

2026

Delivery Organization Information Application
Hospital or Ambulatory Surgery Center



FIRST LOCATION

NAME OF FACILITY

STREET ADDRESS

CITY

STATE

ZIP CODE

EMAIL

PHONE NUMBER

FAX NUMBER

TAX IDENTIFICATION NUMBER

FACILITY PERSON

NPI NUMBER

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

CITY

STATE

ZIP CODE

EMAIL

PHONE NUMBER

FAX NUMBER

CONTACT PERSON

SECOND LOCATION - If more than two locations, please attach a separate listing.

NAME OF FACILITY

STREET ADDRESS

CITY

STATE

ZIP CODE

EMAIL

PHONE NUMBER

FAX NUMBER

TAX IDENTIFICATION NUMBER

FACILITY PERSON

NPI NUMBER

BILLING ADDRESS (IF DIFFERENT FROM ABOVE)

CITY

STATE

ZIP CODE

EMAIL

PHONE NUMBER

FAX NUMBER

CONTACT PERSON

2026**Delivery Organization Information Application
Hospital or Ambulatory Surgery Center****GENERAL BUSINESS INFORMATION**

BEGINNING DATE OF OPERATION

OWNERSHIP NAME

TYPE OF OWNERSHIP: ☐ INDIVIDUAL ☐ PARTNERSHIP ☐ CORPORATION
OTHER, PLEASE EXPLAIN:

ADMINISTRATOR NAME

PHONE NUMBER

ADMINISTRATOR EMAIL

ACCREDITATION INFORMATIONIs your organization currently accredited with one of the following accrediting bodies below? ☐ Yes ☐ No

If yes, please mark those that apply and submit a copy of your current accreditation letter or certificate:

If pending, please indicate the date of survey or application: _____

AAAHC Accreditation ☐ Yes ☐ No CHAP Accreditation ☐ Yes ☐ NoAASM Accreditation ☐ Yes ☐ No JCA Accreditation ☐ Yes ☐ NoCARF-CCAC Accreditation ☐ Yes ☐ No CAO Accreditation ☐ Yes ☐ No

Other:

Were there any deficiencies from your last survey? ☐ Yes ☐ No

If yes, please attach an explanation and your action plan to address recommendations.

Have deficiencies been removed from your record? ☐ N/A ☐ Yes ☐ No Effective Date: _____**LICENSE AND MEDICARE INFORMATION**

STATE LICENSE NUMBER:

DEA NUMBER:

STATE BOARD OF PHARMACY NUMBER:

MEDICARE NUMBER:

Please indicate one or more of the following and submit a copy of your current license:

☐ NC Department of State Health Services # _____ ☐ CLIA Certificate # _____☐ Occupational License # _____ ☐ Operational License # _____Were there any deficiencies from your last survey? ☐ Yes ☐ No

If yes, please attach an explanation and your action plan to address recommendations:

Have deficiencies been removed from your record? ☐ N/A ☐ Yes ☐ No Effective Date: _____**GENERAL BUSINESS INFORMATION**

INSURANCE COMPANY NAME (NOT AGENT):

POLICY NUMBER

EXPIRATION DATE

AMOUNTS PER INCIDENT/AGGREGATE FOR PROFESSIONAL LIABILITY COVERAGE. NOTE: MINIMUM COVERAGE IS \$1M/\$3M

STATEMENT TO APPLICANTS

All organizations applying for network participation have the right to review information obtained by HealthTeam Advantage to evaluate their credentialing application. The only exception to this policy is information that we are prohibited by law from being released.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have 10 days to submit additional information to correct the discrepancy or provide clarification that may positively impact the credentialing decision.

PLEASE SUBMIT COPIES OF THE FOLLOWING DOCUMENTS WITH THIS APPLICATION

- CMS Participation Letter
- CLIA
- NC Dept. of Health Services – Hospital License
- NC Board of Pharmacy License
- DEA
- DPS
- General/Professional Liability
- Accreditation Certificate
- W-9 (Currently dated)

ADDITIONAL REQUIRED INFORMATION:

Please complete attachments.

SEND ALL COMPLETED APPLICATIONS AND SUPPORTING DOCUMENTS TO:

credentialing@htanc.com

IF YOU HAVE ANY QUESTIONS, CONTACT YOUR HEALTHTEAM ADVANTAGE PROVIDER CONCIERGE BY PHONE OR BY EMAIL AT:

providerconciierge@htanc.com, 844-806-8217 option 5

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GENERAL INFORMATION

NAME OF HOSPITAL OR AMBULATORY SURGICAL CENTER

GENERAL BUSINESS INFORMATION

TYPE OF OWNERSHIP

☐ CHAIN ☐ FEDERAL ☐ HOSPITAL ☐ NON-PROFIT ☐ PROPRIETARY ☐ STATE

PROPRIETARY/CHAIN ORGANIZATION NAME (AS REGISTERED WITH THE IRS)

ADDRESS

THIS FACILITY IS LICENSED TO PROVIDE SERVICES BED SIZE FOR:

☐ GENERAL ACUTE CARE	BED SIZE _____	☐ AMBULATORY SURGERY
☐ CRITICAL CARE (ICU)	BED SIZE _____	☐ DIAGNOSTIC EVALUATION
☐ LONG-TERM ACUTE CARE	BED SIZE _____	☐ HOME HEALTH
☐ PSYCHIATRIC	BED SIZE _____	☐ HOSPICE
☐ REHABILITATION	BED SIZE _____	☐ RADIATION THERAPY
☐ SKILLED NURSING	BED SIZE _____	☐ OTHER
☐ INPATIENT SUBSTANCE ABUSE TREATMENT OR DETOXIFICATION	BED SIZE _____	
☐ ALCOHOL/DRUG REHABILITATION CENTER (CDU)	BED SIZE _____	

AMBULATORY SURGICAL FACILITY (FREE-STANDING)

MEDICARE NUMBER

OFFICIAL NAME OF UNIT

UNIT TYPE

☐ HOSPITAL-BASED ☐ FREE-STANDING

DO YOU HAVE MULTIPLE
OPERATING SUITES?

☐ YES ☐ NO

ARE THE MAJORITY OF THE PROCEDURES
PERFORMED UNDER GENERAL ANESTHESIA?

☐ YES ☐ NO

DO YOU HAVE A TRANSFER AGREEMENT WITH A LOCAL HOSPITAL?

☐ YES ☐ NO

(IF YES, PLEASE ATTACH A COPY OF TRANSFER AGREEMENT.)

ARE FACILITY FEES BILLED AS:

☐ SINGLE UNIT CHARGE PROCEDURE
☐ ITEMIZED LINE ITEM CHARGE

IS THERE A PROFESSIONAL FEE INCLUDED IN
THE CHARGE STRUCTURE NOTED ABOVE?

☐ YES ☐ NO

ARE PHYSICIAN AND ANESTHESIOLOGY
FEES BILLED BY YOUR FACILITY?

☐ YES ☐ NO

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE

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CHEMICAL DEPENDENCY AND PSYCHIATRIC UNIT

MEDICARE NUMBER		OFFICIAL NAME OF UNIT	
UNIT TYPE: ☐ HOSPITAL-BASED — INPATIENT ☐ FREE-STANDING — INPATIENT ☐ HOSPITAL-BASED — OUTPATIENT ☐ FREE-STANDING — OUTPATIENT		TYPE OF TREATMENT: ☐ DETOXIFICATION ☐ SUBSTANCE ABUSE ☐ MENTAL/BEHAVIORAL HEALTH	
		LEVEL OF TREATMENT: ☐ ADULT ☐ ADOLESCENT ☐ PARTIAL HOSPITALIZATION	
WHAT IS THE AVERAGE LENGTH OF STAY?	WHAT IS THE AVERAGE CHARGE PER ADMISSION?	ARE UNIT POLICIES AND PROCEDURES APPROVED BY A STATE LICENSING ENTITY? ☐ YES ☐ NO	
ARE PROFESSIONAL COMPONENTS FOR SERVICES RENDERED IN THE UNIT INCLUDED IN THE DAILY FACILITY CHARGE? ☐ YES ☐ NO IF NO, HOW ARE THESE CHARGES BILLED?			

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

HOME HEALTH

MEDICARE NUMBER	OFFICIAL NAME OF UNIT
UNIT TYPE: ☐ HOSPITAL-BASED ☐ FREE-STANDING	

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

HOSPICE

OFFICIAL NAME OF UNIT	UNIT TYPE: ☐ HOSPITAL-BASED — INPATIENT ☐ HOSPITAL-BASED — OUTPATIENT ☐ FREE-STANDING
IS THE PROGRAM DESIGNED TO TREAT THE TERMINALLY ILL PATIENT DURING THE FIRST STAGES OF TERMINAL ILLNESS? ☐ YES ☐ NO	ARE PATIENTS ADMITTED TO THE PROGRAM ONLY WHEN LIFE EXPECTANCY IS SIX MONTHS OR LESS? ☐ YES ☐ NO
IS THE TREATMENT PROVIDED BY A TEAM OF TRAINED MEDICAL PERSONNEL WHO ACT UNDER AN INDEPENDENT, LEGALLY LICENSED HOSPICE ADMINISTRATION? ☐ YES ☐ NO	

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

REHABILITATION UNIT

MEDICARE NUMBER	OFFICIAL NAME OF UNIT
UNIT TYPE ☐ HOSPITAL-BASED ☐ FREE-STANDING	

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

SKILLED NURSING UNIT

MEDICARE NUMBER	OFFICIAL NAME OF UNIT
UNIT TYPE ☐ HOSPITAL-BASED ☐ FREE-STANDING	

ATTACH A COPY OF YOUR FACILITY'S STATE LICENSE, IF APPLICABLE

**HEALTH DELIVERY ORGANIZATION STATEMENT OF ATTESTATION & AUTHORIZATION
FOR RELEASE OF INFORMATION**

I hereby affirm that the information furnished by me is true and complete to the best of my knowledge and is furnished in good faith. I fully understand that any significant misstatement in, or omissions from, this application, whether intentional or not, shall constitute cause for summary dismissal as a Care N' Care Insurance Company of North Carolina, Inc., provider. In the event that participation privileges have been granted prior to discovery of misstatement or omission, such discovery may result in termination from Care N' Care Insurance Company of North Carolina, Inc.

I agree that I have a continuing affirmative duty to inform Care N' Care Insurance Company of North Carolina, Inc., immediately of any material changes that may affect my organization's status. I authorize the release of all information that may be relevant to an evaluation of my organization's credentials, including information about disciplinary actions or other confidential or privileged information, to Care N' Care Insurance Company of North Carolina, Inc., or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which my organization participates as a Care N' Care Insurance Company of North Carolina, Inc., provider. I release Care N' Care Insurance Company of North Carolina, Inc., its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my organization's credentials.

I submit this application in the expectation that confidentiality and privacy will be preserved, and that the information will be used only for credentialing, peer review, and quality assurance activities.

Facility Name _____

Date _____

Signature _____

Name _____

Title _____