ORGANIZATION/FACILITY CREDENTIALING/RECREDENTIALING APPLICATION

Indicate type of organization:

- ☐ Acute Care Hospital
- ☐ Behavioral Health Care Facility
  - ☐ Ambulatory
  - ☐ Inpatient
  - ☐ Residential Treatment Facility for Behavioral Health Care
  - ☐ Residential Treatment for Substance Abuse
  - ☐ Methadone Maintenance Program
  - ☐ Chemical Dependency Program/Facility
- ☐ Clinical Laboratory
- ☐ Comprehensive Outpatient Rehabilitation Facility (CORF)
- ☐ End Stage Renal Disease Provider
- ☐ Free-Standing Surgical Center
- ☐ Home Health Agency
- ☐ Hospice
- ☐ Occupational Therapy Provider
- ☐ Physical Therapy Provider
- ☐ Portable X-Ray Supplier
- ☐ Skilled Nursing Facility/Nursing Home
- ☐ Speech Pathology Provider
- ☐ Urgent Care Center

Required Documentation:

- Accreditation certificate(s)
- If not accredited, copy of last state or Medicare survey
- State license (as applicable)
- Professional and general liability certificates of insurance;
  minimum coverage of $1 million occurrence/$3 million aggregate; and
  minimum coverage of $3 million occurrence/$5 million aggregate for hospitals
- If self insured, send proof of insurance and limits of coverage
- W-9 form

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Demographics *(If the facility operates more than two patient sites (inpatient or outpatient), please indicate additional demographic information on a separate piece of paper.)*

Address (1):

Facility Name:

Facility Type:

Address:

City:	State :	Zip Code:
Phone Number	Fax Number:	
Federal Tax ID Number:	NPI Number:	
Contact Name:	Contact Title:	
Contact Phone Number:	Contact Email Address:	

Contact Address (if different from above):

City:	State:	Zip Code:

Address (2):

Facility Name:

Facility Type:

Address:

City:	State :	Zip Code:
Phone Number	Fax Number:	
Federal Tax ID Number:	NPI Number:	
Contact Name:	Contact Title:	
Contact Phone Number:	Contact Email Address:	

Contact Address (if different from above):

City:	State:	Zip Code:

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Licensure/Accreditation/Certification:

License Number:	License Expiration Date:	License Type:

Is your license in good standing with the State? ☐Yes ☐ No

Have you ever had any action taken against your license? ☐Yes ☐ No

Medicare certified? ☐Yes ☐ No	Medicare Certification Number:

Is your Medicare certification in good standing? ☐Yes ☐ No

Has your participation in Medicare ever been suspended or denied? ☐Yes ☐ No

Last Medicare survey date:

Joint Commission Accreditation? ☐Yes ☐ No* If yes, last survey date:

Are you accredited by any other agency? If yes, last survey date:

Name of accrediting agency:

*For non-accredited facilities, please provide the most recent copy of your state and/or Medicare survey. The survey must include any identified deficiencies and corrective plan(s), if applicable.

If a state or Medicare survey has not been completed, you will be contacted by a Kaiser Permanente representative to conduct a site visit.

Insurance/Claims

Professional Liability Insurance Carrier Name:

Dates of Coverage From : To:	Level of coverage: /

General Liability Insurance Carrier Name:

Dates of Coverage From : To:	Level of coverage

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AUTHORIZATION/ATTESTATION:

I hereby submit this application for credentialing/re-credentialing in the Provider Network administered by Kaiser Permanente of the Mid-Atlantic States (KPMAS) and understand that this application will be reviewed based on the information I have provided here. I certify that the information and documentation provided is true and correct, and that this facility is in good standing with all applicable state, federal and other regulatory agencies.

I understand that any information found to be false could result in denial or subsequent termination of this facility's membership in the KPMAS network. I am an officer of the above named organization with the authority to provide KPMAS the requested information, documentation and to execute this attestation.

By the signature below, I hereby attest to the accuracy, validity and completeness of the information and documentation.

Printed Name and Title:

Signature:

Date:

Return Initial Applications to:
Kaiser Permanente
Regional Office- Contracting 2 East
2101 East Jefferson Street
Rockville, MD 20852

Return Re-credentialing Applications to:
Kaiser Permanente
Regional Office-PPQA 6-West
2101 East Jefferson Street
Rockville, MD 20852
Email: ppqa-mas@kp.org