AULTCARE

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
- 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- Outdated forms will not be accepted.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
- 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)			
☐ New Facility	Eff Date:	☐ Deleting Facility	Eff Date:
☐ Add Location	Eff Date:	☐ Deleting Location	Eff Date:
☐ Facility Address Change	Eff Date:	☐ Correspondence Change	Eff Date:
☐ Billing Address Change	Eff Date:	☐ Update Information	Eff Date:
☐ 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)			
☐ 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 #
City	State	County	Zip
Telephone #	Fax #		

BUSINESS HOURS FOR LOCATION (List start & end times)	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Start End Closed ☐	Start End Closed ☐	Start End Closed ☐	Start End Closed ☐	Start End Closed ☐	Start End Closed ☐	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	Doorways wide enough to ensure safe passage by individuals using mobility aids ☐YES ☐ NO	Wheelchair accessible restrooms with grab bars and accessible lavatories ☐YES ☐ NO
ASL signage and raised tactile text characters at office, elevator, and restroom doors ☐YES ☐ NO	Medical equipment accessible to patients using mobility aids ☐YES ☐ NO	Exam rooms accessible to patients using mobility aids ☐YES ☐ NO

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

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: ☐ Same as office location				
Street Address	Suite #	City	State	Zip

Billing address for remit purposes: ☐ Same as office location ☐ Same as correspondence address				
Street Address	Suite #	City	State	Zip

Printed Name of Person completing this form ______________________________

Signature of Person completing this form ______________________________ Date________________