SIERRA HEALTH AND LIFE, INC
Credentialing Department, Mail Stop 2716-4
P.O. Box 15645
Las Vegas, NV 89114-5645
Fax: (702) 242-6781

APPLICATION FOR INSTITUTIONAL PROVIDERS

1. IDENTIFYING INFORMATION

____

BUSINESS/INSTITUTION NAME

____

ADDRESS OF BUSINESS/INSTITUTION **CITY** **STATE** **ZIP**

ADDRESS OF ADMINISTATIVE OFFICES **CITY** **STATE** **ZIP**

PHONE **FAX** **email:**

____

NAME OF ADMINISTRATOR RESPONSIBLE FOR INSTITUTION LICENSING AND ACCREDITATION

____

LIST ALL OWNERS OF YOUR AGENCY/FACILITY, AND ANY NAME CHANGES OR PAST NAMES FOR THIS FACILITY

____

NPI Number

SERVICES PROVIDED

2. LICENSING AND CERTIFICATION

MEDICARE/MEDICAID NUMBER:_____________________ **TAX ID NUMBER:** _____________________________

*PLEASE ATTACH PROOF OF MEDICARE ELIGIBILITY, SUCH AS A LETTER FROM HCFA/CMS.

SERVICES YOU BILL MEDICARE FOR____

STATE LICENSE NUMBER:________________ **EXPIRATION DATE:** ________ **LICENSE TYPE**______________

*PLEASE ATTACH A COPY OF THIS LICENSE

FEDERAL LICENSE NUMBER:________________ **EXPIRATION DATE:** ________ **LICENSE TYPE**______________

*PLEASE ATTACH A COPY OF THIS LICENSE

DO YOU HAVE A LABORATORY ON PREMISES? ☐**YES** ☐**NO**

IF YES, WHAT IS YOUR CLIA CERTIFICATE NUMBER?_______________ **EXPIRATION DATE?**_________

*PLEASE ATTACH A COPY OF THIS LICENSE

IF NO, WHO DO YOU SEND LAB WORK TO? ____

NAME

IS YOUR INSTITUTION ACCREDITED BY A NATIONAL ACCREDITING ORGANIZATION, SUCH AS JCAHO, CARF, AAAHC, ETC? ☐**YES** ☐**NO**

IF YES, BY WHOM?______________________________________

*PLEASE ATTACH A COPY OF ACCREDITATION

PLEASE ATTACH A COPY OF YOUR MOST RECENT STATE INSPECTION REPORT.

3. SANCTIONS, RESTRICTIONS, COMPLAINTS OR FINES BY STATE, FEDERAL, OR MANAGED CARE ORGANIZATIONS

HAS YOUR AGENCY IN THE LAST 36 MONTHS HAD ANY:

SANCTIONS OR EXCLUSIONS: ☐**YES** ☐**NO**

IF "YES", BY: ______________________ **DATE:** ________________

RESTRICTIONS: ☐**YES** ☐**NO**

IF "YES", BY: ______________________ **DATE:** ________________

COMPLAINTS: ☐**YES** ☐**NO**

IF "YES", BY: ______________________ **DATE:** ________________

FINES: ☐**YES** ☐**NO**

IF "YES", BY: ______________________ **DATE:** ________________

***FOR ANY "YES" ANSWER, PLEASE PROVIDE A COPY OF ALL RELEVANT DOCUMENTS AND EXPLANATIONS.**

I understand that any material misstatements, misrepresentation or omissions in this application shall constitute cause for denial or for subsequent revocation of participation. I hereby certify that the information in this application is correct and complete.

____

Signature of Administrator ***Printed Name of Administrator*** ***Date***

PLEASE ATTACH THE FOLLOWING (WHEN APPROPRIATE):

_____**COPY OF YOUR STATE LICENSE FOR EACH TYPE OF SERVICE YOU PROVIDE**

_____**DOCUMENTS THAT PROVE MEDICARE/MEDICAID ELIGIBILITY**

_____**COPY OF CLIA CERTIFICATION (IF APPLICABLE)**

_____**COPY OF NATIONAL ACCREDITATION CERTIFICATION (IF APPLICABLE)**

_____**COPY OF BUSINESS LICENSE**

_____**COPY OF LIABILITY INSURANCE**

_____**COPY OF YOUR SURVEY FROM BUREAU OF LICENSURE AND CERTIFICATION, AND ANY OTHER REQUIRED SURVEY/INSPECTION IN THE LAST 12 MONTHS**