2026
Delivery Organization Information Application
Radiology Services

healthteam advantage℠

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	

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GENERAL BUSINESS INFORMATION

BEGINNING DATE OF OPERATION	OWNERSHIP NAME ifupodifjaosdif

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

ADMINISTRATOR NAME po[	PHONE NUMBER pok

ADMINISTRATOR EMAIL
pok

ACCREDITATION INFORMATION

Is 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 ☐ No
AASM Accreditation ☐ Yes ☐ No
JCA Accreditation ☐ Yes ☐ No
CARF-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: kjlk	DEA NUMBER: lkj	STATE BOARD OF PHARMACY NUMBER:	MEDICARE NUMBER: lkjlk

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
jlpo

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:

- Accrediting entity certification (JCAHO, CHAP, etc.) —**OR** — site visit survey
- License (State, Occupational, Operational, Pharmacy, CLIA, etc.)
- Medicare Participation Letter
- Professional Liability Insurance Certificate ($1,000,000/$3,000,000)
- Employer Identification Number (EIN) letter
- W-9 (Currently dated)
- American College of Radiology Accreditation Modalities (Applicable to facility)
  - Breast/MRI
  - Breast Ultrasound
  - Computed Tomography (CT)
  - Mammography
  - MRI
  - Nuclear Medicine
  - PET
  - Radiation Oncology
  - Radiography/Fluoroscopy
  - Stereotactic
  - Ultrasound

ADDITIONAL REQUIRED INFORMATION:

Please complete attachments. (if any)

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:

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

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 _____