Capital BlueCross
OUTPATIENT DIAGNOSTIC CENTER SURVEY

Provider Name: _____
CBC #: _____ **Medicare #:** _____ **Medicaid #:** _____
Accrediting Organization: _____ **Date of most recent accrediting survey:** _____
Person completing survey: _____ **Phone:** _____ **Date:** _____
Contact person (if different than above): _____ **Phone:** _____

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

Days & Hours of operation: _____
Handicap access ☐ Yes ☐No
Written compliance program ☐ Yes ☐No
Compliance program officer ☐ Yes ☐No
Internal compliance audits ☐ Yes ☐No
Review of the Medicare/Medicaid sanction report ☐ Yes ☐No
Frequency of review: _____
Written policy on patient confidentiality ☐ Yes ☐No
Written policy on medical record confidentiality ☐ Yes ☐No
Written policy for release of medical records ☐ Yes ☐No
Written policy for maintenance/retention of medical records ☐ Yes ☐No
Written patient medical emergency plan ☐ Yes ☐No
Emergency medical equipment/supplies available ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Written policy for checking:
Emergency medical equipment/supplies ☐ Yes ☐No
Defibrillator ☐ Yes ☐No
Policy includes frequency of checks ☐ Yes ☐No
Written policy for transfer to acute care ☐ Yes ☐No
Written transfer agreement to acute care ☐ Yes ☐No
If yes, list facilities: _____
Written agreement with emergency transportation service ☐ Yes ☐No
Reliance on 911 system ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities

Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes utilization review ☐ Yes ☐No
Frequency of meetings: _____
List two current Quality Studies:
1. _____
2. _____
Development of improvement activities based on identified issues ☐ Yes ☐No
Written infection control policies ☐ Yes ☐No

Clinical Management

Written policy on addressing advanced directives ☐ Yes ☐No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Issues identified:
1. _____
2. _____
Results forwarded to PI Committee ☐ Yes ☐No
Written patient/family complaint process ☐ Yes ☐No

Patient Education

Pre-procedure phone call ☐ Yes ☐No
Post-discharge phone call ☐ Yes ☐No
Patient/Family education ☐ Yes ☐No
Documented in medical record ☐ Yes ☐No
Services available for hearing impaired ☐ Yes ☐No
Services available for speech impaired ☐ Yes ☐No
Services available for visually impaired ☐ Yes ☐No
Bilingual services ☐ Yes ☐No
Bilingual patient education materials ☐ Yes ☐No
Languages offered: _____

Data Collection

Incident Reports ☐ Yes ☐No
Types of procedures ☐ Yes ☐No
Transfer to inpatient facility ☐ Yes ☐No
Failed preps ☐ Yes ☐No
Repeat studies ☐ Yes ☐No
Technology related ☐ Yes ☐No
Equipment related ☐ Yes ☐No
Patient related ☐ Yes ☐No

Provider Name:

List other data: _____

CLINICAL STAFF

Clinical Competency Evaluation ☐ Yes ☐No
During probationary period ☐ Yes ☐No
Annually ☐ Yes ☐No
Written policy for verification of all of the following for all licensed/certified staff: ☐ Yes ☐No
- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Number of mandatory educational programs staff attends annually: _____
Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No
Written policy for credentialing of physicians ☐ Yes ☐No
Written policy for recredentialing of:
- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Frequency: _____

Medical Staff

Medical Director ☐ Yes ☐No
Name: _____
Specialty: _____
Board Certified ☐ Yes ☐No
Radiologists ☐ Yes ☐No
Board Certified ☐ Yes ☐No
If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Support Staff

Registered Radiology Technicians ☐ Yes ☐No
Certified Mammography Techs. ☐ Yes ☐No
Respiratory Therapists ☐ Yes ☐No
Laboratory Technicians ☐ Yes ☐No
Registered Nurses ☐ Yes ☐No
EKG Technicians ☐ Yes ☐No
Phlebotomists ☐ Yes ☐No
Written policy defining staff requiring CPR certification ☐ Yes ☐No
_____ **%** Direct patient care givers CPR certified
Nurse Practitioner ☐ Yes ☐No
If **yes**, list specialties: _____

SERVICES

Cardiology ☐ Yes ☐No
If **yes**, please list: _____
CT Scans ☐ Yes ☐No
Gastroenterology ☐ Yes ☐No
Laboratory ☐ Yes ☐No
Mammography ☐ Yes ☐No
DOH Certified: _____
Pulmonary Function Studies ☐ Yes ☐No
Radiology ☐ Yes ☐No
Other: _____

FACILITIES & EQUIPMENT

Bioengineering specialist ☐ Yes ☐No
If **no**, person responsible for maintenance of biomedical equipment ☐ Yes ☐No
Written policy for handling of biohazardous materials ☐ Yes ☐No
Written preventive maintenance plan ☐ Yes ☐No
Written plan for equipment failure ☐ Yes ☐No
Written emergency preparedness plan ☐ Yes ☐No
Plan includes:
- Fire ☐ Yes ☐No
- Loss of Utilities ☐ Yes ☐No
- Inclement Weather ☐ Yes ☐No

Written policy for fire/disaster drills ☐ Yes ☐No
Results of drills documented ☐ Yes ☐No

As a reminder, please be sure to include:
- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***

COMMENTS

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Name: ____________
Services Provided: ____________
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ____________
Address: ____________
City: ____________
Phone: ____________
Contact Person: ____________
Counties Served: ____________

Provider Name:

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:_____
Parent:_____
Affiliation:_____
Affiliation:_____

Number of Years in business:_____

Type of Control

☐**Voluntary Nonprofit**

☐**Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)

- ☐ Individual _____
- ☐ Partnership_____
- ☐ Corporation_____
- ☐ Other_____

☐**Government**

- ☐ Federal
- ☐ State
- ☐ County
- ☐ Other, explain:_____

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

☐Yes, explain:_____
☐No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

☐Yes
☐No
If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: _____

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Adams ☐ _____
Berks ☐ _____
Centre ☐ _____
Columbia ☐ _____
Cumberland ☐ _____
Dauphin ☐ _____
Franklin ☐ _____
Fulton ☐ _____
Juniata ☐ _____
Lancaster ☐ _____
Lebanon ☐ _____
Lehigh ☐ _____
Mifflin ☐ _____
Montour ☐ _____
Northampton ☐ _____
Northumberland ☐ _____
Perry ☐ _____
Schuylkill ☐ _____
Snyder ☐ _____
Union ☐ _____
York ☐ _____

Other ☐ _____
_____
_____
_____
_____