



BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PROFESSIONAL PHYSICIAN/PRACTICE ASSESSMENT FREE STANDING FACILITY

Please complete the requested information in this assessment and return it with all documentation to **CareCore National, LLC (CareCore)** at the address for fax number below:

CareCore National
Attention: Credentialing Department
400 Buckwalter Place Boulevard
Bluffton, South Carolina 29910

Fax Number: 845-298-8384

If you have questions, contact CareCore at 800-918-8924, extension 10190.

REQUIRED DOCUMENTS (as applicable)

Please attach the following documents to this Professional Physician/Practice Assessment:

- _____ 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 positron emission tomography (PET) services
- _____ Current American College of Radiology (ACR), Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories (ICANL), Intersocietal Accreditation Commission (IAC) or American Institute of Ultrasound in Medicine (AIUM) accreditation for the following equipment as specified below. For new/newly added equipment, American College of Radiation (ACR) certification must be provided within six months of first clinical use or modality privilege shall be deactivated.
 - Mammography: Food and Drug Administration (FDA) certificate and ACR accreditation for all devices
 - Magnetic resonance imaging (MRI): ACR or IAC accreditation for all devices
 - Computed tomography (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 (NPI) 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)
- _____ 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 CCN's web site. These standards are subject to regular and/or as needed review, 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 the following web site:

www.carecorenational.com/pdfs/min equip_standards.pdf

Lead Physician's 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 Identification (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. 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 and Zip:			
County:		Number of years at this address:	
Telephone:	()	Fax:	()
E-mail:		Web site:	
Tax ID #:		National Provider Identifier (NPI):	

II. FACILITY INFORMATION

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

Facility Name:			
Street Address:			
City, State and Zip:			
County:		Number of years at this address:	
Telephone:	()	Fax:	()
E-mail:		Web site:	
Tax ID #:		NPI:	

Lead Physician's Initials: _____

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): _____

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

If yes, please complete table A in the Addendum.

b. Have an ownership or other financial interest in any of the office space utilized by your practice?

Yes No

If yes, please complete table B in the Addendum.

c. Have any form of compensation arrangement with your practice (e.g., provide medical, consulting, administrative, billing, etc.)?

Yes No

If yes, please complete table C in the Addendum.

Lead Physician's Initials: _____

4) Is the facility shared with any other physician, physician group or other legal entity?
 Yes No If yes, please complete table D in the Addendum.

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"/> Dual energy x-ray absorptiometry (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 /	Mammography /	Digital Mammography /
Nuclear Medicine /	CT /	MRI /
MRA /	Ultrasound /	DEXA /
PET /	PET/CT /	Fluoroscopy /
MRI Spectroscopy /	MRI Guided Breast Biopsy /	
Other special invasive procedures (explain):		
Other (explain):		

I. Contact Names, Telephone Numbers, E-mail Addresses:

Medical Director:		Specialty:	
Billing/Collection:			
Office Manager:			
Credentialing Manager:			

J. Days and Hours of Operation

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
A							
P							

Lead Physician's Initials: _____

K. Physician Site Coverage:			
Does the site have onsite staffing by a board certified radiologist for a minimum of seven hours per day during normal business hours (Monday through Friday)? <input type="checkbox"/> Yes <input type="checkbox"/> 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

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 ____/____/____			
Digital Imaging and Communications in Medicine (DICOM) Compatible?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Manufacturer:		Model #:	
Model Description:			
Date manufactured:	/ /	Date installed:	/ /

Lead Physician's Initials: _____

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, Electrocardiogram (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 onsite	
<input type="checkbox"/> Magnetic resonance angiography (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:	/ /
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, number of slices per rotation:	
CTA (Lower Extremities)	<input type="checkbox"/> Yes* <input type="checkbox"/> No	If yes, number 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 Number:	

Lead Physician's Initials: _____

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
Breast Imaging Reporting and Data System (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 Number:	
Model Description:			
Date Manufactured:	/ /	Date Installed:	/ /
Staffed by mammography certified technologist(s)		<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. DEXA-Bone Density:			
Manufacturer:		Model Number:	
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 Radiologic Technologist (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"/> Stationary Non-Single-Photon Emission Computerized Tomography (SPECT) <input type="checkbox"/> Stationary SPECT <input type="checkbox"/> Mobile		
Number of Detectors:		Manufacturer:	
Model:			
Date Manufactured:	/ /	Serial Number:	
Collimator (check as applicable)	<input type="checkbox"/> Low Energy High Resolution (LEHR) Low Energy <input type="checkbox"/> Medium Energy <input type="checkbox"/> High Energy		

Lead Physician's Initials: _____

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 Nuclear Medicine Technology Certification Board (NMTCB) and Certified American Registry of Radiologic Technologists (ARRT)			
Quality Assurance Requirements Automatic Integral and Field Uniformity (Computed) < Five Percent SPECT:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Center of Rotation (COR) and Floods (Computed) < One-Two Pixels:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Date of Last Jazczak 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	Number Slices Per Rotation:	
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 Number:	
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 Number:	
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

Lead Physician's Initials: _____

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 American Registry for Diagnostic Medical Sonography (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 Number:	_____
J. Radiography and Fluoroscopy			
Manufacturer:	_____	Model Number:	_____
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 ATTACHED INFORMATION TO BE COMPLETE AND CORRECT.

Radiology Group: _____

Name (please print): _____

Signature of Lead Physician: _____

Title: _____ **Date:** _____

Lead Physician's Initials: _____

ADDENDUM

Ownership Status/Business Affiliations

Do any physicians who make referrals to your practice have any of the following relationships with your practice?

A. Have an ownership or other financial interest in any of the equipment utilized by your practice? If yes, please list physician name and NPI below:					
Physician Name					
Specialty					
State					
License Number					
NPI					
Relationship					

B. Have an ownership or other financial interest in any of the office space utilized by your practice? If yes, please list physician name and NPI below:					
Physician Name					
Specialty					
State					
License Number					
NPI					
Relationship					

C. Have any form of compensation arrangement with your practice (e.g. provide medical, consulting, administrative, billing, etc.)? If yes, please list physician name and NPI below:					
Physician Name					
Specialty					
State					
License Number					
NPI					
Relationship					

Lead Physician's Initials: _____

D. Is the facility shared with any other physician, physician group or other legal entity? If yes, please list physician name and NPI below:					
Physician Name					
Specialty					
State					
License Number					
NPI					
Relationship					

CareCore National is an independent specialty benefit management company that manages precertification services on behalf of Blue Cross and Blue Shield of Alabama.

Lead Physician's Initials: _____