Highmark Professional Provider Privileging Application

INSTRUCTIONS

1. Complete this application if you provide any diagnostic imaging services.

2. Please complete a separate application for each physical location where imaging services are provided.

3. **Professional** or “**Read-Only**” **Groups** interpreting imaging procedures at a physician office or hospital must complete Section II in addition to all other relevant sections.

4. If the location does NOT provide or interpret imaging services, fill in the practice name, address, Tax Identification Number, and Highmark billing provider number in Section I-A and check NO in the Practice Information Section (I) that asks: “Does this practice perform and/or interpret diagnostic imaging studies?”

5. Please call (888) 972-9642 if you have any questions regarding this application.

6. Please keep a copy of the completed application for your records.

7. Completed application may be faxed to (916) 852-2676 or mailed to:
   
   **National Imaging Associates, Inc.**  
   **Attn: Provider Assessment Department**  
   **11050 Olson Drive, Suite 200**  
   **Rancho Cordova, CA 95670**
I. PRACTICE INFORMATION

Indicate the type of practice (check only one)

☐ Physician office
☐ Professional or Read-Only provider (billing professional component only)

Does this practice perform and/or interpret diagnostic imaging studies?  ☐ Yes  ☐ No

(If no, complete only Section I-A below and return to NIA)

Please indicate billing methodologies utilized by this location.

☐ Professional (using modifier 26 only)  ☐ Technical (using modifier TC only)  ☐ Global

A. General Information

Name of Practice (Legal Name)

Tax ID Number

Highmark Billing Provider Number

Address Line 1 (Physical Location)

Address Line 2

County

City

State

Zip Code

Telephone Number

Email Address

Contact Name

Contact Telephone Number

Contact Fax Number

Mailing Address Line 1 (If different from Physical Address above)

Mailing Address Line 2

City

State

Zip Code

Scheduler’s Name

Scheduler’s Telephone Number

Scheduler’s Fax Number

Highmark Privileging Application (Physician Office)- CPA 1-10-2005

Page 2 of 8
Hours of Operation:
M________ T________ W________ Th________ F________ Sat________ Sun________

Does this location utilize teleradiology?
☐ Yes  ☐ No

Is this location accessible to persons with disabilities?
☐ Yes  ☐ No

Is parking available?
☐ Yes  ☐ No

List any other names under which this practice currently or formerly has done business (i.e., all DBA’s).

____________________________________________________________

Specialty Type (check only one)
☐ Cardiology  ☐ Neurology  ☐ Pulmonary Medicine
☐ Chiropractic  ☐ Nuclear Medicine  ☐ Radiology
☐ Endocrinology  ☐ OB/Gynecology  ☐ Reproductive Endocrinology
☐ Gastroenterology  ☐ Oral Maxillofacial  ☐ Rheumatology
☐ General/Family Practice  ☐ Orthopedics  ☐ Urology
☐ Internal Medicine  ☐ Otolaryngology  ☐ Vascular Surgery
☐ Multi-specialty (2 or more)  ☐ Podiatry  ☐ Other ___________________

B. Diagnostic Imaging Services/Equipment
Indicate the diagnostic imaging services performed or interpreted at this location, as well as specific equipment utilized where applicable.

☐ MRI  (Magnet Strength _________)
☐ MRA
☐ MRS
☐ Breast MRI
☐ Open MRI
☐ Stand Up MRI
☐ Short Bore MRI

☐ CT
☐ EBCT
☐ Spiral CT
☐ CT Biopsy
☐ CTA

☐ Ultrasound
☐ General Ultrasound
☐ Obstetrical Ultrasound
☐ Gynecological Ultrasound
☐ Echocardiography
☐ Stress Echocardiography
☐ Peripheral Vascular Ultrasound

☐ Diagnostic Nuclear Medicine
☐ Nuclear Cardiology
☐ PET
☐ Full Ring PET
☐ Coincidental PET

☐ Plain Films
☐ Mammography
☐ Digital

☐ Bone Densitometry
☐ Axial DEXA
☐ Quantitative CT
☐ Other

☐ Fluoroscopy
C. Is this practice serviced by a mobile unit(s)? (Do not indicate non-transported ‘portable’ units.)  ☐ Yes ☐ No
If YES, please indicate which modalities are serviced by the mobile unit:

☐ MRI
☐ CT
☐ Ultrasound
☐ Diagnostic Nuclear Medicine
☐ PET
☐ Plain Films
☐ Mammography
☐ Fluoroscopy

II. PROFESSIONAL INTERPRETATION

List the name, Tax ID Number and Highmark Billing Provider Number for each hospital and/or practice at which this group performs professional interpretation services.

Name of Hospital/Practice

Tax ID Number                                      Highmark Billing Provider Number

Name of Hospital/Practice

Tax ID Number                                      Highmark Billing Provider Number

Name of Hospital/Practice

Tax ID Number                                      Highmark Billing Provider Number

Name of Hospital/Practice

Tax ID Number                                      Highmark Billing Provider Number

Name of Hospital/Practice

Tax ID Number                                      Highmark Billing Provider Number
### III. IMAGING PHYSICIANS

A. Imaging Physicians

List all physicians who perform or interpret imaging procedures at this location. ALL PROVIDERS PRACTICING AT THIS LOCATION MUST BE IDENTIFIED. Only list physicians billing under the Tax Identification Number and Highmark Billing Provider Number listed in Section I.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Designation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ MD</td>
<td>☐ DC</td>
<td>☐ DO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highmark Provider ID Number</th>
<th>Tax ID Number</th>
<th>Specialty</th>
</tr>
</thead>
</table>

☐ Board Certified ☐ Board Qualified
Credentialed and contracted by Highmark? ☐ Yes ☐ No  (If incomplete, answer will default to no)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Designation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ MD</td>
<td>☐ DC</td>
<td>☐ DO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highmark Provider ID Number</th>
<th>Tax ID Number</th>
<th>Specialty</th>
</tr>
</thead>
</table>

☐ Board Certified ☐ Board Qualified
Credentialed and contracted by Highmark? ☐ Yes ☐ No  (If incomplete, answer will default to no)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof Designation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>☐ MD</td>
<td>☐ DC</td>
<td>☐ DO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Highmark Provider ID Number</th>
<th>Tax ID Number</th>
<th>Specialty</th>
</tr>
</thead>
</table>

☐ Board Certified ☐ Board Qualified
Credentialed and contracted by Highmark? ☐ Yes ☐ No  (If incomplete, answer will default to no)

B. Radiology Over-Read

List the name, Tax ID Number and Highmark Billing Provider Number for the individual physician or group of radiologists that performs radiological interpretation services for the practice listed in Section I.

Name of Practice

<table>
<thead>
<tr>
<th>Tax ID Number</th>
<th>Highmark Billing Provider Number</th>
</tr>
</thead>
</table>
IV. ATTESTATION

I certify the following to be true:

A. There are registered/certified technologists taking films at this location.
   Certification type(s)?  [ ] ARRT  [ ] State  [ ] ARDMS  [ ] NMTCB  [ ] CNMT  [ ] RCVT
   If NO, does a physician perform the imaging procedures?  [ ] Yes  [ ] No

B. This location utilizes an automatic processor.
   [ ] Yes  [ ] No  [ ] N/A

C. This location has an established quality control program.
   [ ] Yes  [ ] No  [ ] N/A

D. This location has an established radiation safety program and ALARA program.
   [ ] Yes  [ ] No  [ ] N/A

E. This location is staffed by a board certified radiologist during all business hours.
   [ ] Yes  [ ] No  [ ] N/A

F. If utilizing equipment producing ionizing radiation, this location has a current (within 3 years) letter of
   state inspection, or calibration report, or physicist’s report.
   [ ] Yes  [ ] No  [ ] N/A

G. This location prepares a written report for each imaging study performed.
   [ ] Yes  [ ] No  [ ] N/A

H. If performing mammography, this location has a current MQSA certificate.
   [ ] Yes  [ ] No  [ ] N/A

I. If performing bone densitometry, this location employs at least one physician and one technologist who:
   [ ] Are accredited by the International Society for Clinical Densitometry (ISCD), or
   [ ] Are in the process of becoming accredited, or
   [ ] Have not begun the accreditation process

J. If performing nuclear cardiology, PET and/or any nuclear medicine procedures, this location has a current
   radioactive materials license. If YES, please provide a copy.
   [ ] Yes  [ ] No  [ ] N/A

K. If performing nuclear cardiology, this location’s imaging system has the capability of assessing both myocardial
   perfusion and contractile function (ejection fraction and regional wall motion).
   [ ] Yes  [ ] No  [ ] N/A

L. If performing cardiac stress studies, the studies are performed under the direct supervision of a licensed
   physician who has a current Advanced Cardiac Life Support (ACLS) or Advanced Radiology Life Support
   (ARLS) certification.
   [ ] Yes  [ ] No  [ ] N/A

M. If performing nuclear cardiology, this location employs at least one physician who:
   [ ] Is certified by the Certification Board of Nuclear Cardiology (CBNC), or
   [ ] Is sitting for the next scheduled CBNC examination, or
   [ ] Meets the American College of Cardiology/American Society of Nuclear Cardiology COCATS training
      guidelines – level 2, or
   [ ] Is board certified in diagnostic radiology or nuclear medicine, or
   [ ] None of the above
N. If performing nuclear cardiology, this location:
   ☐ Is accredited in nuclear cardiology by the American College of Radiology (ACR) or the Intersocietal Commission for the Accreditation of Nuclear Labs (ICANL), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process

O. If performing MRI, this location:
   ☐ Is accredited by the American College of Radiology (ACR), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process

P. If performing obstetrical ultrasound, this location:
   ☐ Is accredited by the American College of Radiology (ACR) or the American Institute of Ultrasound in Medicine (AIUM), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process

Q. If performing gynecological ultrasound, this location:
   ☐ Is accredited by the American College of Radiology (ACR) or the American Institute of Ultrasound in Medicine (AIUM), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process

R. If performing cardiac ultrasound (echocardiography), this location:
   ☐ Is accredited in cardiovascular ultrasound by the Intersocietal Commission for the Accreditation of Echocardiography Labs (ICAEL), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process

S. If performing cardiac ultrasound (echocardiography), the system has Color Flow Doppler capability.
   ☐ Yes ☐ No ☐ N/A

T. If performing peripheral vascular ultrasound, this location:
   ☐ Is accredited in peripheral vascular ultrasound by the American College of Radiology (ACR) or the Intersocietal Commission for the Accreditation of Vascular Labs (ICAVL), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process

U. If performing peripheral vascular ultrasound, the system has Color Flow Doppler capability.
   ☐ Yes ☐ No ☐ N/A

V. If performing breast ultrasound, this location:
   ☐ Is accredited in breast ultrasound by the American College of Radiology (ACR), or
   ☐ Is accredited in breast ultrasound by the American Society of Breast Surgeons (ASBS), or
   ☐ Is in the process of becoming accredited, or
   ☐ Has not begun the accreditation process
V. DECLARATION AND RELEASE

I hereby declare the above information to be true, accurate and complete. I authorize Highmark and National Imaging Associates, Inc., to verify any of the information given. I agree to produce documentation supporting current compliance with the above guidelines, if requested. I acknowledge a continuing obligation to supplement these answers and agree to report any changes in this information within fifteen (15) days of the change coming to my attention. I understand and agree to comply with the imaging guidelines established by Highmark. I hereby release from any and all liability Highmark, its subsidiaries and affiliates, and National Imaging Associates, Inc., its employees, and agents for relying on this information. The undersigned is authorized to make the representations herein on behalf of the group practice identified herein and/or himself and to bind the group practice.

____________________________________________________________ ___________________________
Signature of Authorized Practice Representative Date

_______________________________________________ ________________________________________
Print Name Title

Completed applications may be faxed to (916) 852-2676 or mailed to:

National Imaging Associates, Inc.
Attn: Provider Assessment Department
11050 Olson Drive, Suite 200
Rancho Cordova, CA 95670

Please keep a copy of the completed application for your records.