BLUECHOICE HEALTHPLAN CORPORATION

FACILITY INFORMATION REQUEST FORM

Return this form along with a copy of your state license and a copy of any site surveys completed within the last three years to our confidential fax: 803-714-0598.

I. DEMOGRAPHIC DATA

1.	Name of Facility				Tax ID#	
	Address				County	
3.	Phone#		Fax#		Email Address	
4.	Type of Facility	☐ Hospital ☐ Ambulatory Surgical Center ☐ Skilled Nursing Facility ☐ Nursing Home				

II. ACCREDITATION

1. Please provide a copy of your state license.
2. Does your facility require a DEA license? ☐ Yes ☐ No **If yes, please provide an <u>updated</u> copy.**.
3. Does your facility participate in the Medicare/caid program? ☐ Yes ☐ No **If yes, please provide <u>a copy of the latest</u> state (SC-DHEC) survey**.
4. Has a Medicare/caid survey ever been performed at your facility? ☐ Yes ☐ No **If yes, please provide <u>a copy of the latest</u> survey**.
5. Is your facility accredited by any of the following ☐ Yes ☐ No

☐ JCAHO	Last survey date: ______________	☐ AOA	Last survey date: ______________
☐ AAAHC	Last survey date: ______________	☐ CCAC	Last survey date: ______________
☐ CARF	Last survey date: ______________	☐ AAAASF	Last survey date: ______________
☐ ACHC	Last survey date: ______________	☐ CHAP	Last survey date: ______________

☐ Other Explain:

____

III. PERSONNEL / SERVICES

1. Size of Staff (MDs) Active = ______________ Consulting = ______________ Courtesy = ______________
2. What percentage of medical staff is board certified by the American Board of Medical Specialities? ______________
3. List services (i.e., labor & delivery, intensive care, etc.)

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4. Do you offer any specialized services (i.e., cancer center, neonatal intensive care, etc.) ☐ Yes ☐ No If yes, list services

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5. Briefly explain credentialing procedures for medical staff:

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6. Do you maintain multi-disciplinary Quality Assurance Committees? ☐ Yes ☐ No

I CERTIFY THAT ALL INFORMATION CONTAINED IN THIS FACILITY INFORMATION REQUEST FORM AND ALL ITS ATTATCHMENTS ARE ACCURATE, COMPLETE AND TRUE.

Completed by: ______________________________ Title: ______________________ Date: ______________

PLEASE PRINT NAME: ______________________________________ Telephone #: ____________________

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