



COLORADO PHYSICAL THERAPY NETWORK

CPTN CLINIC CREDENTIALING CHECK LIST

1)	<input type="checkbox"/>	COMPLETED CLINIC MEMBERSHIP APPLICATION
2)	<input type="checkbox"/>	PHOTOCOPY OF GENERAL LIABILITY INSURANCE FACE-SHEET
3)	<input type="checkbox"/>	PHOTOCOPY OF PROFESSIONAL LIABILITY INSURANCE COVERAGE FACE-SHEET
4)	<input type="checkbox"/>	W-9 FORM (ENCLOSED)
5)	<input type="checkbox"/>	JOB DESCRIPTIONS FOR THERAPY ASSISTANTS AND AIDES
6)	<input type="checkbox"/>	COMPLETE LIST OF EQUIPMENT
7)	<input type="checkbox"/>	EQUIPMENT CALIBRATION DATE REPORT
8)	<input type="checkbox"/>	EXPLANATION OF ANY "YES" ANSWERS ON QUESTIONS 9-16 IN OWNERSHIP SECTION
9)	<input type="checkbox"/>	COPY OF WHICHEVER IS APPLICABLE: A) PARTNERSHIP AGREEMENT B) ARTICLES OF OPERATING AGREEMENTS C) ARTICLES OF INCORPORATION AND BYLAWS
10)	<input type="checkbox"/>	COPY OF LEASE
11)	<input type="checkbox"/>	COPY OF FIRE INSPECTION
12)	<input type="checkbox"/>	CREDENTIALING CHECK LIST IS COMPLETE AND INCLUDED FOR EACH THERAPIST BEING CREDENTIALIED
13)	<input type="checkbox"/>	\$1380 ANNUAL MEMBERSHIP FEE - CAN BE ASSESSED ON A MONTHLY OR A QUARTERLY BASIS

****ABOVE INFORMATION MUST BE COMPLETED AND RETURNED FOR EACH FACILITY BEING CREDENTIALIED BEFORE CPTN WILL PROCESS THE APPLICATION****



COLORADO PHYSICAL THERAPY NETWORK

Membership Guidelines

OWNERSHIP

The clinical business is unequivocally, principally (51%) owned and controlled by a Physical Therapist, Occupational Therapist, Speech Language Pathologist or a combination thereof.

There must be no monetary gain, directly or indirectly, by any referral source

INSURANCE AND MALPRACTICE

Minimum malpractice/liability insurance of \$1 million/3 million

All owners, partners and employees are covered by malpractice/liability insurance.

LEGAL

All employees are covered by Worker's Compensation insurance. The business is covered for property damage and premises liability.

The facility is in compliance with all federal, state and local laws and regulations.

All professional therapists practicing at the facility are in compliance with all applicable national and state laws and regulations.

The clinical staff practice is in compliance with all state laws governing the practice of Occupational, Physical and Speech therapy, including laws of incorporation.

Each of the clinic's clinical staff must hold a current Colorado Physical Therapy License, or a current Colorado Occupational Therapy License, or CCCSP. No clinical staff member shall have engaged in conduct subject to disciplinary action by the State of Colorado as set forth in the Physical Therapy Practice Act. Further, no clinical staff member shall have engaged in conduct subject to disciplinary action of his or her professional organization's ethical standards (or equivalent) committee or board.

Each CPTN approved therapist in the facility shall sign a statement agreeing to be bound by the *CPTN Provider Agreement*.

PHYSICAL PLANT

The physical plant is in compliance with all state and local fire, safety and building codes.

The clinic provides functional, safe, sanitary surroundings for patients, personnel and the public.

The facility provides 500 square feet of working space per therapist (exception: home health).

Parking and accessibility to buildings are adequate for the facility's caseload and meet state and federal requirements.

Equipment and space plan are adequate for the facility's caseload.

There is evidence of annual calibration of equipment.

There is evidence of policy and implementation of infection control.

Hand washing facilities are adequate.

Work surfaces, floors, and linens are clean.

Lighting is adequate.

STANDARDS OF CARE

The physical, occupational therapist or speech pathologist provides the majority of direct patient care.

The ratio of physical therapists to assistants and aides is in compliance with the Colorado State Physical Therapy Practice Act.

Assistants do not evaluate patients or initiate or change treatment programs.

Aides do not evaluate patients, initiate or change treatment programs, carry independent patient loads, perform Level II procedures as described by Workers' Compensation RVS.

Aides work only under the on-site supervision of the therapist.

The professional staff has adequate time for each patient. Time is allowed for initial evaluation and treatment (30 to 60 minutes) and the average number of patients scheduled per therapist does not exceed two (2) per hour.

Patient's initial appointment is scheduled promptly as is appropriate for his/her diagnosis.

The facility has a flexible scheduling process for appointments.

Treatment usually begins within 10 minutes of the patient's scheduled appointment.

The patient's need for privacy is met.

There is evidence of continuity of care (The patient is rarely or only occasionally treated by a substitute therapist)

All therapists upon initial application to CPTN will provide documentation to show satisfactory evaluation of five (5) CPTN patients. Failure to comply with this will result in non-credentialing. The therapist may reapply for membership and must again meet this evaluation review.

All professional staff possess current knowledge and skills as evidenced by professional development such as continuing education, teaching, publications, research, etc.

CPTN approved therapists are encouraged to be members of the APTA, AOTA, or ASHA.

All professional staff engage in ongoing professional development activities.



General Information

Clinic Name _____
Address _____ How Long? Years _____ Months _____

Phone: () _____ FAX: () _____
Registered Trade Name _____
Billing Address _____ Office Manager _____

On-Site Clinical Supervisor _____
Previous Address? _____ How Long? Years _____ Months _____

Identifying Numbers: Anthem (BC/BS) _____ CCIA _____ Other _____
Tax ID#: 1) _____ 2) _____ 3) _____

Malpractice Information

Please attach a photocopy of malpractice insurance for all therapists, assistants, and aides in your clinic

1. Has there ever been any claim or complaint filed with a government agency or made in a lawsuit against the clinic or the practice of physical therapy?
Yes _____ No _____
2. CPTN requires a minimum of \$1,000,000 each incident / \$3,000,000 aggregate malpractice liability for each practicing therapist. Is your malpractice insurance in compliance?
Yes _____ No _____
3. Are all owners, partners and employees who participate in patient care covered by malpractice insurance?
Yes _____ No _____

Employee Information

Please complete and enclose the CPTN therapist application form for each therapist in your clinic who will be providing services to CPTN patients.

1. How many therapists are practicing at this clinic? ____ Part-time (up to 30 hrs/week) ____ Full-time (over 30 hrs/week)
2. How many therapy assistants/aides are employed at this clinic? ____ Part-time (up to 30 hrs/week) ____ Full-time (over 30 hrs/week)
3. Please attach a copy of the job responsibilities/description of therapy assistants/aides in your clinic

Facility Information

1. What is the square footage area of the clinic? _____
2. List treatment focus programs _____
3. Is your clinic wheelchair accessible? ____ Yes ____ No
4. Describe parking availability and accessibility to your clinic _____
5. Attach a list of equipment in your clinic. _____
6. Attach your records of the most recent equipment calibration survey.
7. Attach a copy of the most recent fire inspection.

Ownership Information

1. Identify by name, address and phone number the persons, partners, or corporations who now or will in the future have a financial interest in the form of loans or equity ownership in the business for which membership is requested.

NAME

HOME ADDRESS

% OWNERSHIP

2. Is the clinic owned as a partnership? ___ Yes ___ No If yes, attach a copy of the partnership agreement.
3. Is the applicant a statutory limited liability company** ___ Yes ___ No If yes, identify all members and manager by name, address and type of interest. Attach a copy of the articles of organization and operating agreement. (** A newly authorized form of doing business as a corporation that is treated as a partnership for tax purposes)
4. Is the applicant a corporation? ___ Yes ___ No If yes, identify all officers, directors, and shareholders by name, address and %age of interest. Attach a copy of articles of incorporation and bylaws with the officer/director/shareholder lists.
5. Does the applicant have legal possession of the premises by: a) ownership ___; b) lease ___; c) other ___ If lease, please supply copy of lease. If other, please supply explanation. If owned, please supply a deed copy.
6. Does the applicant receive the benefit of any financial assistance or support in the operation of its business, directly or indirectly, from any person, partnership, corporation or company? ___ Yes ___ No If yes, please specify:

7. Have you or has any other professional at your facility, in any jurisdiction, ever had a license to practice therapy denied, revoked, suspended, voluntarily relinquished, modified or restricted in any way? ___ Yes ___ No
8. Have any claims, complaints or suits ever been legally upheld against you, or any others in the facility, with respect to professional conduct, duties or obligations? ___ Yes ___ No
9. Has your membership, or the membership of any other professional at your facility, in any professional society, organization or association, ever been denied, suspended, terminated or threatened, or is any such action pending? ___ Yes ___ No
10. Have you, or any associate or employee at your facility, ever been investigated by Medicare or Medicaid for violation of their statutes, rules or regulations? ___ Yes ___ No
11. Within the last three years have you, or any business associate affiliated with your facility, made an assignment for the benefit of creditors, filed a petition in bankruptcy, had a petition in bankruptcy filed against you or had a receiver appointed over a substantial amount of your assets?
___ Yes ___ No
12. Has the facility operated under a different business name within the last three years? ___ Yes ___ No If yes, please supply explanation.
13. Is the facility owned, managed or controlled by or otherwise affiliated with a CPTN member or applicant? ___ Yes ___ No
14. Do you or any other professional at the facility have an agreement, written or oral, with any person, organization or institution for the referral of patients to your clinic? ___ Yes ___ No If yes, please supply explanation.

Membership Guidelines

1. Physical therapist (s) must own a controlling interest in a private practice physical therapy clinic.
2. All services must be rendered under the exclusive control and supervision of physical therapist (s).
3. Except for fees paid to CPTN, the member clinic must be entitled to payment of all compensation from CPTN patients or their third party payor for services rendered.
4. The clinic shall be independently operated without subsidization from any source in cash, or kind, including but not limited to discounted rental or free use of space, equipment or personnel and discounted or interest free loans.
5. No patient referral source may receive any compensation, directly or indirectly, from the clinic.

I hereby authorize CPTN to verify any information contained in this document and authorize it to inspect and review any of my professional and related business records.

I hereby agree to hold harmless and indemnify CPTN, its officers, directors, committee members, employees, agents and representatives from and against all claims, liability and costs (including reasonable attorney's fees) resulting from or arising out of any and all claims, suits or legal or equitable proceedings initiated, brought, pursued or made by me or my employees, agents or representatives in connection with or relating to CPTN's review, evaluation and final determination of my application, credentials, qualifications and records.

I hereby further authorize and consent to the release, upon written request to CPTN, of information to hospitals, medical associations and other medically related organizations and relevant agencies; and I hereby release from any liability any and all individuals and organizations who provide information to CPTN in good faith and without malice as provided hereunder.

I hereby swear the information supplied is accurate to the best of my knowledge.

Signature of Applicant

Date

Signature of Applicant

Date

Signature of Applicant

Date

Signature of Applicant

Date

Attachments

1. Photocopy of malpractice insurance for all employees who participate in patient care.
2. Applications for all CPTN therapists.
3. Job description for therapy assistants and aides.
4. Equipment list.
5. Equipment calibration date report.
6. Information indicated by "d" responses.
7. Copy of whichever is applicable:
 - A) Partnership Agreement
 - B) Articles and Operating Agreements
 - C) Articles of Incorporation and Bylaws
8. Lease.
9. Copy of fire inspection.

Request for Taxpayer Identification Number and Certification

**Give form to the
requester. Do not
send to the IRS.**

Print or type See Specific Instructions on page 2.	Name	
	Business name, if different from above	
	Check appropriate box: <input type="checkbox"/> Individual/ Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other ▶	
	<input type="checkbox"/> Exempt from backup withholding	
	Address (number, street, and apt. or suite no.)	
City, state, and ZIP code		
List account number(s) here (optional)		
Requester's name and address (optional)		

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

Social security number
+

or

Employer identification number
+

Note: If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

Sign Here

Signature of
U.S. person ▶

Date ▶

Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

U.S. person. Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee.

Note: If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Foreign person. If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515**, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien.

Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.



CPTN

C O N T R A C T I N F O R M A T I O N

Beech Street

Acquired by MultiPlan – CPTN retains contract with Beech Street – over next 2 years will likely move to MultiPlan

Anthem Blue Cross/ Blue Shield

Moratorium on new clinic adds by Anthem in urban areas

Rocky Mountain Health Plans

TheraMatrix/ Ford Motor Co.

MedRisk

GEHA/PPO USA Network

Contract termination eff. 12/31/10 – merge with United HealthCare

Cigna Healthcare

Great-West Healthcare

7/01/10 – Merge with CIGNA effective

Cofinity (the old Sloans Lake)

Colorado Access

FOCUS Healthcare

In contract discussions with Coventry Health Care

CorVel Corp.

Universal SmartComp

First Choice of the Midwest

Devon Health Services