Hospital and Ancillary Facility Application

PARAMOUNT
HMO/PPO, MEDICARE, MARKETPLACE

Please complete all sections of the application that are applicable to your facility. If the application is not complete or if requested documents are not submitted, the application will be returned. **Incomplete applications will not be considered for participation.**

Please submit individual applications for each Tax Identification Number (TIN) and Billing National Provider Identification Number (BNPI) combination. This includes separate applications for CBHC and SUD.

Documents Required (please check box to indicate document is attached)

☐ State License
☐ W-9 Form (The W-9 (http://www.irs.gov/pub/irs-pdf/fw9.pdf) should indicate what location the 1099 should be sent to at the end of the fiscal year, per Tax ID number listed on this application.)
☐ Accreditation Letter(s) and/or Certificate(s) (include CLIA if applicable)
☐ Medical Liability Insurance Documentation
☐ Medicare Certification Letter
☐ Roster of employed practitioners who will provide services

Legal/Organization/Facility Name:							
DBA (Doing Business As) Name:							
TIN:	BNPI:			Type: 1 ☐ 2 ☐		Medicare/PTAN:	
Address:							
City:	State:			Zip Code:			
Website:							
Hours of Operation:	Monday:	Tuesday:	Wednesday:	Thursday:	Friday:	Saturday:	Sunday:
Service Areas (Counties):				Number of Beds:			
Practice/Office website address:				Handicap accessibility?: Select			
Languages spoken by office staff:				Public Transportation (in close proximity?): Select			
Are you currently seeing Paramount members?: Select				Primary Billing Specialty:			
Remittance Information (where you want the payment sent)							
Checks payable to:							
Remittance Address:							
City:	State:			Zip Code:			
Phone:	Fax:			Email (if applicable):			
Accreditation, Licensure, and Certifications							
Accrediting Agency Name:							
Accreditation Status:				Accreditation Date:			
Have you ever been denied accreditation by any accrediting body?: ☐ Yes ☐ No							

If yes, please provide details:	
Do you hold CMS Deemed Status Certification:	Last Survey Date:
License Number and Status:	CLIA Number (if applicable):

Hospital (check all services that apply)		
☐ Acute Inpatient Hospital	☐ Mammography	☐ Urgent Care
☐ Cardiac Surgery Program	☐ Physical Therapy	☐ Residential Behavioral Health
☐ Cardiac Catheterization Services	☐ Occupational Therapy	☐ OP Clinical Behavioral Health
☐ Critical Care Services – ICU units	☐ Speech Therapy	☐ Hospice
☐ Surgical Services (OP or ASC)	☐ Inpatient Psychiatric (Behavioral Health)	☐ Home Health
☐ Skilled Nursing	☐ Outpatient Infusion/Chemotherapy	☐ Inpatient Rehabilitation
☐ Diagnostic Radiology	☐ Emergency Services	☐ Long Term Care

Home Health Agency or Skilled Nursing Facility (check appropriate box and complete the questions below)	
☐ Home Health Agency	☐ Skilled Nursing Facility
CMS Star Rating:	If rating is less than 3 stars, your application will not be considered for credentialing.
Do you admit high risk patients (sex offenders, recovering substance abusers, etc.)?: ☐ Y ☐ N	*If Yes, please include a copy of the policy in place for this location as required per the Ohio Department of Health (ORC 3721.122)

Ancillary Facility (not hospital, home health agency, or skilled nursing facility) check all that apply		
☐ Ambulance	☐ Hospice	☐ Rural Health
☐ Ambulatory Surgical Center	☐ Palliative Care: ☐ Y ☐ N	☐ Speech Therapy
☐ Cardiac Monitoring	☐ Hyperbaric Medicine	☐ Urgent Care
☐ Clinic: Type 2 NPI	☐ Infusion Center	☐ Other
☐ Dialysis Center	☐ Laboratory	☐ Type 2 NPI
☐ Durable Medical Equipment	☐ Occupational Therapy	
☐ Federally Qualified Health Center	☐ Pain Management	
☐ Health Department	☐ Physical Therapy	
☐ Home Infusion	☐ Radiology	

Behavioral Health Providers (complete the questions below)		
Laboratory Services: ☐ Y ☐ N	Submit Lab Claims: ☐ Y ☐ N	
Gender Limitations	Male only ☐ (check box)	Female only ☐ (check box)
Age Limitations	Minimum Age	Maximum Age
Other Practice Limitations	☐ Y ☐ N	If Yes, explain

Contact Information

Who will be designated as the contact person for Paramount relating to **BILLING** issues?

Name: Phone:

Title: Email:

Who will be designated as the contact person for Paramount relating to **CREDENTIALING** issues?

Name: Phone:

Fax:

Title: Email:

Who will be designated as the contact person for Paramount relating to **CONTRACT** issues?

Name: Phone:

Title: Email:

Authorization and Attestation

I am the authorized agent of the Applicant described above and have the authority to execute this document on behalf of the Applicant. I understand that as part of the credentialing application process to participate as a Provider with Paramount Health Care, all Applicants are required to provide sufficient and accurate information for proper evaluation of all criteria used by Paramount for determining initial and ongoing eligibility for Participation. I have verified that the above information is true and complete to the best of my knowledge and agree to inform Paramount promptly if any material change in such information occurs, whether before or after my entering into an agreement with Paramount for the provision of medical services.

Document Prepared by: Signature:

Title: Date:

Phone Number:

Please return completed application and contract by email to:

Paramount Health Care

P.O. Box 928

Toledo, OH 43697-0928

PHCProvider.Contracting@MedMutual.com (email)

Attention: Provider Contracting Department