



### HOSPITAL AND FACILITY APPLICATION

Hospital/Facility Name: \_\_\_\_\_

DBA Name: \_\_\_\_\_  
(If your facility does business under a different name from the facility name listed)

#### A. HOSPITAL/FACILITY INFORMATION

Main Address:

Billing Address:

Street \_\_\_\_\_

Street \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_ County \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Credentialing Contact: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Direct Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_ NPI \_\_\_\_\_

Tax ID (FEIN): \_\_\_\_\_ Claim form facility uses for billing: \_\_\_\_\_ UB04 \_\_\_\_\_ CMS1500

#### Type of Facility:

Hospital  Ambulatory Surgical Center  DME  Lab  Home Health  Home Infusion

Other \_\_\_\_\_ Accreditation: \_\_\_\_\_

#### HOSPITAL/FACILITY ATTESTATION AND RELEASE OF INFORMATION

I hereby certify that the information contained herein is true and correct and that any omission or misrepresentation may void this application or be cause for termination of my facility's participation in the MedCost program. Further, I give my permission to MedCost, LLC and/or its designee to verify the facilities credentials and by so doing hereby authorize release of the requested information concerning the facilities licensing and accreditation.

I, the undersigned, release all individuals and organizations from all liability for any damages which may result from issuing this information.

\_\_\_\_\_  
Facility Name (printed or typed)

\_\_\_\_\_  
Facility Officer's Signature

\_\_\_\_\_  
Date

**Applicants have the responsibility of producing adequate information for the proper evaluation of their application. Failure to produce this information will prevent the application from being evaluated and acted upon.**

#### Please sign and date this completed application and return with items listed below, if applicable, to:

1. Copy of applicable accreditation (JCAHO, URAC, NCQA, ACR, AAAHC, NACC, ACHC, American Lithotripsy Society, CHAP, CARF, AAAASF, American Bd for Certification in Orthotics & Prosthetics, ISO9000-(DME companies), AASM, ICAVL, CLIA, Board for Orthotist/Prosthetist Certification - (BOC), HQAA, (DNV) – Det Norske Veritas Healthcare, Inc., The Compliance Team-deemed by CMS, Medicare, AAPSF, Mastectomy Fitter training certificate)
2. Copy of *State License*
3. Copy of *Medicare Certification*
4. Copy of *Medicaid Certification*
5. Copy of *Malpractice Insurance (face sheet)*
6. Copy of *Secondary or excess Malpractice Insurance (face sheet)*