IOWA STATEWIDE
UNIVERSAL FACILITY APPLICATION
ATTACHMENT WORKSHEET

This worksheet is intended to provide you with additional information that may be required to be submitted with or attached to your Iowa Statewide Facility Application. Credentialing entities to which you are applying will require some or all of the following documents to be submitted with this application. Some entities require originals, copies or notarized copies. This list may not be all-inclusive. A specific list of required documents is available from the entity to which you are applying or providing credentialing information.

Documents that may be required:

Copy of Malpractice Insurance Face Page

Original Federal W-9 Tax Identification Form

Copy of Quality Assurance Plan

You should contact the entity to which you are providing the Iowa Statewide Facility Application for additional information on any documents that will be required.

IOWA STATEWIDE
UNIVERSAL FACILITY APPLICATION

Name: _____
(Please print full name of facility)

FOR: ☐ **INITIAL CREDENTIALING**

☐ **RECREDENTIALING**

☐ **OTHER**

- **Type or print responses in ink.**
- **Complete this form in its entirety and attach all requested documentation and explanations.**
- **If a question does not apply to your facility, answer with "Non-Applicable" or "NA".**
- **If additional space is necessary to provide answers, attach additional sheet(s) of paper.**
- **All dates must be formatted as: Month/Date/Year (MM/DD/YYYY).**

THIS APPLICATION MUST BE SIGNED AND DATED WHERE INDICATED

SECTION A: PROVIDER INFORMATION:

Type of Provider: (*Choose all that apply*)

☐ Ambulance

☐ Ambulatory Surgery Center

☐ Birthing Center

☐ Community Mental Health Center

☐ Dialysis Center

☐ Durable/Home Medical Equipment Supplier

☐ Free Standing Substance Abuse Facility

☐ Home Health Agency

☐ Home Infusion Therapy

☐ Hospice

☐ Hospital
- ☐ Acute Care
- ☐ Critical Access

☐ Independent Laboratory

☐ Magnetic Resonance Imaging Center

☐ Orthotics & Prosthetics Supplier

☐ Radiology Center (X-Ray)

☐ Skilled Nursing Facility

☐ Other: _____

Is your facility ADA accessible? …… ☐ Yes ☐ No

SECTION B: **DEMOGRAPHIC INFORMATION:**

(Please provide appropriate information for all your services/locations.)

Facility Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

Contact Person (*the person you wish us to contact regarding information on this application*):

Contact Name: _____ Title: _____

Phone Number: (_____)_____ Fax Number: (_____)_____ Email Address: _____

SECTION C: **PAYMENT/BILLING INFORMATION:**

Facility Name: _____

Street Address: _____

City: _____ County: _____ State: _____ Zip Code: _____

Phone Number: (_____)_____ Fax Number: (_____)_____

NPI #: _____ Tax Identification Number: _____ (Please provide an Original Federal W-9 tax identification form)

Billing Contact Name: _____ Phone #: (_____)_____

Quality Assurance Contact: _____ Phone #: (_____)_____

SECTION D: **OWNERSHIP/MANAGEMENT:**

President /CEO
Name: _____ Title: _____ Phone #: (_____)_____

CFO
Name: _____ Title: _____ Phone #: (_____)_____

Medical Director
Name: _____ Title: _____ Phone #: (_____)_____

SECTION E: **ACCREDITATION/CERTIFICATION/LICENSURE {See (A.) or (B.) below}:**

Agency	License or Certification or Accreditation Number *(if applicable)*	Last Review /Renewal	Expiration Date
Accrediting Association for Ambulatory Healthcare			
American Board of Certification			
American College of Radiology			
American Institute of Ultrasound in Medical OB & Abdominal Ultrasound			
American Osteopathic Association			
Chemical Dependency Certificate			
Clinical Laboratory Improvement Act			
College of American Pathologists			
DEA Registration			
Department of Health and Human Services			
FDA Mammography Facility Certification			
Joint Commission			
Medicaid			
Medicare			
State Controlled Substance Certificate			
State License			
State Nuclear/Radioactive Materials License			
State Radiological Registration			
The Rehabilitation Accreditation Commission			
Others (*please list*)			

A. Please provide a copy of these documents as applicable, including the results of the survey and a report that shows the effective dates of accreditation or certification, deficiencies, and approved plan for corrective action.

B. If not accredited or certified, please note where you are in the process of obtaining accreditation or certification and by what date you expect to complete the process. _____
_____

C. Hospice providers – If not licensed, please provide copy of most recent CMS survey.

SECTION F: **LIABILITY COVERAGE:**

A. In the space provided, list your liability carrier and the dates of general liability coverage to include month, day and year of beginning coverage and expiration date.

Current Carrier: _____

Agency Name: _____

City: _____ State: _____ Phone #: (_____)_____

$ Amount Per Occurrence: _____ $ Amount Aggregate: _____

Dates of Coverage: From:_____ /_____/_____ To:_____/_____/_____

List any privileges/procedures which are excluded or restricted under your current policy. Be specific. If none, click this box. ☐

_____

_____

_____

B. Please check the appropriate answer for the following questions:

	Yes	No
1. Have you ever had a liability case brought against you?	☐	☐
2. Have any judgments ever been brought against you in a liability case?	☐	☐
3. Have any settlements ever been made on your behalf?	☐	☐
4. Are there any open claims or cases presently filed against you?	☐	☐

If you answered "Yes" to a question, explain on a separate sheet. Explanations should include a concise summary of all pertinent facts, dates, and current status or disposition.

SECTION G: **ADDITIONAL INFORMATION:**

Please answer all of the questions, explaining any "Yes" answers on the space provided below.

A. In the past five years:

	Yes	No	NA
1. Has the corporation, an officer or a board member ever been convicted of a felony?	☐	☐	
2. Has your State License *(if applicable)* ever been denied, suspended or revoked for any reason?	☐	☐	☐
3. Has your DEA Registration or State Controlled Substance Certificate *(if applicable)* ever been denied, suspended, or revoked for any reason?	☐	☐	☐
4. Have you ever been subjected to sanctions by a Professional Review Organization *(PSRO or PRO)*, the Medicare/Medicaid Program, a Third Party Payor, or a Regulatory agency *(CLIA, OSHA, etc.)*?	☐	☐	

Explanation:

_____

_____

_____

SECTION H: **MALPRACTICE HISTORY:**

A. In the past five years:

	Yes	No
1. Has this facility's professional liability insurance coverage ever been denied or cancelled?	☐	☐
2. Has this facility's current or previous professional liability carrier ever made an out of court settlement or paid a judgment of a professional liability claim on the facility/service behalf?	☐	☐
3. Is or has the facility ever been involved in a malpractice suit(s), grievance(s) filed with a county or state medical society or licensing agency, or arbitration(s) proceeding(s)?	☐	☐

If you answered "Yes" to any of the above three questions, please supply a claims summary from your malpractice carrier.

SECTION I: **CERTIFICATION AND RELEASE:**

SECTION J: **CERTIFICATION AND RELEASE OF THE INDIVIDUAL PREPARING THE APPLICATION:**

SECTION K: **HOSPITAL ADDENDUM** *(Complete only if you are a hospital provider)*:

A. Beds

Total Licensed Bed Capacity: _____ Total Number of Medicare Certified Beds: _____

B. Services Available

- ☐ Air Ambulance
- ☐ Alcohol/Chemical Dependency
  - ☐ Inpatient
  - ☐ Outpatient
  - ☐ Adolescent
- ☐ Alzheimer's Diagnosis and Assessment
- ☐ Birthing Rooms
- ☐ Blood Bank
- ☐ Burn Unit
- ☐ Cardiac Care Unit
- ☐ Cardiac Rehab Program
- ☐ CT Scanner
- ☐ Diabetic Education Program
- ☐ Dialysis
- ☐ Geriatric Services
- ☐ Home Health Services
- ☐ Home Infusion
- ☐ Hospice
- ☐ Hospital Based Ambulance
- ☐ Intensive Care Unit
- ☐ Lithotripsy
- ☐ MRI Scanner
- ☐ Neonatal ICU
- ☐ Nuclear Medicine
- ☐ Nursery
- ☐ Nursing Facility
- ☐ Obstetrics
- ☐ Occupational Therapy
  - ☐ Inpatient
  - ☐ Outpatient
- ☐ Open Heart Surgery
- ☐ Organ Transplant
  - ☐ Specify _____
- ☐ Outpatient Surgery
- ☐ Pain Management
- ☐ Pediatrics
- ☐ PET Scanner
- ☐ Physical Therapy
  - ☐ Inpatient
  - ☐ Outpatient
- ☐ Psychiatric Services
  - ☐ Inpatient
  - ☐ Outpatient
  - ☐ Pediatric
  - ☐ Adolescent
- ☐ Radiation Therapy
- ☐ Speech Pathology
  - ☐ Inpatient
  - ☐ Outpatient
- ☐ Tissues Transplant
- ☐ Trauma Facility/ER Dept.
  - ☐ Resource
  - ☐ Regional
  - ☐ Area
  - ☐ Community
- ☐ Ultrasound
- ☐ Urgent Care Center
- ☐ Ventilator Care –Long Term
- ☐ Residential Day Care
- ☐ Skilled Nursing Facility
- ☐ Sports Medicine
- ☐ Swing Bed Program

Other Services: _____

Are there services provided off-campus that would fall under the hospital outpatient billing and Tax ID? ☐ Yes ☐ No
If yes, please list these services, names, and locations: *(use additional sheet if necessary)* _____
_____
_____
_____

Are there any other certified facilities based at your hospital and if so, what are they (i.e., home health, hospice, skilled nursing, dialysis)? _____
_____
_____
_____

Do you contract with any facility or provider group to provide services at the hospital? If so, what are the services, i.e., radiology, MRI, lab, ER, anesthesiology, DME, reference lab) _____
_____
_____
_____

SECTION L:

DURABLE/HOME MEDICAL EQUIPMENT & ORTHOTIC AND PROSTHETIC SUPPLIERS ADDENDUM *(Complete only if you are a DME or O&P provider)*:

A. Categories of Services

Which of the following services do you provide?

1. DME
   - ☐ Respiratory
   - ☐ Orthotics
   - ☐ Medical Equipment and Supplies
   - ☐ Urological Supplies
   - ☐ Prosthetics

2. Critical Care
   - ☐ Mechanical Ventilators
   - ☐ Parenteral
   - ☐ Bi-Pap
   - ☐ Enteral

3. Rehabilitation (Customer fabricator of products):
   - ☐ Wheelchairs
   - ☐ Power wheel chairs
   - ☐ Prosthetics
   - ☐ Orthotics
   - ☐ Other (please specify):

4. Medical Equipment Repair/Service
   - ☐ Repair/Service of Medical Equipment by Certified, Licensed or Technically Trained Personnel

Please provide a description of services you provide that are not listed above: _____
_____

Do you provide emergency maintenance or back-up equipment? ☐ Yes ☐ No
If yes, please explain your process: _____
_____
_____

B. Permit/License Information

Please provide the following permit/license numbers and a copy of the license as applicable.

Agency	**License or Certification or Accreditation Number *(if applicable)***	**Last Review /Renewal**	**Expiration Date**
Retail Sales Tax Permit Number			
Wholesale Drug License Number			
Household Hazardous Materials Retailers Permit Number			

C. Service Area

Please describe your service area: _____
_____
_____

Please provide information regarding any limitation of services due to geographic reasons: _____
_____
_____

Wellmark Blue Cross and Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association.

Wellmark, Inc.
Statewide Universal Facility Application Addendum

If you are interested in contracting with Wellmark, Inc. doing business as Wellmark Blue Cross and Blue Shield of Iowa or any of its affiliates, Wellmark of South Dakota, Inc. doing business as Wellmark Blue Cross and Blue Shield of South Dakota, or Wellmark Health Plan of Iowa, Inc., (collectively, "Wellmark") for participation in any Wellmark network, please complete and submit this application addendum. In its sole discretion, Wellmark reserves the right not to process or accept a provider's application for any Wellmark network and to determine a provider's participation in a Wellmark network.

ADDITIONAL DOCUMENTATION TO INCLUDE:

CMS Approval Letter: hospital, hospice, skilled nursing facility, dialysis center, home health agency, ambulatory surgery center, freestanding substance abuse facility, rural health clinic, federally qualified health center, home infusion therapy

SECTION M. ADDITIONAL LOCATION INFORMATION

What is the effective date to perform services for Wellmark members? _____

Scheduling Phone Number _____ TDD Phone Number (hearing impaired) _____

Date of your most recent on-site CMS Survey or State Survey? _____/_____/_____

SECTION N. PROVIDER IDENTIFICATION NUMBERS

Enter your Organizational National Provider Identifier (NPI) number.

Acute Hospital _____
Ambulance _____
Ambulatory Surgery Center _____
Community Mental Health Center _____
Dialysis _____
Durable Medical Equipment _____
Federal Qualified Health Centers _____
Freestanding Radiology _____
Home Health Agency _____
Home Infusion Therapy _____
Hospice _____
Independent Lab _____
Orthotic and Prosthetic _____
Psychiatric Medical Institutes for Children _____
Psychiatric _____
Public Health Agency _____
Rehab _____
Skilled Nursing _____
Sleep Center _____
Specialty Hospital _____
Swing-bed _____
Urgent Care Center _____
Visiting Nurse Association _____
Other: _____

SECTION O. LIABILITY INSURANCE

Wellmark needs liability information to cover your effective date and also when you are credentialed by Wellmark. If the liability information on page 5 of this application doesn't cover both of those dates, please complete the information below.

Carrier Name _____ City / State _____

Policy Number _____

$ Amounts Per Occurrence _____ $ Amounts Aggregate _____

Date from *(mm/dd/yyyy)* _____/_____/_____ Date to *(mm/dd/yyyy)* _____/_____/_____

SECTION P. AMBULANCE

What services do you provide (mark all that apply)? ☐ Air Ambulance ☐ Ground Ambulance

SECTION Q. DURABLE MEDICAL EQUIPMENT SUPPLIER

If you do not have the ability to bill CMS, please explain on the last page.

SECTION R. HOME INFUSION THERAPY

To determine eligibility, please e-mail: providercredentialing@Wellmark.com

SECTION S. INDEPENDENT LABORATORY

What level of CLIA certification does the lab have? ☐ Accreditation ☐ Compliance

SECTION T. ORTHOTICS/PROSTHETICS

What services do you provide (mark all that apply)? ☐ Orthotics ☐ Prosthetics ☐ Mastectomy ☐ Ocularist

SECTION U. PUBLIC HEALTH AGENCY

As a Public Health Agency, are you designated as such by the County Board of Supervisors or Board of Health?
☐ Yes ☐ No

SECTION V. SLEEP CENTER

Is the Medical Director Board Certified in Sleep Medicine ☐ Yes ☐ No

SECTION W. URGENT CARE CENTER

Do you meet the Urgent Care Center network participation requirements as stated in the Wellmark, Inc. Credentialing and Network Participation section of the Provider Guide? ☐ Yes ☐ No
The Wellmark, Inc. Credentialing and Network Participation section of the Provider Guide can be found at: http://www.Wellmark.com/Provider/CommunicationAndResources/PDFs/S5780_ContractsandCredentialingProviderGuide.pdf

SECTION X. VISITING NURSE ASSOCIATION

As a Visiting Nurse Association, are you a member of the Visiting Nurse Association of America? ☐ Yes ☐ No

SECTION Y. CONTACT INFORMATION

Directory Validation E-Mail
This e-mail will be used to validate Wellmark Provider Directory information
E-Mail Address _____

Credentialing Contact
This e-mail will be used as contact for provider credentialing questions and to send the recredentialing application.
Credentialing Contact E-mail _____
Credentialing Contact Name (first and last) _____
Credentialing Contact Address, City, State and Zip Code _____
Credentialing Phone number (_____) _____

Notifications
This e-mail will be used to send electronic confirmation communication.
☐ Check here if the below is the same as the Credentialing Contact
Primary Contact E-mail _____
Primary Contact Name (first and last) _____
Primary Contact Phone number (_____)_____

SECTION Z. WELLMARK CERTIFICATION AND RELEASE

Certification and Release
I understand that any information entered on the Wellmark, Inc. Statewide Universal Facility Application and Addendum that subsequently is found to be false could result in immediate dismissal from any Wellmark, Inc. network.

I hereby certify that the information contained in this addendum is accurate, true and complete. I authorize release of information as may be required by Wellmark, Inc. to process this application.

My signature on this application does not constitute a contract with Wellmark, Inc. By signing this application, I authorize Wellmark, Inc. to release that information to Wellmark, Inc. subsidiaries and affiliates.

Authorized Signature _____ _____/_____/_____
Date *(mm/dd/yyyy)*

Authorized Person's Name and Title (please type or print) _____

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application.
- You may correct any erroneous information found in your credentialing file.
- You will be notified of any information collected during the credentialing process varies substantially from the information you submitted.

Send any corrections or requests to : providercredentialing@Wellmark.com

Provider Agreements

Wellmark will send the Provider Agreement(s) to you by email through DocuSign® to review, complete, and sign. DocuSign allows you to sign the Provider Agreement(s) electronically in a safe, secure, and legally binding environment. With DocuSign there are no minimum system requirements, installation, application download, or log in necessary.

Submission Status Tracker

The Submission Status Tracker is a tool for tracking provider credentialing, recredentialing applications and change requests online in real-time. Status information is available by submitting the provider's National Provider Identifier (NPI) number. In addition, you are able to see Wellmark's average processing time overall. The Submission Status Tracker is located at Wellmark.com: http://www.Wellmark.com/Provider/CredentialingandEnrollment/SubmissionTracker.aspx

Wellmark.com registration:

Once you have received a notification letter indicating your network effective date, you are considered a participating provider and you can then complete the registration process to obtain secure access to Wellmark.com. There are many time-saving self service tools and resources available to you upon registration. Learn more about these tools and complete the registration by going to Wellmark.com (Provider>Working with Wellmark.com).

ADDITIONAL INFORMATION: