ CONFIDENTIALITY

All the information submitted in this application is true and complete. I understand that misleading statements or material omissions may constitute cause to reject this application, or if subsequently discovered, to terminate my contract with Rehab Provider Network.

I release from liability all representatives of Rehab Provider Network, any corporate affiliate of such corporation, and all officers, directors, employees, agents and representatives, for their acts performed in good faith and without malice in connection with evaluating the information provided in the Facility Application Form, my credentials and qualifications, and with delivering such information, credentials and qualifications to any third party in the course of business. I release from any liability any individuals organizations who provide information to Rehab Provider Network in good faith and without malice concerning my professional competence, ethics, character and other suspensions, curtailment or privileges by any hospital, or other healthcare provider and by any federal or state licensing or regulatory authority and Rehab Provider Network. I further consent to the release of professional liability, malpractice, or other insurance information to Rehab Provider Network.

_____ _____

Signature (Stamped Signature is not Accepted) Date

Printed Name: _____

Please mail or fax completed application to:

Rehab Provider Network Attn: Judy Gentry 3301 Benson Dr. Ste 135B Raleigh, NC 27609
Fax: (717) 635-3311