

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, IAC or JCAHO (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), American College of Radiology(ACR), or the Intersocietal Accreditation Commission (IAC) (if applicable)

ONE CALL MEDICAL INC.

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):	Medicaid # (if applicable):	Workers' Comp# (if applicable):

REMIT ADDRESS INFORMATION:

Federal Tax ID No.:	Electronic Billing: <input type="checkbox"/> Yes <input type="checkbox"/> 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 #:

Commercial General Liability

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

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

Professional 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 (max. weight of patient):	Maximum girth of patient:
Fixed or Mobile Unit:	Tesla:	

CT

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

PET Scan

Make:		<input type="checkbox"/> PET <input type="checkbox"/> PET/CT Combo
Model:	Year Manufactured:	
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	

State Licensure

Is your organization or facility licensed by the state?

Yes No

If yes, please submit a copy of your state license.

JCAHO Accreditation

Is your organization (hospital) accredited by JCAHO?

Yes No

If yes, please submit certificate and letter of accreditation.

If no, does your organization plan to apply?

Yes No

ACR Accreditation

Is your organization or facility accredited by the ACR for MRI services?

Yes No

Is your organization or facility accredited by the ACR for PET Scan services?

Yes No

If yes, please submit certificate and/or letter of accreditation.

If no, has your facility applied for accreditation?

Yes No

If your facility hasn't applied, do you plan to apply in the future?

Yes No

IAC Accreditation

Is your organization or facility accredited by the IAC for MRI services?

Yes No

Is your organization or facility accredited by the IAC for PET Scan services?

Yes No

If yes, please submit certificate and/or letter of accreditation.

If no, has your facility applied for accreditation?

Yes No

If your facility hasn't applied, do you plan to apply in the future?

Yes No

Attestation

I represent and warrant to One Call Medical, Inc. that the information contained in this application is accurate and complete to the best of my knowledge and belief. I agree to inform One Call Medical, Inc. if any material change in such information occurs, whether before or after entering into an agreement with One Call Medical, Inc. I attest by signing this application that the following statements are true:

- (I) This facility is licensed according to state law.
- (II) All Radiology Technologists at this facility are licensed by the American Registry of Radiologic Technologists (ARRT) or by the applicable state licensing agency.
- (III) This facility has a current General Liability Insurance/slip and fall policy.
- (IV) This facility agrees to either (a) maintain medical malpractice insurance in the amounts of at least \$1 million per occurrence with an annual aggregate of \$3 million, or in minimum coverage amounts required in the state where facility is affording Covered Services or (b) ensure that all employed Health Care Providers maintain medical malpractice insurance of at least \$1 million per occurrence with an annual aggregate of \$3 million, or in minimum coverage amounts required in the state where Provider is affording Covered Services.

Name (Please Print)

Signature

Title (Please Print)

Date

Direct questions to: Phone: (800) 872-2875
Fax: (973) 257-9512

Mail/return to: One Call Medical, Inc.
20 Waterview Boulevard
P. O. Box 614
Parsippany, NJ 07054-0614

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	

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

