Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

Radiology Center Assessment Tool (RCAT)

Please complete this form for each site location and return with all required documentation to:

Horizon Blue Cross Blue Shield of New Jersey
Attention: Network Programs Department
3 Penn Plaza East, PP-14N
Newark, NJ 07105-2200

Or fax all documentation to Horizon BCBSNJ's Network Programs Department at **1-732-938-1386**.
If you have questions, please call the Network Programs Department at **1-973-466-8215**.

Revised 10/15/2012

Please attach the following documents to this RCAT (applicable to your provider type).

SITE REQUIRED DOCUMENTS (as applicable):

___ Copy of the Premises Liability Coverage face sheet for each site (minimum $1/3 million).

___ Copy of the Professional Liability Insurance for Non-Physicians/Technicians.

___ Copy of a completed W-9 for each site.

___ Copies of the National Provider Identifier (NPI) notification(s) for each provider and site.

___ Copy of the site's NJDEP/Radioactive Materials License if providing Nuclear Medicine, PET or Radiation Therapy services.

___ Copy of The Joint Commission (TJC) certification for hospital based sites.

EQUIPMENT REQUIRED DOCUMENTS (as applicable):

___ Copy of NJDEP Radiation Producing Machine Registration Application for all ionizing radiation equipment: X-ray, Fluoroscopy, DXA, CT, Mammography, PET, PET/CT and Stereotactic Breast Biopsy.

___ Copy of NJDOHSS for each site that performs CT, MRI, PET and PET/CT.

___ Copy of current accreditation for the following equipment as specified below:

- CT: ACR or ICACTL accreditation for all devices.
- MRI: ACR or ICAMRL accreditation for all devices.
- Breast MRI: ACR or ICAMRL accreditation for all devices.
- Mammography: FDA/MQSA certificate and ACR accreditation for all devices.
- Stereotactic Breast Biopsy: ACR accreditation for all devices.
- Nuclear Medicine/Nuclear Cardiology: ACR or ICANL accreditation for all devices.
- PET: ACR or ICANL accreditation for all devices.
- PET/CT: ACR or ICANL accreditation for all devices.
- Ultrasound: ACR, AIUM, or ICAVL accreditation for all devices.
- Ultrasound Guided Biopsy: ACR or AIUM accreditation for applicable body region for all devices.
- Breast Ultrasound: ACR or AIUM accreditation for all devices.
- Echocardiography: ICAEL accreditation for all devices.
- Radiation Therapy: ACR or ACRO accreditation for all devices.

Note: Any new or newly added equipment must provide ACR or accrediting agency certification six (6) months from first clinical use, or modality privileges will be deactivated.

___ Copy of current State/Physicist inspection for the following and any corrective action taken for deficiencies:

- CT
- DXA (Bone Densitometry)
- Fluoroscopy
- General X-ray
- MRI
- Mammography
- PET/CT (only for CT portion)

___ Copy of the Image Gently (www.imagegently.com) and Image Wisely (www.imagewisely.com) confirmation form for CT, Fluoroscopy and General X-ray.

___ Submit a statement from your physicist that your CT, Fluoroscopy and General X-ray scanner(s) and scan protocols meet the requirements of the Image Gently and Image Wisely Program.

This form is designed to evaluate the modalities and scope of services performed and in no way constitutes an agreement or contract for services to be performed.

1.	Is your facility/group currently participating with Horizon BCBSNJ?	☐ Yes ☐ No
If yes, please provide tax identification number:		
A. Is this an additional site to the hospital practice or joint venture with hospital?		☐ Yes ☐ No
If yes, please provide tax identification number if different than hospital:		
B. Is this an additional site to an existing radiology center?		☐ Yes ☐ No
C. Is this an additional modality to an existing radiology center or hospital practice?		☐ Yes ☐ No
If answer to 1.C is yes, please list modalities and first clinical use date:		
2.	Is this a new request for participation with Horizon BCBSNJ?	☐ Yes ☐ No
If yes, please provide tax identification number:		
Please note: radiology centers may only bill globally.		

I. FACILITY/SITE INFORMATION

A.

Corporate or Hospital Name (if applicable):		Tax Id #:	
Facility/Site Name:		Tax Id #:	
D.B.A. Name:		Tax Id #:	
Street Address:			
City, State & Zip:			
County:		Number of years at this address:	
Telephone:	( )	Fax:	( )
Website:			
Medicare #:		NPI #:	

Type of facility:

☐ Freestanding Radiology Imaging Center ☐ Hospital Owned Freestanding Radiology Imaging Center

☐ Hospital-Based Off Site Ambulatory Care Facility ☐ Hospital (Outpatient Department)

☐ Hospital Satellite Emergency Department (SLED) ☐ Ambulatory Surgery Center

☐ Radiation Therapy Center (Freestanding) ☐ Radiation Therapy Center (Hospital Based Outpatient)

☐ Cardiology office performing Nuclear Cardiac Imaging

☐ Mobile Provider ☐ Other Practice Specialty (list): _____

C. Owner Information (required):

Name:		Tax ID#:	
Address:			
Phone:	( )	Fax:	( )

D. Operational structure (check all that apply):

☐ Corporation ☐ Limited Liability Company ☐ Government ☐ Partnership

☐ Professional Corporation ☐ Sole Proprietorship ☐ Subsidiary ☐ Faculty Practice Plan

☐ Not-for-Profit Corporation ☐ Limited Liability Partnership

If more than one box is checked, please explain:

If subsidiary box is checked, please provide name and address of the parent company:	

E. Physicians. List all physicians who practice at this site and their relationship to this site, e.g., shareholder, partner, member, employee. Please list board certification status of each physician and, if board eligible, date of initial board eligibility (attach additional sheet if needed). Not required for hospital based sites.

List each physician:	**Physician # 1**	**Physician # 2**	**Physician # 3**	**Physician # 4**	**Physician # 5**
First name:					
Last name:					
Specialty:					
State:					
License number:					
NPI #:					
Relationship:					
Board certified?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
If yes, name of board:					
If no, date eligible:					
Fellowship training in:					
If yes, location and date:					

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II. PROFESSIONAL GROUP INFORMATION (If you outsource the PC component to a radiology group for interpretations i.e., virtual reads or other group, please complete this section.)

Group Name:			
Street Address:			
City, State & Zip:			
County:		Number of years at this address:	
Telephone:	( )	Fax:	( )
Website:			
Tax ID #:		Medicare #:	
NPI #:			

F. Ownership Status/ Business Affiliations

1) If any item of equipment is leased, from whom?

☐ Bank ☐ Hospital ☐ Leasing company

☐ Full-time equipment ☐ Turnkey facility lease ☐ Per diem/Facility lease

☐ Facility lease/equipment manufacturer

☐ Other physician group (explain):_____

☐ Other (explain): _____

2) Does your practice lease or own its office space? ☐ Lease ☐ Own

If leased, from whom? _____

☐ Commercial landlord ☐ Hospital ☐ Members of your own group

☐ Other physician group (explain): _____

☐ Other (explain): _____

3) Do any physicians who make referrals to your practice have any of the following financial relationships with your practice:

a. Have an ownership or other financial interest in any of the equipment utilized by your practice?
☐ Yes ☐ No

b. Have an ownership or other financial interest in any of the office space utilized by your practice?
☐ Yes ☐ No

c. Have any form of compensation arrangement with your practice (e.g., provide medical, consulting, administrative, billing)?
☐ Yes ☐ No

4) Is the facility shared with any other physician, physician group or other legal entity?
☐ Yes ☐ No

G. Exams performed on site (check all that apply):

Primary Imaging	Advanced Imaging
☐ General X-ray ☐ Digital ☐ Analog (Film Screen) ☐ Fluoroscopy ☐ C-Arm ☐ Interventional Radiology ☐ MRI Guided Breast Biopsy ☐ CT Guided Biopsy ☐ Fluoroscopic Guided Biopsy ☐ Stereotactic Guided Biopsy ☐ Ultrasound ☐ Breast Ultrasound ☐ Breast Ultrasound Guided Biopsy ☐ General Body ☐ Obstetrical ☐ Gynecological ☐ Musculoskeletal ☐ Vascular ☐ Ultrasound Guided Biopsy ☐ Thyroid ☐ Masses ☐ Other _____ ☐ Echocardiography ☐ Transthoracic Echocardiography ☐ Stress Echocardiography ☐ Transesophageal ☐ Pediatric Echocardiography ☐ Mammography ☐ Digital Mammography ☐ Film Screen Mammography (Analog) ☐ Computer Aided Detection (CAD) ☐ Stereotactic Breast Biopsy (Attachment to Mammography Unit) ☐ Stereotactic Breast Biopsy (Prone Biopsy Table or Stand Alone) ☐ Full Field Digital Mammography ☐ Digital Breast Tomosythesis ☐ DXA (Bone Densitometry)	☐ Closed MRI ☐ Short Bore ☐ Open MRI ☐ Head ☐ Spine ☐ Body ☐ Musculoskeletal (MSK) ☐ MRA ☐ Neuro ☐ Breast MRI ☐ MRI Spectroscopy ☐ Cardiac MRI ☐ Functional MRI ☐ Stand-up MRI ☐ PET ☐ PET/CT Combined Unit ☐ Cardiac PET ☐ CT ☐ CTA ☐ Cardiac CTA ☐ Nuclear Medicine ☐ General Body (Planar Imaging) ☐ SPECT (Single Photon Emission Computerized Tomography) ☐ Nuclear Cardiology ☐ Other (please list.) _____ _____ _____

H. Radiation Therapy Equipment on site (check all that apply):

☐ 3-D CRT	☐ SRS	☐ SBRT	☐ IMRT
☐ CEBRT	☐ IGRT	Other (explain):	

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I. Billing Address, Contact Names, Telephone Numbers, E-mail Addresses:			
Billing Address:			
City, State & Zip:			
Billing Manager:		Phone # :	
Email:			
Medical Director:		Phone# :	
Email Address:			
Office Manager:		Phone # :	
Email Address:			
Credentialing Manager:		Phone # :	
Email Address:			

J. Days and Hours of Operation:

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
a.m.							
p.m.							

K. Physician Site Coverage:

A board certified radiologist must be immediately available to supervise cases, and/or respond to requests for protocol alterations by the technologist 100% of the time that any site is in operation. All contrast studies must be performed under the direct supervision of a board certified radiologists, or a NJ licensed physician trained in knowledge and treatment of contrast reactions.

Is a board certified radiologist immediately available? ☐ Yes ☐ No

L. Critical Operating Policies/ Procedures

Policy:	
Quality Improvement Plan	☐ Yes ☐ No ☐ NA
Emergency Cart Policy	☐ Yes ☐ No ☐ NA
Nuclear Medicine Spills Policy	☐ Yes ☐ No ☐ NA
Film Labeling Standards	☐ Yes ☐ No ☐ NA
Written techniques/protocols for each individual study.	☐ Yes ☐ No ☐ NA
Film Processor Maintenance Policy	☐ Yes ☐ No ☐ NA
Blood Borne Pathogen Compliance Policy and Procedure	☐ Yes ☐ No ☐ NA
Incident Reporting Policy	☐ Yes ☐ No ☐ NA
Fire and Disaster Plan	☐ Yes ☐ No ☐ NA
Patient Drug Reaction Policy	☐ Yes ☐ No ☐ NA

Results Reporting Policy	☐ Yes ☐ No ☐ NA
Radiation Safety	☐ Yes ☐ No ☐ NA
Quality Control Plan for each piece of equipment.	☐ Yes ☐ No ☐ NA
Chemical Hazards Safety Plan	☐ Yes ☐ No ☐ NA
Complaints Policy and Procedures	☐ Yes ☐ No ☐ NA
Electronic Medical Records	☐ Yes ☐ No ☐ NA
HIPAA Policies	☐ Yes ☐ No ☐ NA
Image Gently/Image Wisely Policy	☐ Yes ☐ No ☐ NA

III. EQUIPMENT - DESCRIPTION, STANDARDS AND CAPABILITIES

If your facility operates more than one of the following pieces of equipment, please complete a copy of this section for EACH system as well as for each machine.

A. Magnetic Resonance Imaging (If more than one machine, this section must be completed for each unit).

ACR or ICAMRL accredited? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

DICOM compatible:	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	
Date of last software upgrade: _____		Number of channel parallel processing: _____	
Is this the primary device?	☐ Yes ☐ No	If yes, is it peripheral only?	☐ Yes ☐ No
Used for cardiac?	☐ Yes ☐ No	If yes, EKG gating:	☐ Yes ☐ No
Field strength:		Gradient strength:	Slew rate:

☐ Open ☐ Fixed ☐ Stand-up ☐ Closed ☐ Short Bore

☐ Table weight capacity (pounds): _____ ☐ No stand-up, but has weight-bearing device.

☐ Mobile (If Mobile, days of week available):_____

Check all that apply:
☐ Staffed by licensed, registered technologist(s).
☐ Spectroscopy
☐ Functional MRI
☐ MRA. If MRA, list anatomic sites:_____
☐ 3-D Imaging
☐ Sedation available on site.
☐ Diffusion Weighted Imaging

Breast MRI provided:	☐ Yes ☐ No	Bilateral capability:	☐ Yes ☐ No

MRI Guided Breast Biopsy: ☐ Yes ☐ No If Breast MRI is provided but not MRI guided breast biopsy, please identify the site where patients are referred to for MRI guided breast biopsy:

_____

List coils:

Additional comments:			
B. Computerized Tomography (If more than one machine, this section must be completed for each unit).			
ACR or ICACTL accredited? (Attach certificate.) ☐ Yes ☐ No ☐ In process - application tracking number: _____			
NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible:	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Slices per rotation:		Number of detectors:	
Check all that apply: ☐ 3-D reformation ☐ Biopsy capability ☐ Bone Densitometry ☐ CT Perfusion ☐ Colonography ☐ Colonoscopy			
Cardiac CT: (only if CT is 64 slices or more)	☐ Yes ☐ No	CTA: (only if CT is 16 slices or more)	☐ Yes ☐ No
Staffed at all times by licensed, registered technologist(s)? ☐ Yes ☐ No			
Additional comments:			
C. Mammography (If more than one machine, this section must be completed for each unit).			
ACR accredited and FDA certified? (Attach certificate.) ☐ Yes ☐ No ☐ In process - application tracking number: _____			
NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible:	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Staffed by mammography certified technologist(s)? ☐ Yes ☐ No			
Check all that apply: ☐ Stereotactic biopsy ☐ Needle localization ☐ Computer aided detection ☐ BIRADS Lexicon and report structure			
Do you utilize a processor dedicated just for mammography use? ☐ Yes ☐ No			

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D. Digital Mammography (If more than one machine, this section must be completed for each unit).

ACR accredited and FDA certified? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible:	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	

Staffed by mammography certified technologist(s)? ☐ Yes ☐ No

Check all that apply:
☐ Stereotactic biopsy ☐ Needle localization
☐ Computer aided detection ☐ BIRADS Lexicon and report structure.
☐ Tomothesis

E. Stereotactic Breast Biopsy (If more than one machine, this section must be completed for each unit).

☐ **Prone Biopsy Table or** ☐ **Stand Alone**

ACR accredited? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible?	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	

Staffed by mammography certified technologist(s)? ☐ Yes ☐ No

Check all that apply:
☐ Stereotactic biopsy ☐ Needle localization ☐ Other: _____

Do you utilize a processor dedicated just for mammography use? ☐ Yes ☐ No

F. Full Field Digital Mammography (If more than one machine, this section must be completed for each unit).

ACR accredited? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible?	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Staffed by mammography certified technologist(s)? ☐ Yes ☐ No			
Please list any additional capabilities:			

G. Digital Breast Tomosyntheses (If more than one machine, this section must be completed for each unit).

ACR accredited? (Attach certificate.)

☐ Yes ☐ No ☐ In process - application tracking number: _____

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible?	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Staffed by mammography certified technologist(s)? ☐ Yes ☐ No			
Please list any additional capabilities:			

H. DXA (Bone Densitometry) (If more than one machine, this section must be completed for each unit).

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible:	☐ Yes ☐ No	☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Capable of performing lumbar spine, hip and forearm studies?			

Fan Beam: ☐ Yes ☐ No		Pencil Beam:	☐ Yes ☐ No
Equipment is staffed at all times by a: ☐ Licensed RT ☐ Physician			
Additional comments:			

I. Nuclear Medicine ☐ **Nuclear Cardiology** ☐
(If more than one machine, this section must be completed for each unit).

ACR or ICANL accredited for Nuclear Medicine? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

ACR or ICANL accredited for Nuclear Cardiology? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible: ☐ Yes ☐ No	☐ Single Head Detection or ☐ Dual Head Detection		
Nuclear camera:	☐ Mobile ☐ Stationary non-SPECT ☐ Stationary SPECT		
Manufacturer:		Number of Detectors:	
Model number:		Model description:	
Date manufactured:		Serial Number:	
Date installed:			
Collimator (check as applicable):	☐ LEHR Low Energy ☐ Medium Energy ☐ High Energy		

Check all that apply:
☐ Cardiovascular nuclear medicine (cardiac nuclear imaging).
☐ Generalized SPECT studies.
☐ Staffed at all times by licensed, registered nuclear medicine technologist(s).

Quality Assurance Requirements: Automatic integral and field uniformity (computed) < 5% Spect:	☐ Yes ☐ No
COS (center of rotation) and floods (computed) < 1-2 pixels:	☐ Yes ☐ No
Date of last Jazczak Phantom acquisition: _____	

J. PET or PET/CT (If more than one machine, this section must be completed for each unit).
☐ Stand Alone PET or ☐ PET/CT Combined Unit

ACR or ICANL accredited? (Attach certificate.)
☐ Yes ☐ No ☐ In process - application tracking number: _____

NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible: ☐ Yes ☐ No		☐ Fixed ☐ Mobile	
Manufacturer:		Model number:	

Model description:		Serial number:	
Date Manufactured:		Date installed:	
Date of last software upgrade: _____		Date of last Phantom Acquisition: _____	
Is PET utilized without CT? ☐ Yes ☐ No		# Slices per rotation:	
Do you use fusion software imaging? ☐ Yes ☐ No		If yes, fusion with: ☐ CT ☐ MRI	
Date of last fusion software upgrade: _____	Sodium iodide detector system: ☐ Yes ☐ No	Cardiac PET: ☐ Yes ☐ No	

K. Ultrasound (If more than one machine, this section must be completed for each unit).

ACR or AIUM accredited? (Attach certificate.)

☐ Yes ☐ No ☐ In process - application tracking number: _____

DICOM compatible: ☐ Yes ☐ No		☐ Fixed ☐ Mobile ☐ Portable (within office only)	
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	
Date of last software upgrade: _____		Utilizes state of-the-art technology: ☐ Yes ☐ No	

Check all that apply:

☐ 4 MHz (abdomen, renal, pelvic, OB aorta)
☐ 7 MHz Linear (vascular)
☐ 7 MHz Curved (pediatric abdomen, renal and pelvic)
☐ 8MHz (endovaginal)
☐ 12 MHz – 14 MHz Linear breast, thyroid, testicular)
☐ 9.0 MHz (endorectal)
☐ Breast Ultrasound
☐ Carotid
☐ Color doppler
☐ Echocardiography
☐ P/V
☐ Biopsy
☐ 3-D/4-D
☐ Recording to film or electronic media
☐ Other:_____

Staffed at all times by ARDMS-certified sonographer(s)? ☐ Yes ☐ No

Additional comments:

L. General X-ray (If more than one machine, this section must be completed for each unit).

NJDEP Registration # :		NJDEP Facility # :	
DICOM compatible: ☐ Yes ☐ No	☐ Fixed ☐ Mobile	☐ Digital ☐ Analog (Film/Screen)	
Manufacturer:		Model number:	
Model description:		Serial number:	

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Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Staffed at all times by licensed, registered technologist(s)? ☐ Yes ☐ No			
Automated Exposure Control Unit: ☐ Yes ☐ No			
Additional comments:			
Combined X-ray/Fluoroscopy Unit?: ☐ Yes ☐ No If yes, please complete Fluoroscopy section.			

M. Fluoroscopy (C-ARM) (If more than one machine, this section must be completed for each unit).			
NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible? ☐ Yes ☐ No			
Manufacturer:		Model number:	
Model description		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Staffed at all times by licensed, registered technologist(s)? ☐ Yes ☐ No			
Additional comments:			

N. Interventional Radiology (If more than one machine, this section must be completed for each unit).			
NJDEP Registration #:		NJDEP Facility #:	
DICOM compatible? ☐ Yes ☐ No			
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Tube serial #:	
Date installed:		Date of last software upgrade: _____	
Please list procedures performed: _____			
Staffed at all times by licensed, registered technologist(s)? ☐ Yes ☐ No			
Additional comments:			

O. Radiation Therapy (CT Simulation should be documented under CT section.)	
External Beam Radiation Therapy:	
ACR or ACRO accredited? (Attach certificate.) ☐ Yes ☐ No ☐ In process. Date of application: _____	
DICOM compatible? ☐ Yes ☐ No	☐ Fixed ☐ Mobile

Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	
Date of last software upgrade: _____		Staffed, at all times by licensed, registered radiation therapist(s)? ☐ Yes ☐ No	

Techniques: (check all that apply)
☐ 3-D CRT ☐ SRS ☐ SBRT ☐ IMRT ☐ CEBRT ☐ IGRT

Devices:
☐ MLC Multi-leaf Collimator ☐ Other: _____

Capabilities:
☐ 3-D Positional Tracking Gating ☐ 3-D Surface Tracking ☐ Other: _____

Workstation/ Workplace Console:

Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	

Proton Beam Radiation Therapy:

ACR or ACRO accredited? (Attach certificate.)
☐ Yes ☐ No ☐ In process. Date of application: _____

DICOM compatible? ☐ Yes ☐ No ☐ Fixed ☐ Mobile

Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date of last software upgrade:	

Staffed, at all times by licensed, registered radiation therapist(s)? ☐ Yes ☐ No

Workstation/ Workplace Console:

Manufacturer:		Model number:	
Model description:		Serial number:	
Date Manufactured:		Date installed:	

Neutron Beam Radiation Therapy:

ACR or ACRO accredited? (Attach certificate.)
☐ Yes ☐ No ☐ In process. Date of application: _____

DICOM compatible? ☐ Yes ☐ No

Manufacturer:		Model number:	
Model description:		Serial number:	

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Date manufactured:		Date installed:	
Date of last software upgrade:		☐ Fixed ☐ Mobile	
Staffed, at all times by licensed, registered radiation therapist(s)? ☐ Yes ☐ No			
Workstation/ Workplace Console:			
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	

Internal Radiation Therapy or Brachytherapy/ HDR:			
ACR or ACRO accredited? (Attach certificate.) ☐ Yes ☐ No ☐ In process. Date of application: _____			
DICOM compatible? ☐ Yes ☐ No			
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	
Date of last software upgrade:		☐ Fixed ☐ Mobile	
Staffed at all times by licensed, registered radiation therapist(s)? ☐ Yes ☐ No			
Techniques (check all that apply): ☐ 3-D CRT ☐ SRS ☐ SBRT ☐ IMRT ☐ CEBRT ☐ IGRT			
Devices: ☐ MLC Multi-leaf Collimator ☐ Other: _____			
Capabilities: ☐ 3-D Positional Tracking Gating ☐ 3-D Surface Tracking ☐ Other: _____			
Workstation/ Workplace Console:			
Manufacturer:		Model number:	
Model description:		Serial number:	
Date manufactured:		Date installed:	

Horizon BCBSNJ's Diagnostic Radiology Quality Standards can be viewed online by

- Visiting the website: www.HorizonBlue.com/Providers.
- Under the *I Want To* section, Click *See Reference Materials*.
- Click the *Utilization Management* link.
- Read the Medical Policy disclaimer and click the statement: *If you have read and agree with the previous statement, you may access Horizon BCBSNJ's Medical Policies by clicking HERE.*
- Within the Medical Policy Manual that displays, click the *Section* tab and then click *Radiology.*

This form is designed to evaluate the modalities and scope of services performed and in no way constitutes an agreement or contract for services to be performed.

- The list is sorted alphabetically. Scroll down for the document entitled: *Standards for Diagnostic Radiology/Imaging Facilities/Freestanding-Office including Surgi-Centers and Diagnostic Dental – Radiographic Imaging.*

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND CORRECT.

Authorized signature: _____
(Medical Director or authorized person)

Name: (please print): _____

Title: _____ Date: _____