

HOSPITAL APPLICATION



THE PREFERRED NETWORK OF GEHA



Part 1. Participating Hospital Profile (please print)

PARTICIPATING HOSPITAL:

Contact Name: _____ Contact Phone Number: _____

Hospital Name: _____ Main Telephone Number: _____

Legal Name of Entity: _____

Street Address: _____ Fax Number: _____

City/State/Zip: _____ Federal Tax ID Number: _____

Legal name under which Tax ID Number is filed: _____

Type of Hospital: **Handicap Accessible:** Yes No

General Acute Care Hosp Psychiatric Hosp Rehabilitation Hosp Children's Hosp

Orthopedic Hosp Surgical Specialty Hosp Other: _____

BILLING LOCATION:

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

ADDITIONAL LOCATION OR AFFILIATE: *(Attach a separate sheet for additional locations.)*

Name: _____ Telephone Number: _____

Street Address: _____ Fax Number: _____

City/State/Zip: _____ Federal Tax ID Number: _____

Legal name under which Tax ID Number is filed: _____

Type of Facility: **Handicap Accessible:** Yes No

Laboratory Radiology Surgicenter PT/OT Dialysis Center PET Scan

Urgent Care Facility Sleep Diagnostic Center Lithotripsy Pain Clinic

Family Planning Center Diagnostic Medicine Cardiac Rehabilitation

Cancer Center Other _____

Day Treatment Ctr - Choose One: Psych Only Chemical Dependency Only Psych & CD

Residential Treatment Ctr - Choose One: Psych Only Chemical Dependency Only Psych & CD

BILLING LOCATION:

Street Address: _____

City/State/Zip: _____

Telephone Number: _____

Part II. Credentials

A. Each facility can provide, at this time or immediately upon request, the current and valid credentials listed below:

1. Appropriate license(s) for state/municipality in which facility is located.

Yes No **If "Yes," please attach copy of license.**

2. General and professional liability/malpractice insurance as required by law.

Yes No **If "Yes," please attach copy of face sheet.**

3. Check all appropriate certifications that apply. **Please attach copy(ies).**

JCAHO

American Osteopathic Association

Medicare

Other: _____

4. Are services at the facility within the range of those expected to be provided?
(Please attach a list of services, if available.)

Yes No **If "Yes," please attach copy of information.**

5. Copy of W-9 for Legal name under which Tax ID Number is filed.

Yes No **If "Yes," please attach copy of information**

B. If any "No" answers above, please explain:

Part III. Utilization Performance

Please identify your facility Utilization Performance indicators for the previous calendar year:

Number of Admissions:	
Average Length of Stay Per Admission:	
Number of Outpatient Procedures:	
Number of Beds:	

Part IV. Contact Person

Please provide contact name and telephone number for questions regarding ongoing network updates.

Name: _____ Telephone Number: _____

Part V. Attestation

I attest that the credentials listed in Part II of this Application are currently in effect and verifiable. Furthermore, I warrant that I have authorization from the Hospital to apply to the PPO USA Network on its behalf.

Signature of Company Officer

Telephone Number

Type or print name of Company Officer

Fax Number

Title

Date of Signature