



*A Very Special  
Invitation*

FACILITY APPLICATION

## I. FACILITY INFORMATION

**Facility Information:** *Please complete a separate application for each facility.*

Facility Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Federal Tax I.D. No: \_\_\_\_\_ Facility License No: \_\_\_\_\_

State License No: \_\_\_\_\_ Web Site Address: **www.** \_\_\_\_\_

Office Manager Name: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ e-mail: \_\_\_\_\_

Scheduling Mgr. Name: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ e-mail: \_\_\_\_\_

Claims Manager Name: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ e-mail: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone & ext. \_\_\_\_\_ e-mail: \_\_\_\_\_

**Mailing Address** (if different than above)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Billing Address** (if different than above)

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing Business Phone: \_\_\_\_\_ Billing Business Fax: \_\_\_\_\_

Billing Manager: \_\_\_\_\_ ext. \_\_\_\_\_ email: \_\_\_\_\_

Practice Management Billing System Used: \_\_\_\_\_

**Are you ACR accredited for MRI's?**  Yes  No  Eligible \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Ownership:** *Please check Type of Ownership:*

Solo Proprietorship  Partnership  Corporation  Hospital Corporation  Limited Liability Co. (L.L.C.)  Other

Please list the owners of this Diagnostic Facility and the percent of ownership: **(Ownership must equal 100%)**

Last Name, First Name, Middle Initial	Medical License Number	SS Number	% of ownership

## II. SERVICES

**Services:** *Please check all that apply...*

Do you provide transportation for patients to your facility?  Yes  No

MRI  Open  Closed

Ultrasound  Mammography  X-Ray  Fluoroscopy  CT Scan  Nuclear Medicine  PET Scans

Bone Densitometry  Bone Scan  MRA Capability  Other \_\_\_\_\_

Do you provide Sedation?  Yes  No Notes: \_\_\_\_\_

### III. INSURANCE INFORMATION

**General Liability Carrier Name:** \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Coverage Limits: \_\_\_\_\_  
Annual Premium: \_\_\_\_\_ Coverage Dates From: \_\_\_\_\_ To: \_\_\_\_\_  
Type of Coverage  Claims Made  Occurrence

### IV. FACILITY HOURS

#### Facility Hours

Monday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Tuesday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Wednesday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Thursday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Friday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Saturday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Sunday: From: \_\_\_\_\_ To: \_\_\_\_\_

### SCHEDULING DEPARTMENT HOURS

#### Scheduling Department Hours Scheduling Phone

Monday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Tuesday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Wednesday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Thursday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Friday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Saturday: From: \_\_\_\_\_ To: \_\_\_\_\_  
Sunday: From: \_\_\_\_\_ To: \_\_\_\_\_

### V. EQUIPMENT

#### Magnetic Resonance Imaging (MRI)\*:

Make/Model \_\_\_\_\_ Year Manufactured \_\_\_\_\_ Tesla \_\_\_\_\_  
Table Weight \_\_\_\_\_ Software Upgrades \_\_\_\_\_ Coils \_\_\_\_\_

#### Computed Tomography (CT)\*

Make/Model \_\_\_\_\_ Year Manufactured \_\_\_\_\_ Table Weight \_\_\_\_\_

#### Mammography\*

Make/Model \_\_\_\_\_ Year Manufactured \_\_\_\_\_

#### Ultrasound\*

Make/Model \_\_\_\_\_ Year Manufactured \_\_\_\_\_

#### Nuclear Medicine\*

Make/Model \_\_\_\_\_ Year Manufactured \_\_\_\_\_

#### Radiography and Fluoroscopy\*

Make/Model \_\_\_\_\_ Year Manufactured \_\_\_\_\_

Utilizes the following exposure reducing technologies:  Collimation  Grids  Intensifying Screens

### VI. CONFIDENTIAL INFORMATION

1. Have you ever been denied participation in Medicare, Medicaid or any other governmental or quasi-governmental health related program? .....  Yes  No
2. Have you ever been reprimanded, censured, excluded, suspended (even if the suspension was stayed), barred or disqualified from participating in Medicare, Medicaid or any other governmental or quasi-governmental health-related program? .....  Yes  No
3. Have any complaints ever been filed against you by a licensing authority? .....  Yes  No
4. Have you ever been denied professional liability insurance coverage or had your professional liability insurance coverage canceled by your carrier? .....  Yes  No
5. Have you ever been refused participation in the network of a managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization? .....  Yes  No

**Please provide an explanation for any question that you responded "yes" to above on a separate page.**

## VII. ATTESTATION & CREDENTIALS VERIFICATION RELEASE

### AUTHORIZATION / ATTESTATION

I hereby authorize **MedCheck** Credentialing Services, LLC acting as a Credentials Verification Organization (CVO), or its designee on behalf of single or multiple Clients to consult and access databases of hospitals, institutions, malpractice carriers, any town, state or federal agency, any health care organization, and/or The National Practitioner Data Bank, in order to verify information contained in my application and interview and authorize **MedCheck** Credentialing Services, LLC or its designee to review any of my professional records, civil and criminal records and criminal background. I hereby release and indemnify **MedCheck** Credentialing Services, LLC, it's directors, committee members, employees, agents, servants, its subsidiaries and divisions as well as all licensing bodies, hospitals, societies, organizations, state or federal agencies, towns, and associations from all liability resulting from the release of records or information to **MedCheck** Credentialing Services, LLC, or its designee for credentialing and verification of the information contained in my application. I hereby agree to allow **MedCheck** Credentialing Services, LLC, or its designee to examine my place(s) of business and to survey and evaluate all equipment, appointment availability or patient files used in the provision of health care services. I hereby represent that I will obtain, when necessary the appropriate releases from my patients to permit access to their records so that **MedCheck** Credentialing Services, LLC may conduct medical record review. This patient release does not apply to disclosure of confidential information for purposes other than credentialing and verification of the information contained in my application. Notwithstanding the foregoing, I understand that information relevant to my history, performance and the quality and efficiency of patient care that I deliver and/or my credentials may be disclosed to other associations and organizations that contract with **MedCheck** Credentialing Services, LLC. I hereby agree to notify **MedCheck** Credentialing Services, LLC, of any changes in the above information. By my signature, I hereby attest, represent and warrant that all of the information submitted in this provider application is correct, truthful and complete in all respects. I further understand any misstatement, submission of false and/or misleading information or withholding of relevant information may constitute a condition which may not be favorable to my credentialing. I understand and agree that I, as the applicant, have the burden of producing adequate and reliable information for the proper evaluation of my professional competence, character, ethics and other qualifications for resolving any questions about my qualifications. I hereby understand that I shall have the right at my sole cost and expense to review any information gathered by **MedCheck** Credentialing Services, which relates to my behalf. In the event, I believe any of the information to be inaccurate or incorrect, I shall have the right at my expense to contact the source directly and dispute the validity of the information. In the event the source verifies the information to be inaccurate or incorrect, verifying information shall be sent to **MedCheck** Credentialing Services, LLC, thereafter **MedCheck** Credentialing Services, LLC, at its expense shall correct any information found to be inaccurate or incorrect.

(This application will not be processed if not signed and dated. STAMPED SIGNATURES ARE NOT ACCEPTED.)

\_\_\_\_\_  
Owner or Authorized Representative Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Social Security Number

***Please remember to include copies of the following documents with your completed application.***

- Certificate of Facility Insurance (General Liability Insurance)
- Operating License
- Certificate of Need (if applicable)
- Copy of W-9 Form
- American College of Radiology (ACR) Certificate(s)

*Please return this form to:*

**MedCheck Credentialing Services, LLC**

**Two Ridgedale Ave, Suite A-10  
Cedar Knolls, NJ 07927**