Diagnostic Testing

AIG Your Partner In Diagnostics
ATLANTIC IMAGING GROUP LLC

110 S Jefferson Rd, Suite 201
Whippany, New Jersey 07981

FACILITY APPLICATION

I. FACILITY INFORMATION

Facility Information: ***Please complete a separate application for each facility.***

Facility Name: ______________________________

Street Address: ______________________________

City: ____________ County: ____________ State: ______ Zip: ______

Phone: ____________ Fax: ____________

Scheduling Phone: ____________ Scheduling Fax: ____________

Federal Tax I.D. No: ____________ Facility License No: ____________

Facility NPI No: ____________ Web Site Address: **www.** ____________

Office Manager Name: ____________ Phone & ext. ____________ e-mail: ____________

Scheduling Mgr. Name: ____________ Phone & ext. ____________ e-mail: ____________

Claims Manager Name: ____________ Phone & ext. ____________ e-mail: ____________

Contact Person: ____________ Phone & ext. ____________ e-mail: ____________

Mailing Address (if different than above)

Address: ____________ City: ____________ State: ______ Zip: ______

Billing Address (if different than above)

Street Address: ______________________________

City: ____________ State: ______ Zip: ______

Billing Business Phone: ____________ Billing Business Fax: ____________

Billing Manager: ____________ ext. ______ email: ____________

Are you ACR accredited for MRI's? ❑ Yes ❑ No ❑ Eligible Expiration Date:

Ownership: *Please check Type of Ownership*:

❑ Solo Proprietorship ❑ Partnership ❑ Corporation ❑ Hospital Corporation ❑ Limited Liability Co. (L.L.C.) ❑ Other

Please list the owners of this Diagnostic Facility and the percent of ownership: **(Ownership must equal 100%)**

Last Name, First Name, Middle Initial	Medical License Number	SS Number	% of ownership

II. SERVICES

Services: *Please check all that apply…*

Do you provide transportation for patients to your facility? ❑ Yes ❑ No

❑ Open MRI ❑ Closed MRI ❑ High Field MRI ❑ CT Scan ❑ Ultrasound ❑ Mammography

❑ X-Ray ❑ Fluoroscopy ❑ Nuclear Medicine ❑ PET Scans ❑ Bone Densitometry ❑ Bone Scan

❑ MRA Capability ❑ Other ____________ **Neuro**: ❑ EMG ❑ NCV

Do you provide Sedation? ❑ Yes ❑ No Notes: ____________

III. INSURANCE INFORMATION (FACILITY'S GENERAL LIABILITY INSURANCE)

General Liability Carrier Name: ______________________________

Street Address: ______________________ City: ______________ State: ________ Zip: __________

Policy Number: ______________________ Coverage Limits: ______________________

Annual Premium: ______________________ Coverage Dates From: ______________ To: ______________

Type of Coverage ❑ Claims Made ❑ Occurrence

IV. FACILITY HOURS — SCHEDULING DEPARTMENT HOURS

Facility Hours			**Scheduling Department Hours Scheduling Phone**		
Monday:	From: ________	To: ________	Monday:	From: ________	To: ________
Tuesday:	From: ________	To: ________	Tuesday:	From: ________	To: ________
Wednesday:	From: ________	To: ________	Wednesday:	From: ________	To: ________
Thursday:	From: ________	To: ________	Thursday:	From: ________	To: ________
Friday:	From: ________	To: ________	Friday:	From: ________	To: ________
Saturday:	From: ________	To: ________	Saturday:	From: ________	To: ________
Sunday:	From: ________	To: ________	Sunday:	From: ________	To: ________

V. EQUIPMENT (fill out only for radiology)

Magnetic Resonance Imaging (MRI)*:

Make/Model ______________ Year Manufactured ______________ Tesla ______________

Table Weight ______________ Software Upgrades ______________ Coils ______________

Computed Tomography (CT)*

Make/Model ______________ Year Manufactured ______________ Table Weight ______________

Mammography*

Make/Model ______________ Year Manufactured ______________

Ultrasound*

Make/Model ______________ Year Manufactured ______________

Nuclear Medicine*

Make/Model ______________ Year Manufactured ______________

Radiography and Fluoroscopy*

Make/Model ______________ Year Manufactured ______________

Utilizes the following exposure reducing technologies: ❑ Collimation ❑ Grids ❑ Intensifying Screens

VI. CONFIDENTIAL INFORMATION

1. Have you ever been denied participation in Medicare, Medicaid or any other governmental or quasi-governmental health related program? ………… ❑ Yes ❑ No
2. Have you ever been reprimanded, censured, excluded, suspended (even if the suspension was stayed), barred or disqualified from participating in Medicare, Medicaid or any other governmental or quasi-governmental health-related program? ………… ❑ Yes ❑ No
3. Have any complaints ever been filed against you by a licensing authority? ………… ❑ Yes ❑ No
4. Have you ever been denied professional liability insurance coverage or had your professional liability insurance coverage canceled by your carrier? ………… ❑ Yes ❑ No
5. Have you ever been refused participation in the network of a managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization? ………… ❑ Yes ❑ No

Please provide an explanation for any question that you responded "yes" to above on a separate page.

VII. ATTESTATION & CREDENTIALS VERIFICATION RELEASE

AUTHORIZATION / ATTESTATION

I hereby authorize **MedCheck** Credentialing Services, LLC acting as a credentials verification organization, or its designee on behalf of single or multiple Clients to consult and access databases of hospitals, institutions, malpractice carriers, any town, state or federal agency, any health care organization, and/or The National Practitioner Data Bank, in order to verify information contained in my application and interview and authorize **MedCheck** Credentialing Services, LLC or its designee to review any of my professional records, civil and criminal records and criminal background. I hereby release and indemnify **MedCheck** Credentialing Services, LLC, it's directors, committee members, employees, agents, servants, its subsidiaries and divisions as well as all licensing bodies, hospitals, societies, organizations, state or federal agencies, towns, and associations from all liability resulting from the release of records or information to **MedCheck** Credentialing Services, LLC, or its designee for credentialing and verification of the information contained in my application. I hereby agree to allow **MedCheck** Credentialing Services, LLC, or its designee to examine my place(s) of business and to survey and evaluate all equipment, appointment availability or patient files used in the provision of health care services. I hereby represent that I will obtain, when necessary the appropriate releases from my patients to permit access to their records so that **MedCheck** Credentialing Services, LLC may conduct medical record review. This patient release does not apply to disclosure of confidential information for purposes other than credentialing and verification of the information contained in my application. Notwithstanding the foregoing, I understand that information relevant to my history, performance and the quality and efficiency of patient care that I deliver and/or my credentials may be disclosed to other associations and organizations that contract with **MedCheck** Credentialing Services, LLC. I hereby agree to notify **MedCheck** Credentialing Services, LLC, of any changes in the above information. By my signature, I hereby attest, represent and warrant that all of the information submitted in this provider application is correct, truthful and complete in all respects. I further understand any misstatement, submission of false and/or misleading information or withholding of relevant information may constitute a condition which may not be favorable to my credentialing. I understand and agree that I, as the applicant, have the burden of producing adequate and reliable information for the proper evaluation of my professional competence, character, ethics and other qualifications for resolving any questions about my qualifications. I hereby understand that I shall have the right at my sole cost and expense to review any information gathered by **MedCheck** Credentialing Services, which relates to my behalf. In the event, I believe any of the information to be inaccurate or incorrect, I shall have the right at my expense to contact the source directly and dispute the validity of the information. In the event the source verifies the information to be inaccurate or incorrect, verifying information shall be sent to **MedCheck** Credentialing Services, LLC, thereafter **MedCheck** Credentialing Services, LLC, at its expense shall correct any information found to be inaccurate or incorrect.

(This application will not be processed if not signed and dated. STAMPED SIGNATURES ARE NOT ACCEPTED.)

Owner or Authorized Representative Signature	Date
Print Name	Social Security Number

Please remember to include copies of the following documents with your completed application.

- ☐ Certificate of Facility Insurance (General Liability Insurance)
- ☐ Operating License
- ☐ Certificate of Need (if applicable)
- ☐ Copy of W-9 Form
- ☐ American College of Radiology (ACR) Certificate(s) for MRIs, CTs, PETs and Nuclear Medicine
- ☐ Roster of Physicians and Physician Application(s)

Please return this form to:

MedCheck Credentialing Services, LLC

110 S Jefferson Rd, Suite 201
Whippany, NJ 07981
Fax: 973-451-9541