

ONE CALL MEDICAL INC

Center Checklist

- Please complete the contact information below:

Office Manager: _____
Phone: _____ Fax: _____ Email: _____
Contract Negotiator/Contact: _____
Phone: _____ Fax: _____ Email: _____
Credentialing Contact: _____
Phone: _____ Fax: _____ Email: _____
Billing Contact: _____
Phone: _____ Fax: _____ Email: _____
Medical Reports Contact: _____
Phone: _____ Fax: _____ Email: _____

- Complete the attached application in its entirety. It's recommended that you maintain a copy of your completed application for your files.
- Type or print your application in legible writing.
- Review your application before signing and mailing. Incomplete applications will not be processed and will be returned to you.
- Sign and date page 3 of the application.

Direct questions to: OCM Credentialing Department
Phone # (800) 872 - 2875 Fax # (973) 257 - 9512

Note: Copies of the following documents must accompany your application.

Physician Roster— <i>submit a list of all radiologists at your facility that will read MRI's, CT's or PET Scans for OCM</i>
Signed Provider Agreement
Current W-9 Tax Form (Signed and Dated)
MRI Facilities only 1 complete study with MRI films & reports for: (please send films from abnormal studies), (A) Cervical Spine (72141) (B) Lower Extremity, Joint (Knee)(73721) <i>Please note that if your facility is accredited by the ACR (for MRI's) then you do not need to submit MRI films. You must, however, submit proof of accreditation (letter and/or certificate).</i>
Copy of Facility License (if applicable)
Copy of Certification by JCAHO, Accreditation Association for Ambulatory Healthcare (AAAH) or American College of Radiology (ACR) (if applicable)

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Center Application Form

PRIMARY ADDRESS INFORMATION:

Name of Center (DBA):		
Corporate Affiliation (if applicable):		
Physical Site Street Address:		
City, State, Zip:		County:
Telephone #:	Fax #:	Scheduling #:
NPI#:	Medicare # (if applicable):	Workers' Comp # (if applicable):

REMIT ADDRESS INFORMATION:

Federal Tax ID No.:	Electronic Billing: Yes No If yes, please list type of Billing Software:
Legal Entity Name (this is the name as it appears on your W-9 for IRS check remit purposes):	
Billing Company Name (if applicable):	
Billing Address (if different from above):	
City, State, Zip:	
Billing Phone #:	Billing Fax #:

MRI HOURS

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

CT HOURS

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

PET SCAN HOURS

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

Commercial General Liability

(Complete and attach a copy of the policy face sheet)

Company:			
Address:			
Telephone #:			
Policy #:			
Limits:	Per Occurrence:	Terms:	To:
	Aggregate:		From:

Statement of Malpractice History

Has your facility had any claims, suits or settlements in the last 5 years?

Yes No

To your knowledge, are there any claims that have not been filed; however, you have been notified of the intent to file?

Yes No

If yes, attach details for each claim

Ownership and Management

(Check all that apply)

Corporation	_____	Partnership	_____	Sole Proprietorship	_____
For Profit	_____	Sponsorship	_____	Privately Held	_____
Not-for-Profit	_____	Hospital	_____	Other Organization	_____

Do Reading Radiologists have ownership in Center?

Yes No

Have any of the principals of the operating entity ever applied, directly or indirectly, for health care facility approval in any state which was revoked?

Yes No

If yes, indicate whom and give details (attach additional sheets if necessary).

Do any of the principals of the operating entity have an ownership, operational or management interest in any other licensed health care facility in any state?

Yes No

If yes, explain the nature of the interest and give name & address of each facility.

Have any principals of the operating entity ever been found guilty of a criminal or administrative charge of resident/patient fraud, abuse or neglect?

Have any of these ever been indicted for the same charge?

Yes No

If yes, explain in detail (attach additional sheets if necessary).

Have any principals of the operating entity ever been indicted for or convicted of a felony crime?

Yes No

If yes, explain in detail (attach additional sheets if necessary).

Attach a list of the names and addresses of partners/stockholders and identify 100% of the ownership, except that for publicly held corporations, identify each principal who has a 10% or greater interest in the corporation.

Equipment

MRI

Make:	
Model:	
Current Software Version:	
List of Software Revisions made and the date that they were made:	
Coils:	
Bore Diameter:	
Year Manufactured:	Table Weight (maximum weight of patient):
	Maximum girth of patient:
Fixed or Mobile Unit:	Tesla:

CT

Make:
Model:
Software Version:
Table Weight (maximum weight of patient):
Year Manufactured:

PET Scan

Make:	<input type="checkbox"/> PET <input type="checkbox"/> PET/CT Combo
Model:	Manufacturer Date:
Table Weight:	Bore Diameter:
Scan Length:	Scannable Range:
Slice Sensitivity/Acquisition Model:	
Name of Supervising Physician:	

Languages

Please circle all languages spoken by staff and/or physicians within your facility:

- | | | | | | |
|-----------|----------|-----------|------------|---------|------------|
| Arabic | Creole | Greek | Japanese | Samoan | Vietnamese |
| Armenian | Croatian | Hebrew | Korean | Sign | Yiddish |
| Cambodian | Danish | Hindi | Mandarin | Spanish | Other_____ |
| Cantonese | French | Hungarian | Portuguese | Swedish | |
| Chinese | German | Italian | Russian | Turkish | |

Modalities

Please check boxes for all modalities offered at your facility:

- MRI
 - MRA
 - Contrast Procedures
 - Arthrogram (*performed at and billed through your location*)
 - Shoulder
 - Elbow
 - Wrist
 - Knee
 - Ankle
 - CT Scan
 - Full Body CT
 - CTA
 - Contrast Procedures
 - General Radiology
 - Orbits
 - Chest/Abdomen
 - Head/Neck
 - Upper Extremity
 - Lower Extremity (spine/pelvis)
 - Nuclear Medicine
 - Bone Scan
 - Fluoroscopy
 - Mammography
 - MR Neurography
 - Myelography
 - PET
 - PET/CT
 - Ultrasound
 - Vertebroplasty
 - Other Modalities _____
-
- IV Sedation available at facility