

## Facility Application

### Instructions

In order to complete the facility credentialing process, Raytel Imaging Network requires the following ***CURRENT*** information/documentation for each imaging facility requesting to join the Raytel Imaging Network of providers. ***An application, which is not accompanied by all required documents noted in the checklist below, will cause a delay in the credentialing process.*** Raytel Imaging Network has an established standard of 180 days to complete the entire credentialing process from receipt of completed application through final credentials decision.

- Complete the Facility Application in its entirety.
- Please type or print application in legible writing – prefer typed.
- Review your application before signing and mailing. **Incomplete applications will not be processed and will be returned to you resulting in a delay in the credentialing process.**
- Sign and date application.
- Keep a copy of your application for your own file.
- ***A Facility Application must be completed for each facility. If you have multiple locations, please reproduce this application, as needed.***

Failure to accurately answer and/or falsifying any of the responses on this application will constitute cause for immediate and automatic denial of affiliation and/or termination of affiliation with Raytel Imaging Network.

***The following information must be attached to Facility Application in order to complete the application and credentialing process. Only applications accompanied by ALL required documentation as noted on attached Facility Credentialing Checklist and Physician Credentialing Checklist will be accepted for review.***

- Facility Application completed in its entirety and signed/dated
- Physician Applications for each physician at the facility must be completed in entirety with Attestation and Release signed/dated
- Preferred Provider Agreement (2 original copies signed by facility)
- Copy of Certificate of Incorporation/Formation Documents
- Copy of all Required Current Facility Licenses/Certifications
- Copy of Current Commercial General Liability Insurance and Professional Liability Insurance, if applicable
- ALL Current Equipment ACR Accreditation Certificates, as applicable; i.e. MRI, CT, Mammography, Ultrasound, PET
- W-9
- Samples of Patient Information/Brochures
- List of all multi-locations, if applicable
- Copies of all applicable certifications for all facility technologists

If you have any questions or need clarification regarding this application, please call the Provider Relations/Credentialing Department at 1-800-453-0574, extension 125.

**Please mail completed Facility Application with all documentation to:**

Raytel Imaging Network  
Attn: Provider Relations/Credentialing  
101 West Fourth Avenue  
Collegeville, PA 19426

**Facility Application**

**Facility Information:** *(A Separate Application Must Be Completed for Each Facility)*

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ County: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Tax Identification # *(W-9 must be attached)*: \_\_\_\_\_ NPI #: \_\_\_\_\_

Facility License/Registration Certificate #/Expiration Date: \_\_\_\_\_

Facility State License #/Expiration Date: \_\_\_\_\_

*(Copy of current license/certificate must be attached)*

**Facility Contact Person:**

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Contract Negotiator Contact Person:**

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Medical Reports Contact Person** *(REQUIRED: FAX # for Medical Reports; RIN f/up is via FAX, not phone)*

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ **FAX:** \_\_\_\_\_

What Bi-Lingual capabilities are available at this Facility? (Specify language(s)): \_\_\_\_\_

Handicap Access?     Yes     No                      Transportation Available?     Yes     No

**Hours/Days of Operation:**

Sunday: \_\_\_\_\_ Monday: \_\_\_\_\_

Tuesday: \_\_\_\_\_ Wednesday: \_\_\_\_\_

Thursday: \_\_\_\_\_ Friday: \_\_\_\_\_

Saturday: \_\_\_\_\_

**Other Managed Care/Insurance Participation (Please check):**

Aetna/USHC     Medicare     Keystone HealthPlan East     Medicaid

AmeriHealth     BC/BS     Personal Choice     Oxford

Other: \_\_\_\_\_

**List all physicians who provide services at this location. (Attach sheet if additional space needed)**

Physician Name	DOB	SS#	DEA#	License #/Expir.

**List all technologists at this location – attach copies of all certificates (Attach sheet if additional space needed)  
- Provide copy of facility policy for Technologist supervision by facility physician.**

Technologist Name	CPR Cert.	TB Cert.	MRI Accred	Mammo Accred	ARRT #/Expir.

**Does your facility perform background checks on all employees?**  Yes  No

If yes, what type? \_\_\_\_\_

**Services Facility Will Provide – Complete attached New Facility Equipment Summary**

**Is your facility part of a group of imaging facilities?**  Yes  No

If yes, attach a separate sheet listing all facilities - name, address, phone and modalities offered at each location.

**Are the payments to go directly to this facility?**  Yes  No

**Remittance Information:**

*(Please note: The IRS requires that Tax ID #, Remit to Name and Remit to Address be exactly as appears on W-9 form. Remit to Name is entity name payment checks are made payable to – not a dba)*

**Remittance Name (complete even if same as facility name):**

\_\_\_\_\_

**Remittance Address (complete even if same as facility address):**

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Remittance Contact:**

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Credentialing Information:**

**Credentialing Contact:**

Name/Title: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Management Information:**

Is Contract being entered into by Facility?  Yes  No Management Group?  Yes  No

**If Management Group:**

Co. Name \_\_\_\_\_ Contact/Title: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ e-mail: \_\_\_\_\_

**Ownership:**

Type of Ownership:  Sole Proprietorship  Partnership  Corporation  Hospital Corporation

Limited Liability (LLC)  Other: \_\_\_\_\_

**Please complete following for each owner of this Facility:**

Name	Medical License #	Social Security #	% Ownership

**Insurance Information:** *(copy of current insurance policy face sheet must be attached)*

**General Liability Insurance:**

Co. Name: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

**Workers Compensation:**

Co. Name: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

**Professional Liability Insurance:**

Co. Name: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

## Attestation and Release

### ***PLEASE READ CAREFULLY BEFORE SIGNING***

By signing this application, I attest that all of the information submitted in this application is true to the best of my knowledge and belief. I understand that any misstatement or omissions from this application may constitute cause for denial of my application, or if subsequently discovered, to terminate my participation with Raytel Imaging Network (RIN).

By applying for membership in RIN, I hereby signify my willingness to discuss information contained in this application. I hereby consent to the inspection by representatives of RIN of all documents that may be material to an evaluation of the facility and consent to RIN's query of such services as the American College of Radiology and as applicable State License verifications, and other agencies.

I hereby release from liability all RIN representatives for their acts performed in good faith and without malice in connection with evaluating the facility application and credentials. I hereby release from any liability any and all individuals and organizations that provide information to RIN in good faith and without malice concerning credentials of the facility this application is being submitted for.

I understand and agree that I, as the owner or authorized provider representative for this facility, have the burden of producing adequate information for proper evaluation of the facility's credentials. I understand that I have the right to correct erroneous information and the right to review information obtained to evaluate the facility credentialing application unless disclosure is prohibited by law or the information is protected by peer review.

***I understand that approval of this application is contingent upon review and acceptance of this application by the Raytel Imaging Network Review Committee and receipt of the signed Preferred Provider Contract, Physician(s) Application(s) and all information/documents referenced in the Facility Credentialing Checklist, which is attached.***

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*Physician or Authorized Provider Representative Signature*

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*Date*

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*Print Name/Title*

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## NEW FACILITY EQUIPMENT SUMMARY

*Please check all services you currently provide at your facility and complete all equipment specifications. In order for Raytel to offer the full services you provide, please be specific regarding coils you have – i.e. Breast MRI*

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### Services Facility Provides (Check all that apply):

- |   |   |   |                                      |  |
|---|---|---|--------------------------------------|--|
| <input type="checkbox"/> MRI              | <input type="checkbox"/> Open MRI           | <input type="checkbox"/> MRA              | <input type="checkbox"/> CT          | <input type="checkbox"/> Bone Densitometry |
| <input type="checkbox"/> X-Ray            | <input type="checkbox"/> Fluoroscopy        | <input type="checkbox"/> Arthrography     | <input type="checkbox"/> Mammography | <input type="checkbox"/> Ultrasound        |
| <input type="checkbox"/> Nuclear Medicine | <input type="checkbox"/> Nuclear Cardiology | <input type="checkbox"/> Echocardiography | <input type="checkbox"/> EKG         | <input type="checkbox"/> Holter Monitoring |
| <input type="checkbox"/> IVP              | <input type="checkbox"/> Doppler Studies    | <input type="checkbox"/> Myelography      | <input type="checkbox"/> EMG         | <input type="checkbox"/> PET               |
| <input type="checkbox"/> Other _____      |   |   |                                      |  |

### Equipment Specifications:

#### Magnetic Resonance Imaging (MRI) – Closed

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_ Field Strength: \_\_\_\_\_  
Table Weight: \_\_\_\_\_ Software: \_\_\_\_\_ Coils: \_\_\_\_\_  
ACR Accreditation #: (Copy of Certificate to be attached) \_\_\_\_\_

#### Magnetic Resonance Imaging (MRI) – Open

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_ Field Strength: \_\_\_\_\_  
Table Weight: \_\_\_\_\_ Software: \_\_\_\_\_ Coils: \_\_\_\_\_  
ACR Accreditation #: (Copy of Certificate to be attached) \_\_\_\_\_

#### Computed Tomography (CT)

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_ Table Weight: \_\_\_\_\_  
Capabilities: \_\_\_\_\_  
ACR Accreditation #: (Copy of Certificate to be attached) \_\_\_\_\_

#### Mammography:

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Capabilities: \_\_\_\_\_  
ACR Accreditation #: (Copy of Certificate to be attached) \_\_\_\_\_  
FDA Certification #: (Copy of Certificate to be attached) \_\_\_\_\_

#### Ultrasound:

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Capabilities: \_\_\_\_\_  
ACR Accreditation #: (Copy of Certificate to be attached) \_\_\_\_\_

#### Nuclear Medicine:

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Capabilities: \_\_\_\_\_  
Current NRC License #: \_\_\_\_\_ Current State Materials License #: \_\_\_\_\_

#### Radiography/Fluoroscopy:

Manufacturer/Model: \_\_\_\_\_ Year Manufactured: \_\_\_\_\_  
Capabilities: \_\_\_\_\_

\_\_\_\_\_  
*Signature Owner or Authorized Provider Representative Completing this Form*

\_\_\_\_\_  
*Date*