INTERWEST Health ®

PROVIDER APPLICATION

For Health Care Facilities

FACILITY INFORMATION

Facility Name: _____

Type: [ ] Hospital
[ ] Other *Please specify*: _____

Tax ID #: _____ Tax ID Name: _____

License #: _____ NPI #: _____ UPIN #: _____

PHYSICAL ADDRESS *

Address: _____

_____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

BILLING ADDRESS *(if different)*

Address: _____

_____

_____

Phone: ( ) _____

Fax: ( ) _____

E-mail: _____

* *If you have more than one location, please provide information on your other locations on a separate piece of paper.*

ACCREDITATION

Accreditation [ ] JCAHO
[ ] Other *Please specify:* _____
[ ] None

Medicare/Medicaid Certified [ ] Yes [ ] No

In good standing with state and federal regulatory bodies [ ] Yes [ ] No *(please explain)*

MALPRACTICE INSURANCE

Dates of Coverage: From: _____ To: _____

Amount of Coverage: Per Occurrence: _____ Annual Aggregate: _____

ATTESTATION

I, the undersigned, hereby attest that the information given in or attached to this Application is accurate and complete. I specifically authorize InterWest Health and its authorized representatives to consult with any third party which may have information bearing on the subject matter addressed by this Application and to inspect or obtain any reports, records, recommendations, or other documents or disclosures of third parties that may be material to the questions in this Application. I also specifically authorize any third parties to release information to InterWest Health and its authorized representatives upon request. I hereby release InterWest Health and its authorized representatives, and any third parties, from any liability for any reports, records, recommendations, or other documents or disclosures involving me that are made, requested, or received by InterWest Health and its authorized representatives to, from, or by any third parties, including otherwise privileged or confidential information, made or given in good faith and relating to the subject matter addressed by this Application.

I warrant that I have the authority to sign this Application on behalf of the health care facility identified herein. I understand that any information which (1) I fail to disclose in this Application or (2) is entered into this Application which subsequently is found to be false could result in InterWest Health's refusal to enter into an Agreement with the facility or termination of any Agreement with the facility. I understand that I have the right to: (1) review information InterWest has obtained in the evaluation of this Application, except for references, recommendations or other information that is peer-review protected; (2) be notified in the event that credentialing information obtained from other sources varies substantially from that provided in this Application and to correct erroneous information submitted by another source; and (3) be informed of the status of this Applications, upon request.

SIGNATURE: _____ **DATE:** _____

NAME: _____

TITLE: _____

ITEMS TO BE SUBMITTED WITH APPLICATION

- Facility license
- Accreditation or Medicare/Medicaid certification
- Malpractice insurance face sheet *(to include carrier name, dates, and coverage amounts)*

PLEASE RETURN APPLICATION, SIGNED AGREEMENT, AND THE ABOVE-NOTED ITEMS TO:

InterWest Health
2809 Great Northern Loop, Suite 400
Missoula, MT 59808
Phone: (406) 542-1912 Fax: (406) 542-8350