| **CPAN (Comprehensive Post Acute Network)**Credentialing Application | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Facility Information** | | | | | | | | | | |
| **Facility Name:** | | | | | | | | | | |
| Facility Address: | | | | | | | | | | |
| City: | | | State: | | | | | ZIP Code: | | |
| Phone: | | | Fax: | | | | | | SNF Beds: | |
| Medicare # | | | Medicaid # | | | | | NPI # | | |
| Tax # | | | County: | | | | | |  | |
| # of Beds: | | | Specialty Unit: | | | | | | Skilled Unit: | |
| List of Counties Served: | | | | | | | | | | |
| **Administrator Name: (include middle initial)** | | | | | | | | | | |
| Phone: | | Fax: | | | | | Email: | | | |
| Years of Service: | | | | |  | | | | | |
| **CPAN Point Person:** | | | | | **Title:** | | | | | |
| Phone: | | Fax: | | | | | Email: | | | |
| **Person Responsible for Letters of Non-Coverage:** | | | | | | | | | | |
| **Name:** | | | | | **Title:** | | | | | |
| Phone: | | Fax: | | | | | Email: | | | |
| **Medical Director’s Name:** | | | | | | | | | | |
| Address: | | | | | | | | | | |
| City: | | State: | | | | | Zip: | | | |
| Phone: | | | | | Fax: | | | | | |
| **Ownership/Corporation Information** | | | | | | | | | | |
| **Name of Ownership/Corporation:** | | | | | | | | | | |
| Address: | | | | | | | | | | |
| City: | | | State: | | | | | ZIP Code: | | |
| Phone: | | | Fax: | | | | | Email: | | |
| **Owner:** | | | | | | | | | | |
| **Chief Executive Officer:** | | | | | | | | | | |
| **Chief Financial Officer:** | | | | | | | | | | |
| **Corporate Contact:** | | | | | Title: | | | | | |
| Phone: | E-mail: | | | | | | | Fax: | | |
| SNF Tax ID for K-1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Corporate Tax ID for K-1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | |
| Address K-1 will be mailed to: | | | | | | | | | | |
| City: | | State: | | | | | Zip Code: | | | |
| **Admissions** | | | | | | | | | | |
| Admissions 24 hours/7 days a week: \_\_Yes \_\_No | | | | | Hours admissions accepted: | | | | | |
| Turnaround time for accepting: | | | | | Turnaround time for denying: | | | | | |
| Competitor: | | | Competitor: | | | | | Competitor: | | |
| **Admissions Representative:** (include middle initial) | | | | | | | | | | |
| Phone: | | | Fax: | | | | | Cell: | | |
| Email address: | | | | | | | | | | |
| Years of Service: | | | | | | | | | | |
| **Billing** | | | | | | | | | | |
| Billing Notices Sent to: SNF or Corporate (Please circle correct location) | | | | | | | | | | |
| **Billing Contact Name:** | | | | | | | | | Title: | |
| Phone: | E-mail: | | | | | | | Fax: | | |
| **List of Services Provided** | | | | | | | | | | |
| **Please circle the list of services you provide** | | | | | | | | | | |
| Accelerated Care Plus | | | | Therapy:  Greater than 5d/wk | | PCA Pumps | | | | Tracheostomy Care |
| Alzheimer Unit:  \_\_\_Secured Unit  \_\_\_Female Unit \_\_\_\_Male Unit | | | | Hospice Care | | Pediatric Service | | | | Transportation for Off-Site Dialysis |
| Aquatic Therapy | | | | Isolation Beds | | Physical Therapy | | | | Ventilator Services |
| Bariatric Over 300 lbs. | | | | IV’s/ Central Lines | | Respiratory Therapy | | | | Vital Stimulation Therapy |
| Bariatric Under 300 lbs. | | | | Occupational Therapy | | Secured Unit Available | | | | WanderGuard\* |
| Behavior Unit :  \_\_\_Secured Unit  \_\_\_Female Unit \_\_\_\_Male Unit | | | | On-site Dialysis | | Smoking | | | | Whirpool Therapy |
| CPAP/Bi-PAP | | | | Orthopedics | | Speech Therapy | | | | Wound Care |
| CVA | | | | Pain Management | | Sub-acute Rehabilitation | | | | Wound Vac. |
| Dementia Unit (\_\_\_\_Female Unit \_\_\_\_Male Unit \_\_\_\_Secure Unit) | | | | Palliative Care | | TPN/Lipid Administration | | | |  |
| Assisted Living Beds # | | | | Adult Day Care | |  | | | |  |
| **List additional services provided:** | | | |  | |  | | | |  |
|  | | | |  | |  | | | |  |
|  | | | |  | |  | | | |  |
| **Request for Credentialing Documents** | | | | | | | | | | |
| Copy of ODH Annual Letter – **Letter of Compliance** | | | | | | | | | | |
| Copy of Hospital **Transfer Agreement** | | | | | | | | | | |
| Copy of **Facility W-9:** Must be signed and dated. Name should clearly identify skilled nursing facilities | | | | | | | | | | |
| Copy of the most recent **Annual State Survey** to include: F,N, K Tags | | | | | | | | | | |
| Copy of **Liability Certificate**: Professional and General Liability coverage. need most current certificate | | | | | | | | | | |
| Copy of Facility **State License Renewal Letter** | | | | | | | | | | |
| Copy of **CLIA Certificate:** Please check the expiration date, need most current | | | | | | | | | | |
| Copy of **Facility State License** | | | | | | | | | | |
| Copy of a **Sample Claim:** Boxes 1, 2 (if different than 1), 5 & 56 completed, must be computer generated or typed | | | | | | | | | | |
| Copy of the **Patient Satisfaction Survey** results that describes the patients number of responses and overall score | | | | | | | | | | |
| Copy of the **Medical Directors CV/Resume** | | | | | | | | | | |
| Clinical Review: Completed and signed by the Medical Director (see attachment) | | | | | | | | | | |
| **Credentialing Process:**  The credentialing process begins once we receive all requested documentation and application. The completed process and contract loading may take up to 90 days. The network will notify you once you have been loaded onto the contract with an effective date.  All referrals that are generated from CPAN contracts will be processed through the network to obtain pre-cert and re-certs through discharge.  An orientation will be provided within the credentialing period for the skilled nursing facility to educate on how to process referrals through the network. | | | | | | | | | | |
|  | | | | | | | | | | |
| **Person Completing Application:** | | | | | | | | | | |
| **Title:** | | | | | | | | | | |
| **Date:** | | | | | | | | | | |