Capital BlueCross
ACUTE CARE PROVIDER 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

Number of Beds: _____
Handicap access ☐ Yes ☐No
Written Hospital-wide on-call policy ☐ Yes ☐No
Policy governs response times ☐ Yes ☐No
Written policy for checking crash carts ☐ Yes ☐No
Includes frequency of checks ☐ Yes ☐No
Written compliance program ☐ Yes ☐No
Compliance program officer: _____
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
Facility based Residency Programs ☐ Yes ☐No
If **yes**, please list programs: _____

Employ/contract with Physician Assistants ☐ Yes ☐No
If **yes**, list areas utilizing PAs: _____

Employ/contract with Nurse Practitioners ☐ Yes ☐No
If **yes**, list areas utilizing Nurse Practitioners: _____

CME requirements for physicians to maintain staff privileges ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities

Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes:
- Utilization Review ☐ Yes ☐No
- Pharmacy Review ☐ Yes ☐No

Development of improvement activities based on identified issues ☐ Yes ☐No
Performance Improvement Committee ☐ Yes ☐No
Frequency of meetings: _____
List two current Quality Studies:
1. _____
2. _____

Quality Reports forwarded to Board of Directors ☐ Yes ☐No
Performance improvement activities for outpatient area ☐ Yes ☐No
Particpate in LeapFrog group patient safety survey ☐ Yes ☐No
Implementation of patient safety reporting system ☐ Yes ☐No
Facility conducts root cause analysis for adverse events ☐ Yes ☐No
Computerized Physician Order Entry System **(CPOE)**
- In place ☐ Yes ☐No
- Mandatory for all physicians ☐ Yes ☐No
- If **no**, implementing CPOE in future ☐ Yes ☐No

Target Date: _____
Written infection control policies ☐ Yes ☐No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Issues identified:
1. _____
2. _____

Results forwarded to the PI Committee ☐ Yes ☐No

Provider Name:

Written patient/family complaint process ☐ Yes ☐No

Patient advocate ☐ Yes ☐No

Clinical Management

Written policy on addressing advance directives ☐ Yes ☐No

Clinical pathways utilized: ☐ Yes ☐No

- CVA ☐ Yes ☐No
- CHF ☐ Yes ☐No
- Community acquired pneumonia ☐ Yes ☐No
- MI ☐ Yes ☐No
- Oral anti-coagulation therapy ☐ Yes ☐No
- Others ☐ Yes ☐No

Disease Management Programs ☐ Yes ☐No

Please list: _____

Case Management and Discharge Planning

Internal case managers available ☐ Yes ☐No

Types: ☐ RN

☐ Social Services

☐ Other: _____

Departments/services involved in discharge planning:

Data Collection

Complications ☐ Yes ☐No

Length of Stay ☐ Yes ☐No

Readmissions ☐ Yes ☐No

Transfers ☐ Yes ☐No

Other: _____

Patient Education/Public Health

Patient/Family education ☐ Yes ☐No

- Documented in clinical record ☐ Yes ☐No

Services for hearing impaired ☐ Yes ☐No

Services for speech impaired ☐ Yes ☐No

Services for visually impaired ☐ Yes ☐No

Bilingual services ☐ Yes ☐No

Bilingual patient education materials ☐ Yes ☐No

List languages offered:

Types of Wellness initiatives and programs offered:

Outpatient Diabetic Education Program ☐ Yes ☐No

Program includes insulin pump training ☐ Yes ☐No

- Certified by DOH ☐ Yes ☐No
  - Date of Certification: _____
- Certified by ADA ☐ Yes ☐No
  - Date of Certification: _____

Clinical Health Care

Indicate which Structured Clinics are part of the Hospital system:

(If any clinics are staffed by out of area physicians, please list the clinic and physician name on a separate attachment. For off-site clinics, identify location and services on attachment II)

	On-site	Off-site
☐ Adolescent	☐	☐
☐ Allergy	☐	☐
☐ Cardiology	☐	☐
☐ Dermatology	☐	☐
☐ Diabetic	☐	☐
☐ Endocrinology	☐	☐
☐ ENT	☐	☐
☐ Eye	☐	☐
☐ Fertility/Infertility	☐	☐
☐ Geriatric	☐	☐
☐ GYN	☐	☐
☐ Hematology	☐	☐
☐ HIV/AIDS	☐	☐
☐ Medical	☐	☐
☐ MH/SA	☐	☐
☐ Nephrology	☐	☐
☐ Oncology	☐	☐
☐ Orthopedic	☐	☐
☐ Pediatric	☐	☐
☐ Prenatal	☐	☐
☐ Pulmonary	☐	☐
☐ Rheumatology	☐	☐
☐ Surgical	☐	☐
☐ Urology	☐	☐
☐ Wound Care	☐	☐

Other Clinics: _____

Provider Name:

STAFF

Written policy for credentialing of:
- Physicians ☐ Yes ☐No
- Allied Health ☐ Yes ☐No

Written policy for verification of the following for all clinical staff:
- License ☐ Yes ☐No
- Education ☐ Yes ☐No
- Certification ☐ Yes ☐No
- Registration ☐ Yes ☐No

Written policy for recredentialing of:
- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Allied Health ☐ Yes ☐No
- Frequency: _____

Written policy for clinical competency evaluation ☐ Yes ☐No
Evaluated during probationary period ☐ Yes ☐No
Evaluated annually ☐ Yes ☐No

Number of mandatory inservices staff is required to attend annually: _____

Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No

Medical Staff

(If known and applicable, indicate number of Physicians to take boards in next 12 months in the Comments sections.)

If physicians are not board certified, competency established through the hospital's credentialing process ☐ Yes ☐No

Behavioral Medicine Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Psychiatrists
_____ Number Board Certified in Psychiatry
_____ Number Board Certified in Child Psychiatry

Cardiac Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Cardiologists
_____ Number Board Certified in Cardiology
_____ Number of Cardiovascular Surgeons
_____ Number Board Certified in Cardio Surgery

Emergency Staff

Director Board Certified in: _____
_____ Number of ER Physicians
_____ Number Board Certified in Emergency Medicine

Number Board Certified in Specialties:
_____ Internal Medicine _____ Surgery
_____ Family Medicine _____ Other

List other specialties: _____

Policy defining qualifications for physicians in the ER ☐ Yes ☐No

Laboratory Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Pathologists
_____ Number Board Certified in Pathology

Obstetrics Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Obstetricians
_____ Number Board Certified in Obstetrics
_____ Number of Neonatologists
_____ Number Board Certified in Neonatology

Oncology Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Oncologists
_____ Number Board Certified in Oncology
_____ Number Board Certified in Hematology

Pediatric Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Pediatricians
_____ Number Board Certified in Pediatrics

Radiology Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Radiologists
_____ Number Board Certified in Radiology
_____ Number of Nuclear Medicine Physicians
_____ Number Board Certified in Nuclear Medicine
_____ Number of Radiation Physicists

Rehabilitation Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Physiatrists
_____ Number Board Certified in Rehabilitation Medicine

Critical/Special Care Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Critical Care Physicians
_____ Number Board Certified in Critical Care Med
_____ Number of Intensivists

Surgical Staff

Director Board Certified ☐ Yes ☐No
_____ Number of Anesthesiologists

Provider Name:

_____ Number Board Certified in Anesthesiology
_____ Number of Surgeons on Staff
_____ Number Board Certified in Surgery
_____ Number of Plastic Surgeons
_____ Number Board Certified in Plastic Surgery

Other Physician Staff

_____ Number of Hospitalists
_____ Number of Internists
_____ Number Board Certified in Internal Medicine
_____ Number of Family Practitioners
_____ Number Board Certified in Family Practice
_____ Number of Neurologists
_____ Number Board Certified in Neurology
_____ Number of Infectious Disease Specialists
_____ Number Board Certified in Infectious Disease

Other: _____

Nursing Staff

	Full Time (Hospital employed 35hr/wk or more)	**Part Time** (Hospital employed less than 35hrs)
RN	_____	_____
LPN	_____	_____
CNA	_____	_____
Clinical Technicians	_____	_____

Written policy for determining appropriate levels of staffing ☐ Yes ☐No

_____ **%** RN/LPN overtime per month

_____ **%** Unlicensed staff overtime per month
(Nursing assistants / Clinical Technicians)

Contracted Staff used ☐ Yes ☐No

Written policy for verification of the following for contracted staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Written procedure for evaluating contract staff's performance ☐ Yes ☐No

Written policy defining staff requiring CPR certification ☐ Yes ☐No

_____ **%** Clinical Staff CPR certified

Other Staff ***(include contracted or employed)***

Behavioral Medicine

_____ Number of Clinical Psychologists
_____ Number of Psychiatric Social Workers
_____ Number of Certified Addiction Counselors
_____ Number of Certified Psychiatric Nurses
_____ Number of Psychiatric Technicians/Assistants

Other: _____

Ob/Gyn Staff

_____ Number of Nurse Midwives
_____ Number of Lactation specialists

Other: _____

OR Staff

_____ Number of OR Surgical Technicians
_____ Number of Registered Nurses
_____ Number of Certified Perioperative Nurses
_____ Number of Registered Nurse First Assistants
_____ Number of Certified Registered Nurse Anesthetists

Other: _____

Pharmacy Staff

_____ Number of Licensed Pharmacists
_____ Number of Pharmacy Aides

Other: _____

Radiology Staff

_____ Number of Registered Radiology Technologists
_____ Number of Registered MRI Technologists
_____ Number of Registered Nuclear Medicine Technologists

Other: _____

Social Services Staff

_____ Number of Masters of Social Work
_____ Number of Bachelors of Social Work

Other: _____

Support Staff

_____ Number of Licensed Audiologists
_____ Number of EEG Technicians
_____ Number of Registered EEG Technicians
_____ Number of EMG Technicians
_____ Number of Registered EMG Technicians
_____ Number of Intraoperative Monitoring Techs.
_____ Number of Certified/Registered Intraoperative monitoring Technicians
_____ Number of ECG Technicians
_____ Number of Certified ECG Technicians
_____ Number of Enterostomal Therapists
_____ Number of Cath Lab Technicians
_____ Number of Registered Cardiovascular Techs.
_____ Number of Registered Dietitians
_____ Number of Occupational Therapists
_____ Number of Certified Occupational Therapy Assistants

Provider Name:

_____ Number of Licensed Physical Therapists
_____ Number of Registered Physical Therapy Assistants
_____ Number of Licensed Physical Therapy Aids
_____ Number of Licensed Speech Therapists
_____ Number of Registered Vascular Technologists
_____ Number of Registered Respiratory Therapists
_____ Number of Registered Recreational Therapists

SERVICES

Behavioral Medicine

Separate Unit ☐ Yes ☐No
- If **YES**, a separate survey will be forwarded for completion
- If **NO**, please complete portion below

Inpatient ☐ Yes ☐No
- Ages Served: _____

Acute Partial ☐ Yes ☐No
- Ages Served: _____

Residential ☐ Yes ☐No
- Ages Served: _____

Outpatient Services ☐ Yes ☐No
Intensive Outpatient *(3 hrs or less/day)* ☐ Yes ☐No
Electroconvulsive Therapy ☐ Yes ☐No
Other: _____

Substance Abuse

Inpatient Detox Unit ☐ Yes ☐No
Inpatient Rehab ☐ Yes ☐No
Outpatient Services ☐ Yes ☐No
Partial Outpatient ☐ Yes ☐No

Cardiac Services

Angioplasty (PTCA) ☐ Yes ☐No
Artherectomy ☐ Yes ☐No
Balloon Angioplasty ☐ Yes ☐No
Cardiac Ablation ☐ Yes ☐No
Catheterization ☐ Yes ☐No
Echocardiography ☐ Yes ☐No
Electrophysiological Mapping ☐ Yes ☐No
Implantable Defibrillator ☐ Yes ☐No
Intracoronary Stents ☐ Yes ☐No
- FDA approved ☐ Yes ☐No

Open Heart Surgery ☐ Yes ☐No
Permanent Pacemaker ☐ Yes ☐No
Stress Testing ☐ Yes ☐No
Other: _____

Critical/Special Care

Adult Intensive Care Unit ☐ Yes ☐No
Pediatric Intensive Care Unit ☐ Yes ☐No
Mixed ICU/CCU ☐ Yes ☐No
Cardiac Only Unit ☐ Yes ☐No
Burn Unit ☐ Yes ☐No
Other: _____

Dialysis Services ☐ Yes ☐No
Contracted out ☐ Yes ☐No

Dialysis	Inpatient	Outpatient
Hemo	☐ Yes ☐No	☐ Yes ☐No
Peritoneal	☐ Yes ☐No	☐ Yes ☐No

Emergency Department

24 hour on-site Physician ☐ Yes ☐No
Designated Trauma Center ☐ Yes ☐No
Level: _____
EMT Command Post ☐ Yes ☐No
ALS Services ☐ Yes ☐No
Air Ambulance Service ☐ Yes ☐No

Laboratory

24 hours access ☐ Yes ☐No
7 day/week coverage ☐ Yes ☐No
CAP Approved ☐ Yes ☐No
CLIA Approved ☐ Yes ☐No
JCAHO Approved ☐ Yes ☐No
Autologous Transfusions ☐ Yes ☐No
Genetic Testing on-site ☐ Yes ☐No
Therapeutic Plasmapheresis ☐ Yes ☐No
Lab contracted as a draw site for an independent lab vendor ☐ Yes ☐No
List Vendors: _____

Obstetrics

Routine Obstetrical Services ☐ Yes ☐No
Birthing Room ☐ Yes ☐No
High Risk Pregnancy Program ☐ Yes ☐No
Nursery ☐ Yes ☐No
Level II NICU ☐ Yes ☐No
- If **yes**, pediatrician available at all times ☐ Yes ☐No

Level III NICU ☐ Yes ☐No
- If **yes**, neonatologist available at all times ☐ Yes ☐No

Genetic Counseling ☐ Yes ☐No
In-Vitro Fertilization ☐ Yes ☐No
Gamete intrafallopian transfer (GIFT) ☐ Yes ☐No
Zygote intrafallopian transfer (ZIFT) ☐ Yes ☐No
Other: _____

Oncology

Oncology Unit ☐ Yes ☐No
Inpatient Hospice Unit ☐ Yes ☐No

Provider Name:

Outpatient Chemotherapy Services ☐ Yes ☐No
Cancer Institution Affiliation ☐ Yes ☐No
If **yes**, please list: _____
Other: _____

Pediatrics

Separate Unit ☐ Yes ☐No
Cardiology Services ☐ Yes ☐No
Medical Services ☐ Yes ☐No
Oncology Services ☐ Yes ☐No
Surgical Services ☐ Yes ☐No
Other: _____

Pharmacy

24 hours access ☐ Yes ☐No
7 day/week coverage ☐ Yes ☐No
Services contracted out ☐ Yes ☐No
Community pharmacy license ☐ Yes ☐No
Other: _____

Physical Rehabilitation

Separate IP Unit ☐ Yes ☐No

- If **YES**, a separate survey will be forwarded for completion
- If **NO**, please complete portion below

	Inpatient	Outpatient
Aquatic Therapy	☐	☐
Brain Injury	☐	☐
Burn Care	☐	☐
Cardiac Rehab	☐	☐
Chronic Pain Mgmt	☐	☐
Hand Clinics	☐	☐
Neuro Rehab	☐	☐
Orthotics	☐	☐
Orthopedic	☐	☐
Pediatric Acute	☐	☐
Pediatric Chronically Impaired	☐	☐
Prosthetics	☐	☐
Pulmonary Rehab	☐	☐
Spinal Cord Injury	☐	☐
Work Hardening	☐	☐

Other: _____

Radiology

24 hours access ☐ Yes ☐No
7 day/week coverage ☐ Yes ☐No
Vascular Lab services ☐ Yes ☐No
Accreditation by Intersocietal Commission for Vascular Laboratories ☐ Yes ☐No
CT on-site ☐ Yes ☐No
DOH-Certified Mammography ☐ Yes ☐No
On-site ☐ Yes ☐No
Magnetic Resonance Angiography ☐ Yes ☐No
MRI on-site ☐ Yes ☐No
Extremity MRI ☐ Yes ☐No
Open MRI ☐ Yes ☐No
Mobile MRI unit ☐ Yes ☐No
Days & Hours of operation: _____
Nuclear Medicine ☐ Yes ☐No
PET ☐ Yes ☐No
Radiation Therapy ☐ Yes ☐No
Gamma Knife ☐ Yes ☐No
Linear Accelerator ☐ Yes ☐No
SPECT ☐ Yes ☐No

Support Services

Occupational Therapy ☐ Yes ☐No
Physical Therapy ☐ Yes ☐No
Recreational Therapy ☐ Yes ☐No
Respiratory Therapy ☐ Yes ☐No
Speech Therapy ☐ Yes ☐No
Other: _____

Surgical Services

Bone Allographs ☐ Yes ☐No
Cardiac ☐ Yes ☐No
Cochlear Implants ☐ Yes ☐No
ENT ☐ Yes ☐No
General ☐ Yes ☐No
Gynecologic ☐ Yes ☐No
Laparoscopy ☐ Yes ☐No
List procedures: _____

Laser ☐ Yes ☐No
List procedures: _____

Lithotripsy ☐ Yes ☐No
ESWL ☐ Yes ☐No
On-site _____ Mobile _____
Neurosurgery ☐ Yes ☐No
Ophthalmology ☐ Yes ☐No
Oral ☐ Yes ☐No
Orthopedics ☐ Yes ☐No
Plastic Reconstructive ☐ Yes ☐No
Stereotactic Breast Biopsy ☐ Yes ☐No
Thoracic ☐ Yes ☐No
Urology ☐ Yes ☐No
Penile Implant ☐ Yes ☐No
Radical Prostatectomy ☐ Yes ☐No

Provider Name:

Vascular ☐ Yes ☐No

Transplant Services

Corneal ☐ Yes ☐No
Bone Marrow ☐ Yes ☐No
Allogenic _____ Autologous _____
Heart ☐ Yes ☐No
Heart/Lung ☐ Yes ☐No
Intestines ☐ Yes ☐No
Kidney ☐ Yes ☐No
Pancreas ☐ Yes ☐No
Simultaneous Pancreas/Kidney ☐ Yes ☐No
Pancreas/Islet ☐ Yes ☐No
Liver ☐ Yes ☐No
Lung ☐ Yes ☐No
Skin ☐ Yes ☐No
Peripheral Stem Cell Transplant ☐ Yes ☐No
☐Inpatient ☐Outpatient
Other: _____
Provide Pediatric Transplant Services ☐ Yes ☐No
If **yes**, list services: _____

Other Services

Home Health Care ☐ Yes ☐No
Home Infusion ☐ Yes ☐No
Home Medical Equipment ☐ Yes ☐No
Hyperbaric Oxygen Unit ☐ Yes ☐No
Extremity Chamber ☐ Yes ☐No
Mono-Chamber ☐ Yes ☐No
Multi-Chamber ☐ Yes ☐No
23 hour Observation ☐ Yes ☐No
Written protocol for admission/discharge ☐ Yes ☐No
Other: _____

Long Term Acute Care Hospital (LTACH)

Is there an LTACH located in your facility ☐ Yes ☐No
If **no**, future plans for LTACH ☐ Yes ☐No
Target date: _____

Skilled Nursing Facility

Licensed SNF ☐ Yes ☐No

- If **yes**, a separate survey will be sent for further information

FACILITIES AND EQUIPMENT

Bioengineering specialist ☐ Yes ☐No
If no, person responsible for maintenance of biomedical equipment ☐ 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
Written policy for handling biohazardous materials ☐ Yes ☐No

Provider Name:

Please indicate campus where services provided:

SERVICE	CAMPUS 1 *(Insert Campus Name Here)*	CAMPUS 2 *(Insert Campus Name Here)*	CAMPUS 3 *(Insert Campus Name Here)*	CAMPUS 4 *(Insert Campus Name Here)*
Behavioral Medicine	☐	☐	☐	☐
Cardiac Services	☐	☐	☐	☐
Critical/Special Care	☐	☐	☐	☐
Dialysis Services	☐	☐	☐	☐
Emergency Department	☐	☐	☐	☐
Laboratory	☐	☐	☐	☐
Obstetrics	☐	☐	☐	☐
Oncology	☐	☐	☐	☐
Pediatrics	☐	☐	☐	☐
Pharmacy	☐	☐	☐	☐
Physical Rehabilitation	☐	☐	☐	☐
Radiation/Nuclear Med.	☐	☐	☐	☐
Surgical Services*	☐	☐	☐	☐
Transplant Services	☐	☐	☐	☐

* **If surgical services are performed at different campuses, please indicate on a separate attachment the surgical services and location.**

Clinical Health Care

Indicate which structured clinics are provided by which campus (1, 2, 3 or 4 from pg 6):

_____ Adolescent Clinic	_____ Medical Clinic
_____ Allergy Clinic	_____ MH/SA Clinic
_____ Cardiology Clinic	_____ Nephrology Clinic
_____ Dermatology Clinic	_____ Oncology Clinic
_____ Diabetic Clinic	_____ Orthopedic Clinic
_____ Endocrinology Clinic	_____ Pediatric Clinic
_____ ENT Clinic	_____ Prenatal Clinic
_____ Eye Clinic	_____ Pulmonary Clinic
_____ Fertility Clinic	_____ Rheumatology Clinic
_____ Geriatric Clinic	_____ Surgical Clinic
_____ GYN Clinic	_____ Urology Clinic
_____ Hematology Clinic	_____ Wound Care Clinic
_____ HIV/AIDS Clinic	

Other / Comments:	

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:

AFFILIATED OR OWNED SERVICES/FACILITIES

Directions: Please indicate all applicable. For each facility *that is NOT considered a department of the Hospital*, complete Attachment I.

ALS Service	_____	Outpatient Laboratories	_____
Ambulatory Surgical Center	_____	Outpatient Psychiatric Services	_____
Birthing Center	_____	Outpatient Radiology Centers	_____
Dialysis Center	_____	Outpatient Rehab Therapy Centers	_____
Home Health Agency	_____	Primary Care Centers	_____
Home Infusion	_____	Prosthetics / Orthotics	_____
Home Medical Equipment	_____	Satellite / Outreach Clinics	_____
Hospice	_____	Skilled Nursing Facility	_____
Industrial Medicine Center	_____	Transport Service	_____
Linear Accelerator	_____	Urgent Care Center	_____
MRI	_____		
Other Services:	_____	Other Services:	_____
Other Services:	_____	Other Services:	_____

Provider Name:

Off-site Initiatives(attachment I)

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Name: ____________________
Service: ____________________
CBC Provider Number: ____________________
Date of Acquisition or Establishment: __________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________

Provider Name:

Off-site Initiatives (attachment I, cont'd)

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Name: ______
Service: ______
CBC Provider Number: ______
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______

Provider Name:

Off-site Clinics (attachment II)

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person:

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address:__________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Name: __________
Service: __________
CBC Provider Number: __________
Date of Acquisition or Establishment: __________
Address: __________
City: __________
Phone: __________
Contact Person: __________

Provider Name:

Off-site Clinic & out of area Physicians

Clinic Site: ________________
Services: ________________

CBC Provider Number: ________________
Date of Acquisition or Establishment: ________________
Address: ________________
City: ________________
Phone: ________________
Contact Person: ________________
Physicians: ________________

Clinic Site: ________________
Services: ________________

CBC Provider Number: ________________
Date of Acquisition or Establishment: ________________
Address: ________________
City: ________________
Phone: ________________
Contact Person: ________________
Physicians: ________________

Clinic Site: ________________
Services: ________________

CBC Provider Number: ________________
Date of Acquisition or Establishment: ________________
Address: ________________
City: ________________
Phone: ________________
Contact Person: ________________
Physicians: ________________

Clinic Site: ________________
Services: ________________

CBC Provider Number: ________________
Date of Acquisition or Establishment: ________________
Address: ________________
City: ________________
Phone: ________________
Contact Person: ________________
Physicians: ________________

Clinic Site: ________________
Services: ________________

CBC Provider Number: ________________
Date of Acquisition or Establishment: ________________
Address: ________________
City: ________________
Phone: ________________
Contact Person: ________________
Physicians: ________________

Clinic Site: ________________
Services: ________________

CBC Provider Number: ________________
Date of Acquisition or Establishment: ________________
Address: ________________
City: ________________
Phone: ________________
Contact Person: ________________
Physicians: ________________

Provider Name:

Off-site Clinic & out of area Physicians

Clinic Site: ____________________
Services: ____________________

CBC Provider Number: ____________________
Date of Acquisition or Establishment: ____________________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________
Physicians: ____________________

Clinic Site: ____________________
Services: ____________________

CBC Provider Number: ____________________
Date of Acquisition or Establishment: ____________________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________
Physicians: ____________________

Clinic Site: ____________________
Services: ____________________

CBC Provider Number: ____________________
Date of Acquisition or Establishment: ____________________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________
Physicians: ____________________

Clinic Site: ____________________
Services: ____________________

CBC Provider Number: ____________________
Date of Acquisition or Establishment: ____________________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________
Physicians: ____________________

Clinic Site: ____________________
Services: ____________________

CBC Provider Number: ____________________
Date of Acquisition or Establishment: ____________________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________
Physicians: ____________________

Clinic Site: ____________________
Services: ____________________

CBC Provider Number: ____________________
Date of Acquisition or Establishment: ____________________
Address: ____________________
City: ____________________
Phone: ____________________
Contact Person: ____________________
Physicians: ____________________

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 ☐	_____
	_____
	_____
	_____
	_____