Network Participation Request Form
Organizational Provider

Thank you for your interest in joining Piedmont Community Health Plan as a network provider. Please note that completion of this request form and/or credentialing application does not guarantee acceptance or approval to the physician/professional networks administered by Piedmont Community Health Plan (Piedmont).

The credentialing and recredentialing processes encompass a thorough review and validation of an organization's credentials and qualifications based upon NCQA and CMS standards. Piedmont's Medical Affairs Committee reviews the qualifications applicants and reapplicants and makes the final determination regarding provider membership.

The Credentialing Coordinator will notify you once the final determination has been made.

The credentialing process will not officially start until we receive all of the requested information below.

Please note that *full credentialing may take up to 60 days after receipt* of all required information, including completed CAQH.

You have the right to:

- Review information we obtain from outside sources (e.g., malpractice insurance carriers, state licensing boards) to support your credentialing application, except for references, recommendations, and peer-review protected information
- Correct erroneous information
- Receive the status of your credentialing or credentialing application, upon request

You can contact us for further information regarding these rights.

If you have questions, please call Annette Stanley at (434) 947-4463, ext. 317 or contact by email at Annette.Stanley@pchp.net

Please send all the following documents:

- A completed "Network Participation Request Form: Organizational Provider"
- Letter of interest
- Copy of liability insurance
- Copy of accreditation
- Copy of business license

by email to: Annette.Stanley@pchp.net or by mail:

Piedmont Community Health Plan
Attn: Annette Stanley
2316 Atherholt Road
Lynchburg, Virginia 24501

PIEDMONT COMMUNITY HEALTH PLAN

Network Participation Request Form
Organizational Provider

Date Application Information Completed:

I. NETWORKS

Select the networks in which participation of the listed provider is requested:

☑ HMO ☐ PPO ☑ Medicare Advantage PPO

☐ VA Premier -Medicaid *(If you/your group has a current contract with VA Premier do not check this box)*

II. GENERAL INFORMATION

Name:

Facility Type Additional Information is Attached

☐ Ambulatory Surgical Center	☐ Diagnostic Imaging Center	☐ Infusion Therapy
☐ Home Health Agency	☐ Orthotics & Prosthetics	☐ Outpatient Diagnostic Lab
☐ Skilled Nursing Facility	☐ Urgent Care	☐ Sleep Diagnostics
☐ Walk-In Clinic	☐ DME *(check type supplied):* ☐ Medical ☐ Diabetic ☐ Respiratory	
☐ Outpatient Rehab Facility (*Describe Services):*		
☐ Other:		

Facility Services

Please indicate the types(s) of services your facility can provide *(check all that apply).*

☐ Angioplasty	☐ X-ray	☐ Rehabilitation – Inpatient	☐ Obstetrics
☐ Cardiac Cath Service's	☐ Lithotripsy	☐ Rehabilitation – Outpatient	☐ Neonatal
☐ Cardiac Rehabilitation	☐ MRI Services	☐ Skilled Nursing	☐ Pediatrics
☐ Cardiac Rehabilitation	☐ CT Scan	☐ Hospice	☐ Reproductive Health Services
☐ Open Heart Surgery	☐ Oncology services	☐ Home Infusion Services	☐ AIDS Unit
☐ Outpatient Surgery	☐ Radiation Therapy	☐ Emergency Services	☐ Hemodialysis
☐ Psychiatric Services	☐ Organ/Tissue Transplant	☐ Trauma Center	☐ Dialysis
☐ Substance Abuse		☐ Burn Unit	
☐ Other:			

PIEDMONT COMMUNITY HEALTH PLAN

Network Participation Request Form
Organizational Provider

III. PRIMARY FACILITY INFORMATION

Address Line 1:				Phone:	
Address Line 2:				Fax:	
City:		State:	Zip:	Email:	
NPI:				Tax ID:	
State License No.				Medicare Provider No.	
Tax Status and Type of Organization Control:	◯ Public/Government	◯ Private/Non-Profit	◯ Investor/For Profit		
Date Organization Established:		Date Facility Opened:			
Name of Chief Administrator:				Title:	
Name of Contact Person:				Title:	

Billing Address

Check here if Billing Address is the same as the Primary Address listed above.	Address Line 1:				
	Address Line 2:				
	City:		State:	Zip:	

IV. MALPRACTICE INSURANCE

Listed below is your current malpractice carrier on file with Med Advantage. Enclose a copy of your current policy certificate and/or declarations page showing the coverage limits and dates of coverage, even if the policy below has not expired.

Current Carrier (Name and Address)	**Policy Number**	**Dates of Coverage (mm/dd/yy)**	**Coverage Limits**

In the space provided below, list the name and address of the malpractice carrier who has provided coverage for you for the most recent five (5) year period. **If there has been more than one carrier, please indicate the dates of coverage with each carrier, and the reason for changing carriers.**

Current Carrier (Name and Address)	**Policy Number**	**Dates of Coverage (mm/dd/yy)**	**Reason for Changing Carriers**

PIEDMONT COMMUNITY HEALTH PLAN

Network Participation Request Form
Organizational Provider

V. ACCREDITATION			
Type			
☐ Accreditation Association for Ambulatory Health Care (AAACHCC)		☐ American Osteopathic Association (AAA)	
☐ Community Health Accreditation Program (CHAP)		☐ American College of radiology (ACR)	
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)		☐ The Joint Commission (JC)	
☐ Other:		☐ *Not Accredited	
Submit a copy all current accreditation letters and certificates.			
Date of last accreditation review:		Duration of accreditation/next review date:	
Were there any contingencies or significant recommendation(s) from your last survey?		◯ Yes	◯ No
If yes, please describe and submit an action plan for addressing recommendation(s):			
*If not accredited, what is your expected date of accreditation?			

VI. FACILITY REVIEW			
Number of prior judgements or settlements against the facility in the past five years: *(if none, please write "none")*			
Please list, by year, the number of lawsuits in which you were a defendant with allegations of malpractice for the past ten years. Also indicate if a case is pending, or if there was settlement or judgment and the amount of same.			
Historical Information			
Indicate Year or Pending	Number of defenses with allegations of malpractice	Settlement or judgment	Amount
Current Pending Cases			
Number of defenses with allegations of malpractice		Settlement or judgment	Amount
Has the facility had: *(mark all that apply)*			
1. Revocations or suspension as a Medicare and Medicaid provider?		◯ Yes	◯ No
2. Malpractice liability insurance cancellation in the last five years?		◯ Yes	◯ No
3. General liability insurance cancellation in the past five years?		◯ Yes	◯ No
4. State licensing investigations or actions?		◯ Yes	◯ No
If yes, please describe and submit an action plan for addressing recommendation(s):			

Network Participation Request Form
Organizational Provider

VII. QUALITY REVIEW	
1. Are the credentials and/or certifications of professional staff members and admitting physicians verified?	◯ Yes ◯ No
2. Are the credentials and/or certifications of professional staff members and admitting physicians verified biennially thereafter?	◯ Yes ◯ No
3. Is continuing education and/or recertification required of your staff?	◯ Yes ◯ No

VIII. ATTESTATION

All information provided on this application or in connection with this application is complete and accurate to the best of the facility's knowledge. The facility understands that this application does not entitle the facility to participation in client's networks. The facility agrees that it is providing information in good faith, pursuant to this release and shall not be liable for any act or omission related to the evaluation or verification of information contained in the application. All information submitted to Med Advantage by such entities will be treated as confidential. The facility further agrees to notify Med Advantage in a timely manner of any changes to the information provided on the application.

The facility hereby authorizes any accrediting body, governmental entity, association, organization, person or insurance company to release the information requested herein and to provide confirmation of the answers contained herein to the client, or any affiliate or subsidiary of the client. This authorization shall be valid for so long as the facility is a contracted provider. A copy of the signature is as binding as the original.

Signature of Authorized Designee:	
Print Name of Authorized Designee:	
Facility Name:	
Date Signed:	

Completed by (Name):_____

Please return this form by email to: Annette.Stanley@pchp.net or by mail:

Piedmont Community Health Plan
Attn: Annette Stanley
2316 Atherholt Road
Lynchburg, Virginia 24501