Facility Application
for Urgent Care Facilities

Required Support Documentation

To avoid any delay in processing a Facility's Application, the following support documentation must be submitted with the Application.

1. Operating Certificate(s) from the state in which the urgent care is located and for each urgent care type being credentialing/recredentialing with MVP.
2. Certificate of accreditation, as applicable from The Joint Commission, AAAHC, CARF, AOA, ACHC, ACR, IAC, CLIA/CLEP,CHAP, HCQAA, HFAP, CABA, or DNV, as appropriate for the urgent care/organization type.
3. Non-accredited urgent care facilities must submit:
   - State review/report conducted within the past three years
   - State required Corrective Action Plan
   - State notification of acceptance of the Action Plan
   - Urgent Care's quality improvement program and structure policy
   - Urgent care's policy for credentialing/recredentialing practitioners
4. Policy binder or face sheet of current professional malpractice and general Liability insurance, including dates and coverage limitations or evidence of Self-insurance/other coverage.

   MVP Health Care® requires Organizational Providers to maintain malpractice and general liability insurance coverage in the amounts of $1 million per incident and $3 million in the annual aggregate.
5. Malpractice claims history including case date, allegation, and status.
6. MVP Urgent Care Site Visit Tool
   - UCCs that are currently accredited by the Joint Commission, Urgent Care Association of America or the National Urgent Care Center Accreditation will not be subject to a practice site assessment

Submitting the Completed Urgent Care Application and Support Documents

Each facility location will be required to submit a separate Facility Application.

Mail the completed application and all support documents to:

ATTN: CREDENTIALING DEPT
MVP HEALTH CARE
625 STATE ST
SCHENECTADY NY 12305-2111

Facility Application
for Urgent Care Facilities

***Required**

Please submit a separate Facility Application for each facility location.

Section 1: Urgent Care Information *(please print)*

Urgent Care Name *(as stated on Licensure/Operating Certificate)* * | Urgent Care DBA Name *

NPI No. * | Tax ID No. * | Entity Name *

Facility Type *(select one)* ☐ Urgent Care ☐ Walk-in Clinic

This urgent care participates with: ☐ Medicare Medicare No. _____ ☐ Medicaid Medicaid No. _____

Does this facility comply with §1128 of the Social Security Act by not hiring, continuing to employ, or contracting with individuals listed on the Office of Inspector General's List of Excluded Individuals/Entities, including owners, employees, subcontractors, and others identified in §1128? ☐ Yes ☐ No

Service Address * | Handicap Accessible * ☐ Yes ☐ No

City * | State * | Zip Code +4 * | County *

Office Email * | Office Phone * ( ) | Office Fax * ( )

Section 2: Contact Information

Contact Name * ☐ Contracting ☐ Credentialing | Title *

Office Email * | Office Phone * ( ) | Office Fax * ( )

Contact Name ☐ Contracting ☐ Credentialing | Title

Office Email | Office Phone ( ) | Office Fax ( )

Contact Name ☐ Contracting ☐ Credentialing | Title

Office Email | Office Phone ( ) | Office Fax ( )

Continued on page 2

Urgent Care Name:

Section 3: Services Information

Is this organization in good standing with all State and Federal Agencies? * ☐ Yes ☐ No If ***No***, provide an explanation.

*For each question below, please provide a written explanation for each **affirmative** response.* *

1. Has any state licensing agency every restricted, denied, limited, suspended, revoked, or reprimanded this urgent care with regard to ability to provide services? ☐ Yes ☐ No
2. Has any governmental agency investigated, suspended, revoked, or taken action against this urgent care? ☐ Yes ☐ No
3. Has this urgent care ever been disciplined by or had its participation in Medicare/Medicaid suspended or revoked? ☐ Yes ☐ No
4. Has this urgent care ever been convicted of a crime? ☐ Yes ☐ No
5. Has this urgent care ever been refused participation, disciplined by, terminated by, or requested to resign from participation in the provider network of a Managed Care Organization (HMO, EPO, or PPO)? ☐ Yes ☐ No
6. Have any professional liability judgments or settlements been entered against or paid on behalf of this facility urgent care the past three years? ☐ Yes If ***Yes***, how many? ☐ No
7. Has this urgent care ever had professional liability insurance refused, revoked, declined, or accepted on special terms? ☐ Yes ☐ No
8. Have accrediting agencies such as The Joint Commission, AAAHC, CARF, ACHC, DNV, ACR, IAC, ISO, CLIA, HFAP, FACT, UHMS, or MSBAQIP ever revoked, suspended, or conditioned this urgent care's accreditation status? ☐ Yes ☐ No

Question number and explanation for each *affirmative* response to the questions above *(or attach additional documentation)*.

Section 4: Malpractice and General Liability Coverage Information

Malpractice and general liability coverage in the amounts of $1 million/$3 million is required. Or attach the Malpractice and Liability facesheet.

Carrier for **General Liability** Coverage * *(attach copy)*		Policy No. *
Policy Effective Date *	Policy Expiration Date *	Limits of Liability * Per occurrence $ Aggregate $

Carrier for **Malpractice (Professional) Liability** Coverage * *(attach copy)*		Policy No. *
Policy Effective Date *	Policy Expiration Date *	Limits of Liability * Per occurrence $ Aggregate $

Continued on page 3

Urgent Care Name:

Section 5: Licensure and Accreditation Information

Type *	State *	Certificate No. * *(attach copy)*	Expiration Date *
Type	**State**	**Certificate No.** *(attach copy)*	**Expiration Date**

Accreditations received for this Urgent Care by a recognized accrediting agency, such as The Joint Commission, AAAHC, CARF, ACR, IAC, CLIA/CLEP, CHAP, HCQAA, HFAP, CABC, or DNV *(attach copy of Certificate)*.

Entity Name	Accrediting Agency

Accreditation Status	Effective Date	Expiration Date
☐ Full/Conditional ☐ Pending		

Entity Name	Accrediting Agency

Accreditation Status	Effective Date	Expiration Date
☐ Full/Conditional ☐ Pending		

Non-accredited Facilities must include the following support documentation when submitting this application:

State review/report conducted within the past three years	*Date of last review:*
State required Corrective Action Plan	*Date of Corrective Action Plan:*
State letter of acceptance of the Action Plan	*Date of acceptance letter:*
Urgent Care's quality improvement program and structure policy	*Date of Policy Review:*
Urgent Care's policy for credentialing/recredentialing practitioners	*Date of Policy Review:*

Section 6: Provider Roster

MVP's policy is that all practitioners providing services in the Urgent Care are providing services in the the Urgent Care are credentialed and in good standing. Please attach a complete roster that includes Provider Names, NPI, Degree, Licence and CAQH information.

Section 7: Information About the Urgent Care

Is a physician (MD/DO) immediately available by phone if not on-site during all posted hours of operation? *	☐ Yes	☐ No
Are written reports emailed/faxed to the patient's Primary Care Physician (PCP) within 24 hours of the patient encounter? * If ***No***, define the process at this urgent care:	☐ Yes	☐ No
Is the patient directed back to their PCP or record or, if the patient has no PCP of record, to a participating MVP physician or urgent care for follow-up care? *	☐ Yes	☐ No
Is a treatment summary provided to all patients upon discharge? *	☐ Yes	☐ No
Is the patient's PCP notified of any patient admission at the time of transfer? *	☐ Yes	☐ No
Is Place of Service (POS) 20 used if urgent care services at this urgent care are billed on form CMS-1500? *	☐ Yes	☐ No

Continued on page 4

Urgent Care Name:

What procedures can be performed in this Urgent Care Center? *

- ☐ X-ray
- ☐ CT
- ☐ MRI
- ☐ Diagnostic US
- ☐ Casting
- ☐ Nebulizer Treatment
- ☐ Sutures
- ☐ IV Therapy
- ☐ COVID-19 testing
- ☐ Pediatrics
- ☐ Orthopedics
- ☐ Cardiology
- ☐ Lab
- ☐ Other *(specify)*:

If x-rays are performed on-site, are the radiologists services billed by this Facility? ☐ Yes ☐ No

If x-rays are not performed on-site, which radiologist or radiology group reads the x-rays for this urgent care?

Does this urgent care send lab work to an outside lab for analysis? * ☐ Yes ☐ No

If ***Yes***, what lab is used for MVP Health Care members?

Does this urgent care offer Telehealth Services? * ☐ Yes ☐ No

Does this urgent care offer Audio/Video? * ☐ Yes ☐ No

Does this urgent care offer Audio only? * ☐ Yes ☐ No

What Platform

Does this Urgent Care have a specialty? I.E. Pediatrics, Orthopedics

Do you agree to participate with all MVP Health Care products? * ☐ Yes ☐ No

Provide the hours of operation for this Urgent Care Center: *

Monday	Tuesday	Wednesday	Thursday
am– pm	am– pm	am– pm	am– pm
Friday	**Saturday**	**Sunday**	**Holidays**
am– pm	am– pm	am– pm	am– pm

List any holidays that this urgent care is closed: *

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Urgent Care Name:

Section 8: Signatures and Attestation

I hereby attest that the Urgent Care Center named on this application maintains a protocol for the urgent/emergent transfer of MVP Health Care patients to an appropriate par MVP hospital, as needed. The urgent care must be able to provide this documentation to MVP upon request. At a minimum, the transfer protocol includes:

- A detailed description of how the Urgent Care Center facilitates the emergent transfer of patients to a hospital setting.
- A description of the communication that takes place between the urgent care center and the receiving hospital, including:
  - That a provider-to-provider conversation with the receiving hospital occurs prior to the patient transfer, that the communication is documented in the patient's medical record, and applicable medical records are provided to the hospital.
  - Within 24 hours, written or verbal communication takes place between the Urgent Care Center and the patient's Primary Care Physician that documents the name of the hospital to which the patient is referred/transferred.

Name (print) * *Title* *

Signature * *Date* *

By placing my signature below, I hereby attest that the information in this application is complete and accurate, and I agree to provide information as required to support this application. I further certify that the above information provided in this application is truthful, correct, and complete in all respects, and I understand that the submission of false and/or significantly misleading information, or the withholding of relevant information is grounds for termination of the contract.

Name (print) * *Title* *

Signature * *Date* *