



PROFESSIONAL PHYSICIAN/PRACTICE ASSESSMENT FREE STANDING FACILITY

Please complete the form below and return with all required documentation to:

**CareCore National, LLC
Attention Credentialing Department
400 Buckwalter Place Boulevard
Bluffton, SC 29910**

Or fax all documentation to CareCore National Credentialing Department at 845-298-8384.
If you have questions, contact the Credentialing Department at 800-918-8924 ext 10190.

Revised 9/1/2009

Please attach the following documents to this Professional Physician/Practice Assessment.**REQUIRED DOCUMENTS (as applicable)**

_____ A copy of the Certificate of Registration for each site

_____ A copy of the Premises Liability Coverage face sheet for each site (minimum \$1/3 million)

_____ A copy of the Professional Liability Insurance for Non-Physicians/Technicians

_____ A copy of a completed W-9 for each site

_____ A copy of the site's Nuclear Medicine Radioactive Materials License if providing Nuclear Medicine or PET services

_____ Current ACR, ICANL, IAC or AIUM accreditation for the following equipment as specified below. For new/newly added equipment, ACR certification must be provided within 6 months of first clinical use or modality privilege shall be deactivated.

- Mammography: FDA certificate and ACR accreditation for all devices
- MRI: ACR or IAC accreditation for all devices
- CT: ACR or IAC accreditation for all devices
- PET: ACR accreditation for all devices
- Nuclear Medicine: ACR or ICANL accreditation for all devices
- Obstetrical Ultrasound: ACR or AIUM accreditation for all devices
- Ultrasound: ACR or AIUM accreditation for all devices

_____ A copy of a current State/Physicist inspection for the following and any corrective action taken for deficiencies:

- Mammography
- MRI
- CT
- Radiography and Fluoroscopy
- Nuclear Medicine
- PET or PET/CT

_____ Copies of the National Provider Identifier notification(s) received from National Plan and Provider Enumerator System for each provider and site.

_____ A copy of the Image Gently confirmation form ([www. imagegently.com](http://www.imagegently.com))

_____ Submit a statement from your physicist that your CT scanner(s) and scan protocols meet the requirements of the Image Gently Program.

EQUIPMENT STANDARDS REQUIREMENT

It is the provider's/practice's responsibility to comply with and remain compliant with the equipment standards as published on the CareCore National website. These standards are subject to regular and/or as needed review, and will change as hardware and software technology evolves and as referenced resources (i.e. ACR, IAC, etc.) are updated.

To view the equipment standards, please visit http://www.carecorenational.com/PDFS/Min_Equip_Standards.pdf.

Lead physician initials: _____

PROFESSIONAL PHYSICIAN/PRACTICE ASSESSMENT

1. Is this a new practice/group?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, provide Practice and/or Site ID#			
A. Is this an additional site to an existing practice contract?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Is this an additional modality to an existing site?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If 1.B is yes, please list modalities:			
2. With which CareCore National affiliated health plan(s) do you wish to participate?			
Aetna NJ	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aetna NY	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Net NJ	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Health Net NY	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
HIP	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Horizon BCBS NJ	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oxford	ID#:	Are you already participating with this plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Is this request for a Global or TC/PC contract? <input type="checkbox"/> Global <input type="checkbox"/> TC/PC SPLIT <input type="checkbox"/> PC ONLY			

I. PROFESSIONAL INFORMATION

A. Radiology Group.

Practice/Group Name:			
Street Address:			
City, State & Zip:			
County:		No. years at this address:	
Telephone:	()	Fax:	()
Email:		Website:	
Tax ID #:		National Provider Identification (NPI) #:	

Lead physician initials: _____

II. FACILITY INFORMATION

A. Facility Name. (Specify if different from name of Practice/Group):

Facility Name:			
Street Address:			
City, State & Zip:			
County:		No. years at this address:	
Telephone:	()	Fax:	()
Email:		Website:	
Tax ID #:		National Provider Identification (NPI) #:	
<p>Type of facility:</p> <p><input type="checkbox"/> Radiology service within a private medical group or practice <input type="checkbox"/> Free standing imaging center</p> <p><input type="checkbox"/> Mobile service <input type="checkbox"/> Hospital-based practice</p> <p><input type="checkbox"/> Other (list) _____</p>			
B. Owner information (required)			
Name:		Tax ID#:	
Address:			
Phone:		Fax:	
C. Operational structure. (Check all that apply):			
<input type="checkbox"/> Corporation	<input type="checkbox"/> Limited Liability Company	<input type="checkbox"/> Government	<input type="checkbox"/> Not-for-Profit Corporation
<input type="checkbox"/> Partnership	<input type="checkbox"/> Professional Corporation	<input type="checkbox"/> Sole Proprietorship	<input type="checkbox"/> Subsidiary
<input type="checkbox"/> Faculty Practice Plan	<input type="checkbox"/> Limited Liability Partnership		
*If more than one is checked, please explain:			
* If subsidiary, name and address of parent company:			

Lead physician initials: _____

D. Physicians.* List all physicians who practice at this site and their relationship to this site, e.g., shareholder, partner, member, employee, etc. Please list board certification status of each physician and, if board eligible, date of initial board eligibility.

Physician Name					
Specialty					
State					
License Number					
NPI #					
Relationship					
Board certified Yes/No?					
If yes, name of board					
If no, date eligible					

E. Physicians. Please list location and date of fellowship training for each physician (if applicable). *Attach a separate sheet if needed.*

Physician name	Fellowship Training (Yes/No)	If yes, location and date
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	

F. Ownership Status/Business Affiliations

1) If any item of equipment is leased, from whom?

- Bank Hospital Leasing company
- Full time equipment Turnkey facility lease Per diem/Facility lease
- Facility lease / Equipment manufacturer
- Another physician group (explain): _____
- Other (explain): _____

Lead physician initials: _____

2) Does your practice lease or own its office space? Lease Own
 If leased, from whom? Commercial landlord Hospital Members of your own group
 Another physician group (explain) _____
 Other (explain): _____

3) Do any physicians who make referrals to your practice have any of the following financial relationships with your practice:

a. Have an ownership or other financial interest in any of the equipment utilized by your practice?
 Yes No

b. Have an ownership or other financial interest in any of the office space utilized by your practice?
 Yes No

c. Have any form of compensation arrangement with your practice (e.g., provide medical, consulting, administrative, billing, etc.)?
 Yes No

4) Is the facility shared with any other physician, physician group or other legal entity? Yes No

G. Equipment On-Site (Check all that apply):

<input type="checkbox"/> X-Ray	<input type="checkbox"/> Mammography	<input type="checkbox"/> Digital mammography	<input type="checkbox"/> Fluoroscopy
<input type="checkbox"/> Nuclear medicine	<input type="checkbox"/> CT	<input type="checkbox"/> MRI	<input type="checkbox"/> MRA
<input type="checkbox"/> Ultrasound	<input type="checkbox"/> DEXA	<input type="checkbox"/> PET	<input type="checkbox"/> PET/CT
<input type="checkbox"/> Nuclear Cardiology	<input type="checkbox"/> Echocardiography	<input type="checkbox"/> Stress Echocardiography	<input type="checkbox"/> Breast MRI
<input type="checkbox"/> Special invasive procedures (detail) _____			
<input type="checkbox"/> Other (explain): _____			

H. Procedure Capacity vs. Current Utilization (Number Procedures Possible per Week vs. Actual Number Performed). Example: 100/50.

X-ray	/	Mammo	/	Digital Mammo	/
Nuclear Medicine	/	CT	/	MRI	/
MRA	/	Ultrasound	/	DEXA	/
PET	/	PET/CT	/	Fluoroscopy	/
MRI Spectroscopy	/	MRI Guided Breast Biopsy		/	
Other special invasive procedures (explain):					
Other (explain):					

Lead physician initials: _____

I. Contact Names, Telephone Numbers, Email Addresses	
Medical Director:	Specialty:
Billing/Collection:	
Office Manager:	
Credentialing Manager:	

J. Days and Hours of Operation							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM							
PM							

K. Physician Site Coverage
 Does the site have on-site staffing by a board certified radiologist for a minimum of seven hours per day during normal business hours (Monday-Friday)? Yes No
 (Sites within a 0.25 mile radius of each other shall be treated as a single site location for the purpose of meeting physician staffing requirements.)

L. Critical Operating Policies/Procedures			
Policy			
Quality Improvement Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Emergency Cart Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Nuclear Medicine Spills Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Film labeling Standards	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Written Techniques/protocols for each individual study	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Film Processor Maintenance Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Bloodborne Pathogen Compliance Policy and Procedure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Incident Reporting Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Fire and Disaster Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Patient Drug Reaction Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Results Reporting Policy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Radiation Safety	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Quality Control Plan for each piece of equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Chemical Hazards Safety Plan	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Complaints Policy and Procedures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA
Electronic Medical Records	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> NA

Lead physician initials: _____

III. EQUIPMENT - DESCRIPTION, STANDARDS AND CAPABILITIES

If your facility operates more than one of the following pieces of equipment, please complete a copy of this Section for EACH individual system as well as for each machine.

A. Magnetic Resonance Imaging					
ACR or IAC accredited? (*If yes, attach certificate.) <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> In process. Date of application: _____ / _____ / _____					
DICOM compatible?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Manufacturer:		Model #:			
Model description:					
Date manufactured:		/ /		Date installed:	
		/ /			
Date of last software upgrade:				/ /	
Is this the primary device?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, is it peripheral only?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Used for cardiac?	
				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, EKG gating				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Number of channel parallel processing					
Field strength:		Gradient strength:		Slew rate:	
<input type="checkbox"/> Open <input type="checkbox"/> Fixed <input type="checkbox"/> Stand-up <input type="checkbox"/> Closed <input type="checkbox"/> No stand-up but has weight bearing device <input type="checkbox"/> Mobile. If Mobile, days of week available: _____					
Check all that apply:					
<input type="checkbox"/> Staffed by licensed, registered technologist(s)			<input type="checkbox"/> 3-D		
<input type="checkbox"/> Spectroscopy			<input type="checkbox"/> Sedation available on site		
<input type="checkbox"/> MRA If MRA, list anatomic sites imaged: _____					
Breast MRI provided:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Bilateral capability:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
MRI guided breast biopsy provider:				<input type="checkbox"/> Yes <input type="checkbox"/> No	
List coils:					
Additional comments:					
B. Computerized Tomography					
ACR or IAC accredited? (*If yes, attach certificate.) <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> In process. Date of application: _____ / _____ / _____					
Manufacturer:		Model #:			
Model description:					
Date manufactured:		/ /		Date installed:	
		/ /			

Lead physician initials: _____

Date of last software upgrade:		/ /	
Slices per rotation:		<input type="checkbox"/> Fixed	<input type="checkbox"/> Mobile
Check all that apply: <input type="checkbox"/> 3-D reformation <input type="checkbox"/> Has weight bearing device <input type="checkbox"/> Staffed at all times by licensed, registered technologist(s)			
Coronary CTA	<input type="checkbox"/> Yes * <input type="checkbox"/> No	If yes, # of slices per rotation	
CTA (Lower Extremities)	<input type="checkbox"/> Yes * <input type="checkbox"/> No	If yes, # of slices per rotation	
Additional comments:			
C. Mammography			
ACR accredited? (*If yes, attach certificate.) <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> In process. Date of application: ____ / ____ / ____			
Manufacturer:		Model #:	
Model description:			
Date manufactured:	/ /	Date installed:	/ /
Date of last software upgrade:	/ /	<input type="checkbox"/> Fixed	<input type="checkbox"/> Mobile
Computer aided detection:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
BIRADS Lexicon and report structure		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Check all that apply: <input type="checkbox"/> Stereotactic biopsy <input type="checkbox"/> Needle localization <input type="checkbox"/> Staffed by mammography certified technologist(s)			
Do you utilize a processor dedicated just for mammography use?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Digital Mammography			
ACR accredited? (*If yes, attach certificate.) <input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> In process. Date of application: ____ / ____ / ____			
Manufacturer:		Model #:	
Model description:			
Date manufactured:		Date installed:	/ /
Staffed by mammography certified technologist(s)		<input type="checkbox"/> Yes	<input type="checkbox"/> No

Lead physician initials: _____

E. DEXA-Bone Density			
Manufacturer:		Model #:	
Model description:			
Date manufactured:	/ /	Date installed:	/ /
Date of last software upgrade		/ /	
Capable of performing lumbar spine, hip and forearm studies?			<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile
Fan Beam	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pencil Beam	<input type="checkbox"/> Yes <input type="checkbox"/> No
Equipment is staffed at all times by a: <input type="checkbox"/> Licensed RT <input type="checkbox"/> Physician			
Additional comments::			
F. Nuclear Medicine			
ACR or ICANL accredited? (*If yes, attach certificate.)			
<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> In process. Date of application: _____ / _____ / _____			
Nuclear camera:	<input type="checkbox"/> Mobile <input type="checkbox"/> Stationary non-SPECT <input type="checkbox"/> Stationary SPECT		
Number of detectors:		Manufacturer:	
Model:			
Date manufactured:	/ /	Serial Number	
Collimator (check as applicable)	<input type="checkbox"/> LEHR Low Energy <input type="checkbox"/> Medium Energy <input type="checkbox"/> High Energy		
Check all that apply:			
<input type="checkbox"/> Cardiovascular nuclear medicine (cardiac nuclear imaging)			
<input type="checkbox"/> Generalized SPECT studies			
<input type="checkbox"/> Staffed at all times by NMTCB and certified ARRT(s) Technologist(s)			
Quality Assurance Requirements Automatic integral and field uniformity (computed) <5% Spect:			<input type="checkbox"/> Yes <input type="checkbox"/> No
COS (center of rotation) and floods (computed) <1-2 pixels:			<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last Jaszczak Phantom acquisition:			/ /
G. PET or PET/CT			
ACR or ICANL accredited? (*If yes, attach certificate.)			
<input type="checkbox"/> Yes* <input type="checkbox"/> No <input type="checkbox"/> In process. Date of application: _____ / _____ / _____			
CT utilized without PET?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# Slices per rotation:	

Lead physician initials: _____

Do you use fusion software imaging?		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, fusion with:		<input type="checkbox"/> CT <input type="checkbox"/> MRI	
Date of last fusion software upgrade:		/ /	
Manufacturer:		Model #:	
Date manufactured:	/ /	Serial Number:	
Sodium iodide detector system:		<input type="checkbox"/> Yes <input type="checkbox"/> No	
H. Ultrasound			
ACR or AIUM accredited? (*If yes, attach certificate.)		<input type="checkbox"/> Yes* <input type="checkbox"/> No	
Manufacturer:		Model #:	
Model Description:			
Date manufactured:	/ /	Date installed:	/ /
Date of last upgrade:	/ /	<input type="checkbox"/> Fixed <input type="checkbox"/> Mobile	
Utilizes state –of-the-art technology		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Check all that apply:			
<input type="checkbox"/> 4 MHz (abdomen, renal, pelvic, OB aorta)		<input type="checkbox"/> 7 MHz Linear (vascular)	
<input type="checkbox"/> 7 MHz Curved (pediatric abdomen, renal and pelvic)		<input type="checkbox"/> 8MHz (endovaginal)	
<input type="checkbox"/> 9.0 MHz (endorectal)		<input type="checkbox"/> 12 MHz Linear breast, thyroid, testicular)	
<input type="checkbox"/> Carotid		<input type="checkbox"/> Color doppler	
<input type="checkbox"/> Echocardiography		<input type="checkbox"/> P/V	
<input type="checkbox"/> Biopsy		<input type="checkbox"/> Recording to film or electronic media	
<input type="checkbox"/> 3 D			
<input type="checkbox"/> Other: _____			
Staffed at all times by ARDMS certified sonographer(s)		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Additional comments:			
I. Digital Imaging			
<input type="checkbox"/> Film processor		<input type="checkbox"/> Digital radiography	
		<input type="checkbox"/> Computed radiography	
Manufacturer:		Model #:	

Lead physician initials: _____

J. Radiography and Fluoroscopy			
Manufacturer:		Model #:	
Model Description:			
Date manufactured:	/ /	Date installed:	/ /
Date of last software upgrade:	/ /		
Staffed, at all times by licensed, registered certified technologist(s)	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Additional comments:			

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND CORRECT.

Radiology group: _____

Name (please print): _____

Signature of lead physician: _____

Title: _____ **Date:** _____

Lead physician initials: _____