

HOSPITAL CREDENTIALS VERIFICATION FORM

(Information may be submitted in paper, e mail and or fax format)

DEMOGRAPHIC INFORMATION

Facility Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

Contact Person: _____ Email: _____

Tax ID number: _____

CERTIFICATION AND LICENSURE (Please attach copies to this application)

	Certificate or License Number	Expiration Date
Medicare Certification	_____	_____
State License	_____	_____
JCAHO	_____	_____

PROFESSIONAL LIABILITY INSURANCE

Carrier Name: _____ Policy Number: _____

Effective Date: _____ Expiration Date: _____

Claims Limits: Occurrence: _____ Aggregate: _____

OTHER REQUIRED INFORMATION

CMS Audit (if applicable) Date Received _____ Date to complete deficiencies _____

Advanced Directives Date Implemented _____ Last Update to policy _____

Devon Hospital Verification From page 2

RESTRICTIONS

Please list any license sanctions or regulatory agency sanctions:

CHECK LIST OF DOCUMENTS REQUIRED FOR SUBMISSION

State License _____
Medicare Certification _____
JACHO _____
Mal Practice Face Sheet _____
CMS Audit (if applicable) _____
Advanced Directives policy _____

I attest and certify that I have answered the above questions truthfully and that information given in or attached to this verification is accurate and completed to the best of my knowledge. I understand that, as a condition to making this verification any misrepresentations or misstatements in, or omission of any of these answers, whether intentional or not shall constitute grounds for the termination from the Devon Health Services, Inc. Provider Network

Signature: _____ Date: _____

Printed Name and Title: _____