Facility Application

I. FACILITY INFORMATION

Facility Information: ***Please complete a separate application for each facility***

Facility Name: ______________________________

Street Address: ______________________________

City: ____________________ County: __________ State: ______ Zip: ______

Phone: ____________________ Fax: ____________________

Scheduling Phone: ____________________ Scheduling Fax: ____________________

Federal Tax I.D. No: ____________________ Facility License No: ____________________

Facility NPI No: ____________________ Website Address: **www.**____________________

Office Manager Name: ______________ Phone & ext. __________ Email: __________

Scheduling Mgr. Name: ______________ Phone & ext. __________ Email: __________

Claims Manager Name: ______________ Phone & ext. __________ Email: __________

Contact Person: ______________ Phone & ext. __________ Email: __________

Mailing Address (if different than above)

Address: ____________________ City: ______________ State: ______ Zip: ______

Billing Address (if different than above)

Street Address: ______________________________

City: ____________________ State: ______________ Zip: ______

Billing Business Phone: ____________________ Billing Business Fax: ____________________

Billing Manager: ____________________ ext. __________ Email: __________

Are you ACR accredited for MRI's? ☐ Yes ☐ No ☐ Eligible Expiration Date: ______________

Ownership: *Please check Type of Ownership:*

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Hospital Corporation ☐ Limited Liability Co. (L.L.C.) ☐ Other

Please list the owners of this Diagnostic Facility and the percent of ownership: **(Ownership must equal 100%):**

Last Name, First Name, Middle Initial	Phone Number	Email Address	Medical License #	SS Number	% of Ownership

II. SERVICES

Services: *Please check all that apply...*

Do you provide transportation for patients to your facility? ☐ Yes ☐ No

☐ Open MRI ☐ Closed MRI ☐ High Field MRI ☐ CT Scan ☐ Ultrasound ☐ Mammography

☐ X-Ray ☐ Fluoroscopy ☐ Nuclear Medicine ☐ PET Scan ☐ Bone Densitometry ☐ Bone Scan

☐ MRI Capability ☐ Other ______________________________ **Neuro:** ☐ EMG ☐ NCV

Do you provide Sedation? ☐ Yes ☐ No ☐ Notes: ______________________________

III. INSURANCE (FACILITY'S GENERAL LIABILITY INSURANCE)

General Liability Carrier Name: ______________________________

Street Address: ____________________ City: ____________ State: ________ Zip: ________

Policy Number: ____________________ Coverage Limits: ____________________

Annual Premium: ____________________ Coverage Dates From: ____________ To: ____________

Type of Coverage ☐ Claims Made ☐ Occurrence

IV. FACILITY HOURS

Monday: ________	From: ________	To: ________
Tuesday: ________	From: ________	To: ________
Wednesday: ________	From: ________	To: ________
Thursday: ________	From: ________	To: ________
Friday: ________	From: ________	To: ________
Saturday: ________	From: ________	To: ________
Sunday: ________	From: ________	To: ________

SCHEDULING DEPARTMENT HOURS

Monday: ________	From: ________	To: ________
Tuesday: ________	From: ________	To: ________
Wednesday: ________	From: ________	To: ________
Thursday: ________	From: ________	To: ________
Friday: ________	From: ________	To: ________
Saturday: ________	From: ________	To: ________
Sunday: ________	From: ________	To: ________

V. EQUIPMENT (FILL OUT ONLY FOR RADIOLOGY)

Magnetic Resonance Imaging (MRI)*

Make/Model: ____________ Year Manufactured: ____________ Tesla: ____________

Table Weight: ____________ Software Upgrades: ____________ Coils: ____________

Computed Tomography (CT)*

Make/Model: ____________ Year Manufactured: ____________ Table Weight: ____________

Mammography*

Make/Model: ____________ Year Manufactured: ____________

Ultrasound*

Make/Model: ____________ Year Manufactured: ____________

Nuclear Medicine*

Make/Model: ____________ Year Manufactured: ____________

Radiography and Fluoroscopy*

Make/Model: ____________ Year Manufactured: ____________

Utilizes the following exposure reducing technologies: ☐ Collimation ☐ Grids ☐ Intensifying Screens

VI. CONFIDENTIAL INFORMATION

1. Have you ever been denied participation in Medicare, Medicaid or any other governmental or quasigovernmental health related program? .... ☐ Yes ☐ No
2. Have you ever been reprimanded, censured, excluded, suspended (even if the suspension was stayed), barred or disqualified from participating in Medicare, Medicaid or any other governmental or quasigovernmental health-related program? .... ☐ Yes ☐ No
3. Have any complaints ever been filed against you by a licensingauthority? .... ☐ Yes ☐ No
4. Have you ever been denied professional liability insurance coverage or had your professional liabilityminsurance coverage canceled by your carrier? .... ☐ Yes ☐ No
5. Have you ever been refused participation in the network of a managedcare organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization? .... ☐ Yes ☐ No

PLEASE SEE PAGE 4 FOR ATTESTATION AND CREDENTIALS VERIFICATION RELEASE

VII. ATTESTATION AND CREDENTIALS VERIFICATION RELEASE

AUTHORIZATION/ATTESTATION

I hereby authorize Carisk Specialty Services, LLC, acting as a credentials verification organization, or its designee on behalf of single or multiple Clients to consult and access databases of hospitals, institutions, malpractice carriers, any town, state or federal agency, any health care organization, and/or The National Practitioner Data Bank, in order to verify information contained in my application and interview and authorize Carisk Specialty Services, LLC, or its designee to review any of my professional records, civil and criminal records and criminal background. I hereby release and indemnify Carisk Specialty Services, LLC, it's directors, committee members, employees, agents, servants, its subsidiaries and divisions as well as all licensing bodies, hospitals, societies, organizations, state or federal agencies, towns, and associations from all liability resulting from the release of records or information to Carisk Specialty Services, LLC or its designee for credentialing and verification of the information contained in my application. I hereby agree to allow Carisk Specialty Services, LLC, or its designee to examine my place(s) of business and to survey and evaluate all equipment, appointment availability or patient files used in the provision of health care services. I hereby represent that I will obtain, when necessary the appropriate releases from my patients to permit access to their records so that Carisk Specialty Services, LLC, may conduct medical record review. This patient release does not apply to disclosure of confidential information for purposes other than credentialing and verification of the information contained in my application. Notwithstanding the foregoing, I understand that information relevant to my history, performance and the quality and efficiency of patient care that I deliver, and/or my credentials may be disclosed to other associations and organizations that contract with Carisk Specialty Services, LLC. I hereby agree to notify Carisk Specialty Services, LLC, of any changes in the above information. By my signature, I hereby attest, represent and warrant that all of the information submitted in this provider application is correct, truthful and complete in all respects. I further understand any misstatement, submission of false and/or misleading information or withholding of relevant information may constitute a condition which may not be favorable to my credentialing. I understand and agree that I, as the applicant, have the burden of producing adequate and reliable information for the proper evaluation of my professional competence, character, ethics and other qualifications for resolving any questions about my qualifications. I hereby understand that I shall have the right at my sole cost and expense to review any information gathered by Carisk Specialty Services, LLC, which relates to my behalf. In the event, I believe any of the information to be inaccurate or incorrect, I shall have the right at my expense to contact the source directly and dispute the validity of the information. In the event the source verifies the information to be inaccurate or incorrect, verifying information shall be sent to Carisk Specialty Services, LLC, thereafter Carisk Specialty Services, LLC, at its expense shall correct any information found to be inaccurate or incorrect.

(This application will not be processed if not signed and dated. STAMPED SIGNATURES ARE NOT ACCEPTED.)

Owner or Authorized Representative Signature ______________________ Date ______________

Print Name ______________________ Social Security Number ______________

Please remember to include copies of the following documents with your completed application.

- ☐ Certificate of Facility Insurance (General Liability Insurance)
- ☐ Operating License
- ☐ Certificate of Need (if applicable)
- ☐ Copy of W-9 Form
- ☐ American College of Radiology (ACR) Certificate(s) for MRIs, CTs, PETs and Nuclear Medicine
- ☐ Roster of Physicians and Physician Application (s)

Please return this form to:

Carisk Specialty Services, LLC
180 Park Ave. Plaza Level, Suite LL103
Florham Park, NJ 07932

Email: providerrelations@cariskpartners.com
Fax: 844-898-6135