SIERRA HEALTH AND LIFE & HEALTH PLAN OF NEVADA

Credentialing Department, Mail Stop 2720-4
P.O. Box 15645
Las Vegas, NV 89114-5645
Fax: (702) 242-6781

APPLICATION FOR INSTITUTIONAL PROVIDERS

1. IDENTIFYING INFORMATION

_____

BUSINESS/INSTITUTION NAME

_____

ADDRESS OF BUSINESS/INSTITUTION **CITY** **STATE** **ZIP**

ADDRESS OF ADMINISTATIVE OFFICES **CITY** **STATE** **ZIP**

PHONE **FAX** **email:**

_____

NAME OF ADMINISTRATOR RESPONSIBLE FOR INSTITUTION LICENSING AND ACCREDITATION

_____

LIST ALL OWNERS OF YOUR AGENCY/FACILITY, AND ANY NAME CHANGES OR PAST NAMES FOR THIS FACILITY

_____

NPI Number

SERVICES PROVIDED

2. LICENSING AND CERTIFICATION

MEDICARE/MEDICAID NUMBER:_____ **TAX ID NUMBER:** _____

*PLEASE ATTACH PROOF OF MEDICARE ELIGIBILITY, SUCH AS A LETTER FROM HCFA/CMS.

SERVICES YOU BILL MEDICARE FOR_____

STATE LICENSE NUMBER:_____ **EXPIRATION DATE:** _____ **LICENSE TYPE**_____

*PLEASE ATTACH A COPY OF THIS LICENSE

FEDERAL LICENSE NUMBER:_____ **EXPIRATION DATE:** _____ **LICENSE TYPE**_____

*PLEASE ATTACH A COPY OF THIS LICENSE

DO YOU HAVE A LABORATORY ON PREMISES? ☐**YES** ☐**NO**

IF YES, WHAT IS YOUR CLIA CERTIFICATE NUMBER?_____ **EXPIRATION DATE?**_____

*PLEASE ATTACH A COPY OF THIS LICENSE

IF NO, WHO DO YOU SEND LAB WORK TO? _____

NAME

IS YOUR INSTITUTION ACCREDITED BY A NATIONAL ACCREDITING ORGANIZATION, SUCH AS JCAHO, CARF, AAAHC, ETC? ☐**YES** ☐**NO**

IF YES, BY WHOM?_____

*PLEASE ATTACH A COPY OF ACCREDITATION

PLEASE ATTACH A COPY OF YOUR MOST RECENT STATE INSPECTION REPORT.

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3. SANCTIONS, RESTRICTIONS, COMPLAINTS OR FINES BY STATE, FEDERAL, OR MANAGED CARE ORGANIZATIONS

HAS YOUR AGENCY IN THE LAST 36 MONTHS HAD ANY:

SANCTIONS OR EXCLUSIONS: ☐YES ☐NO

IF "YES", BY: _____ DATE: _____

RESTRICTIONS: ☐YES ☐NO

IF "YES", BY: _____ DATE: _____

COMPLAINTS: ☐YES ☐NO

IF "YES", BY: _____ DATE: _____

FINES: ☐YES ☐NO

IF "YES", BY: _____ DATE: _____

***FOR ANY "YES" ANSWER, PLEASE PROVIDE A COPY OF ALL RELEVANT DOCUMENTS AND EXPLANATIONS.**

I understand that any material misstatements, misrepresentation or omissions in this application shall constitute cause for denial or for subsequent revocation of participation. I hereby certify that the information in this application is correct and complete.

_____

Signature of Administrator ***Printed Name of Administrator*** ***Date***

PLEASE ATTACH THE FOLLOWING (WHEN APPROPRIATE):

_____COPY OF YOUR STATE LICENSE FOR EACH TYPE OF SERVICE YOU PROVIDE

_____DOCUMENTS THAT PROVE MEDICARE/MEDICAID ELIGIBILITY

_____COPY OF CLIA CERTIFICATION (IF APPLICABLE)

_____COPY OF NATIONAL ACCREDITATION CERTIFICATION (IF APPLICABLE)

_____COPY OF BUSINESS LICENSE

_____COPY OF LIABILITY INSURANCE

_____COPY OF YOUR SURVEY FROM BUREAU OF LICENSURE AND CERTIFICATION, AND ANY OTHER REQUIRED SURVEY/INSPECTION IN THE LAST 12 MONTHS