PreferredOne®

Provider Selection Criteria for PreferredOne Participating Certified Registered Nurse Anesthetists

General Criteria

1. Practitioner must serve a specialty and/or geographic need for the good of the PreferredOne product for which they are applying.

2. Practitioner must have a current unrestricted/unconditional license/registration in each state services are provided and certification as required.

3. If a practitioner has hospital admitting or attending privileges, the practitioner must have privileges and be a member in good standing of the medical staff at a PreferredOne participating hospital. The existence of any restrictions on privileges must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

4. Practitioner must accept PreferredOne fee schedules.

5. Practitioner must have arranged for 24-hour coverage, 7 days per week.

6. Practitioner must accept patients from all purchasers of the specific PreferredOne products applied for.

7. Practitioner must agree to maintain referrals and admissions at all times within the existing provider network except as authorized by the Medical Director or designee.

8. Practitioner must maintain professional liability (malpractice) insurance in amounts as established from time to time by PreferredOne Boards of Directors.

9. The presence of any past disciplinary or corrective action or current investigation by the State Licensing, Certifying or Registering Board or any other regulatory authority (i.e. Medicare, Medicaid, etc.) having jurisdiction over the practitioner must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

10. The existence of any pending or past professional liability claims must be disclosed and will be examined and acted upon as deemed necessary by the Credentialing Committee.

11. Practitioner agrees to authorize review organizations to release to PreferredOne and information relating to practitioner's professional competence or conduct. Practitioner may present his/her own information also.

12. Practitioner agrees to participate in and cooperate fully with all procedural terms and requirements of the PreferredOne Network Management Services Program that monitors provider performance in terms of chart review (both inpatient and outpatient) for the purpose of identifying quality issues.

13. Practitioner must disclose any restricted/conditioned licensure/registration in each state services are provided. The information will be examined and acted upon as deemed necessary by the Credentialing Committee.

14. A practitioner must be able to document his/her:
    - Training, experience, and demonstrated competence
    - Adherence to the ethics of their profession, good reputation, and character
    - Physical & emotional health status
    - Ability to work with others

15. Practitioner agrees to promptly inform PreferredOne of any changes in licensure, disciplinary actions, professional liability actions, or practice circumstances.

16. Practitioner agrees to inform PreferredOne if charges are pending or if currently charged with or ever been indicted or found guilty of a felony, gross misdemeanor, misdemeanor (other than a minor traffic violation), or other offense.

17. Practitioner must have an absence of a physical or mental condition that would adversely affect the practitioner's ability with or without accommodation, to provider appropriate care to patients and must be able to perform the essential functions in the practitioner's area of practice without posing a health or safety risk to patients.

Specific Criteria for Certified Registered Nurse Anesthetists

1. Provider must be a Registered Nurse and certified as a CRNA with a satisfactory completion of a certified course.

PreferredOne®

Pre-Application for Certified Registered Nurse Anesthetist

This pre-application serves to provide us with general information regarding your practice and professional background. **This form must be completed for each practitioner in the clinic and returned along with a completed "New Clinic/Facility Information Form"**. Incomplete pre-applications will be immediately pended. Thank you for your interest. Please print or type.

Name:	**Degree/License:**
NPI #:	

1. Please list all current State Licensure numbers:

State Licensure:	**Number:**	**Expiration Date:**

2. Please list current DEA number:

Number:	**Expiration Date:**

3. Are you Board Certified?

☐ **Yes** **Board Name:**	**Date:**
☐ **No** **Eligibility Status:**	

4. Are you currently a PreferredOne Provider with a different practice? ☐ **Yes** ☐ **No**
If yes, will you continue to practice at this location? ☐ **Yes** ☐ **No**

5. Please list any Special/Unusual Skills or Services?

6. Please list Hospital Staff Appointments:

Hospital	***Department***

I affirm that the foregoing are True Statements and Facts ☐

Signature:	**Date:**

(If filling out this form electronically, please just check the above box and type in your name and date)

PreferredOne®

Provider Assurance Statement for Telemedicine

Provider Name	NPI

This Assurance Statement is an addendum to the Provider Agreement.

Telemedicine definition

Telemedicine is the delivery of health care services or consultations through electronic communication while the patient at one site and the licensed health care provider at a distant site. Effective January 1, 2018, PreferredOne covers medically necessary services and consultation by a licensed health care provider through telemedicine in the same manner as if the service or consultation was delivered in person. (Minn. Stat. 256B.0625, Subd. 36).

Applicant Assurance Statement

By initialing each requirement and signing below, I, the above-named applicant, attest to compliance with the following and acknowledge that I will maintain documentation proving compliance with these requirements:

_____ I have written policies and procedures specific to telemedicine services that I review and update regularly.

_____ I have policies and procedures that adequately address patient safety, before during and after the telemedicine service is rendered.

_____ I have established quality assurance process related to telemedicine services which includes all applicable Health Insurance Portability and Accountability Act (HIPPA) requirements.

_____ My agency has documentation of each occurrence of a health care service provided by telemedicine that includes all of the following

- The type of service provided
- The time the service began and the time the service ended
- A description of the provider's basis for determining that telemedicine is an appropriate and effective means for delivering service to the recipient
- The mode of transmission of the telemedicine service
- The location of the originating and the distant site

APPLICANT NAME (authorized representative)	APPLICANT SIGNATURE	Date

Fax the signed Applicant Assurance Statement with your completed PreferredOne Provider Enrollment Application packet & other required documents to 763-847-4010

PreferredOne®

New Clinic/Facility Information Form

Corporate Name: **List in PreferredOne Directory?** ☐ **Yes** ☐ **No**	**Clinic/Facility Name:**
Administrator Name & Phone:	**Billing Manager Name & Phone:**

Billing/Remit Information	**Physical Site Information** ***(Site 1)***	**Physical Site Information** ***(Site 2)***
Claims Form Type: ☐ **HCFA** or ☐ **UB92** **Tax ID** (as filed with IRS)**:**	This section is to be completed for location(s) that patients will be seen	This section is to be completed for location(s) that patients will be seen
Billing Name:	**Clinic Name:**	**Clinic Name:**
NPI:	**NPI:**	**NPI:**
Address:	**Address:**	**Address:**
City/State/Zip:	**City/State/Zip:**	**City/State/Zip:**
Phone: **Fax:**	**Phone:** **Fax:**	**Phone:** **Fax:**
Email:	**Email:**	**Email:**
Website:	**Hours:**	**Hours:**
Billing ID ***(Internal use only)*****:**	**PGID** ***(Internal use only)*****:**	**PGID** ***(Internal use only)*****:**

Provider/Facility Information							***(Internal use only)***			
List in Directory? (Y or N)	**NPI**	**Name (First, MI, Last)**	**Degree**	**Specialty**	**License Number**	**Site Number (1, 2, etc.)**	**Effective Date**	**Term Date**	**Prov/Fac ID Episodes**	**Facets ID**

(Internal use only)

Comments/Instructions

System Updated					
☐ Episodes	Date:	Initials:	☐ Facets	Date:	Initials:
☐ Provider Guide	Date:	Initials:	☐ NetworksPro	Date:	Initials:
			Tracking Number:		