2022 Provider Profile and Credentialing Application

alacura Medical Transportation Management

The following application is designed to simplify and accelerate the provider enrollment and credentialing process with Alacura. If you have questions or need assistance with this form, please contact providers@alacura.com

HITRUST CSF Certified

urac ACCREDITED Health Utilization Management Expires 04/01/2024

This is a fillable PDF.

Organization Information

Company Name (on W-9)

Any DBA Name(s) _____

Corporate Address

Street | Suite | City | State | Zip

ID Numbers

_____ Tax ID Number | _____ NPI Number

_____ Medicare CERT Number | _____ Medicaid CERT Number | _____ State

Primary Contact Information

_____ Name | _____ Title | _____ Phone Number

_____ Email Address

Intake/Dispatch Information

_____ Phone | _____ Email Address

Intake services are handled ☐ Centrally ☐ Regionally

Billing Contact Information

_____ Name | _____ Title | _____ Phone Number

_____ Email Address

_____ Street | _____ Suite | _____ City | _____ State | _____ Zip

Billing services are handled ☐ Centrally ☐ Regionally Other: _____

*If there are multiple facilities, please include spreadsheet including Name, Tax ID, Facility, Billing address, Phone Number, and Emails for all locations

Medical Director Information

_____ Name | _____ Title | _____ Phone Number

_____ Email Address

Services

	Mode of Service	QTY	
Services Provided (Check all that apply)	☐ Fixed Wing - Turboprop		Please see additional forms and complete for Fixed Wing, Rotor, and Ground Ambulance
	☐ Fixed Wing - Piston		
	☐ Fixed Wing - Jet		
	☐ Rotary (Helicopter)		
	☐ Ground Ambulance		
	☐ Clinical Escort		
	☐ NEMT		

Service Level (Check all that apply)

☐ Basic Life Support

☐ Advanced Life Support
*What services require this level in your protocols? _____

☐ Critical Care
*What services require this level in your protocols? _____

☐ Specialty Care Transport
*What services require this level in your protocols? _____

☐ High Risk Obstetrical
*Do you have any gestation or ruptured membrane limits? _____

☐ COVID +
*Do you have any limitations? _____

☐ Neonatal
*Do you have any age or size limitations? _____

	☐ General Pediatric Care ☐ *Do you have any age or size limitations? _____	
	☐ Pediatric Intensive Care *Do you have any age or size limitations? _____	
	☐ Bariatric	
SARS-COV-2 - COVID 19 Specific Questions	☐ Are you accepting transports for COVID-19 patients?	
	☐ Do you allow other riders? *If yes Is a negative test or proof of vaccination required? ☐YES ☐NO	
	☐ Do you have any requirements or limitations we need to know about? *If yes, please describe: _____	

Medical Services Equipment

Equipment (Check all that apply)	☐ CPAP	☐ High Flow Nasal Cannula: Adult
	☐ BIPAP	☐ High Flow Nasal Cannula: Pedi
	☐ Oxygen	☐ Ventilator
	☐ Heart Monitor	* Name of Vent: _____
	☐ IV Pump	☐ Inhaled Gases (Nitric) Balloon Pump
	☐ ECMO	☐ Impella Heart Pump
	☐ Isolation Pod	☐ Pedimate *Min Weight: _____ *Max Weight: _____
	☐ Bariatric or/bed *Door Width: _____ *Max Weight: _____	☐ Own isolate
	☐ Ventricular Assist Devices	☐ Can borrow isolate
Is there any equipment you are trained on but you have to take from the hospital/facility? (ex: Balloon Pump, Impella,	☐ YES ☐NO	
Standard IV Medications you carry	☐ Morphine	
	☐ Propofol	
	☐ Dilaudid	
	☐ Ativan	
	☐ Precedex	
	☐ Fentanyl	
	☐ Other: _____	

Staffing

Professional Staff (# of licensed)	RN	AEMT
	CFRN	EMR
	MD	EMTA
	PA	RT
	NP	Perfusionist
	Paramedic	
Are your clinical staff employed and managed by your organization If answer is no, who manages the clinical staff? (Please provide credentialing P&Ps and Training Program)	☐ YES	☐ NO
Describe your routine medical *ground* crew configuration	☐ EMR/EMT	☐ Paramedic/Paramedic w/additional training
	☐ EMT/EMT	☐ Paramedic/Nurse
	☐ EMT/AEMT	☐ Paramedic/RT
	☐ EMT/Paramedic	☐ Other: _____
	☐ EMT/AEMT	☐ Other: _____
Describe your routine medical *air* crew configuration	☐ Doctor/Nurse	☐ Nurse/Nurse
	☐ Paramedic/Nurse	☐ RT/Nurse
	☐ Other: _____	

Do you currently do Bedside to Bedside transports? (air crew goes to hospital on both sides)	☐ YES	☐ NO
If NO, are you willing to do this for all Alacura patients?	☐ YES	☐ NO
Crews in house, on base 24/7	☐ YES	☐ NO
Call in crew available? (one that is not on base)	☐ YES	☐ NO
Have access to a perfusionist	☐ YES	☐ NO
Pedi ICU nurses on team	☐ YES	☐ NO
Can call in special team for pedi patient	☐ YES	☐ NO
NICU nurses on team	☐ YES	☐ NO
Can call in special team for NICU	☐ YES	☐ NO
Can borrow NICU team from hospital that agree to take patient not associated	☐ YES	☐ NO
Have Respiratory Therapists on team	☐ YES	☐ NO
Languages Spoken by Medical Crew	☐ English ☐ Spanish ☐ Portuguese ☐ Italian ☐ French ☐ German	☐ Japanese ☐ Chinese ☐ Greek ☐ Russian ☐ Other:_____
For companies that provide Medical Escort Services, attach a list of medical equipment/supplies carried on commercial flights		

Vehicles			
Ground Ambulance Information			
Are your vehicles	☐ Owned	☐ Leased	☐ Outsourced
Do you do your own	☐ YES	☐ NO	
Have you had any accidents in the past 3 years?	☐ YES	☐ NO	
Crew Duty Times			
Do you accept pets? If YES, any limitations?	☐ YES	☐ NO _____	
Do you transport patients in a prone or supine position?	☐ Prone	☐ Supine	
Please describe License/Certification/Award that are: 1)rate regulated 2) exclusive operating areas 3) service area specific (include state, county, services, and regulating authority)			
State(s) in Ground Service Area (If specified)			

County(s) in Ground Service Area (if specified)			
Fixed Wing Aircraft Information			
Are your vehicles	☐ Owned	☐ Leased	☐ Outsourced
Registered Business Name of Air Operator / Certificate Holder			
Certificate # of Registered Air	#_____		
Do you do your own dispatching and flight following?	☐ Yes	☐ No	
Have you had any aircraft accidents in the past 3 years?	☐ Yes	☐ No	
Have you had any aircraft incidents in the past 3 years? *If YES to either, please attach explanation	☐ Yes	☐ No	
Flight Crew Duty Times			
Do you accept pets? If YES, any limitations?	☐ Yes	☐ No	
Are pilots employed and managed by your organization If NO, please explain	☐ Yes	☐ No	
Attach a standard equipment list for each aircraft			
Do you transport patients in a prone or supine position?	☐ Prone	☐ Supine	
Operational Details for Air Ambulance			
What do you require to decide to accept a transport?			
Average time frame to accept a normal transport request?	☐ 2HRS	☐ 4HRS	☐ 6HRS
Average time frame to accept an urgent transport request?	☐ 15MIN	☐ 30MIN	☐ 1HR
What is your AVG Call Out Time?	☐ 30MIN	☐ 1HRS	☐ OTHER:_____HRS
Dispatch Staff	☐ 24/7 w/Multiple Shifts	☐ M/F Set hours w/On-Call Staff	
Do you employ and manage the dispatch staff?	☐ YES	☐ NO	
If no, who manages them?			
How do you track your aircraft?	☐ 2HRS	☐ 4HRS	☐ 6HRS
Are the tail numbers viewable on FlightAware?	☐ YES	☐ NO	
If NO, would you be able to provide permission for Alacura to view?	☐ YES	☐ NO	
State(s) in Air Service Area (If specified)			
County(s) in Air Service Area (if specified)			

Areas of Operation (Check all that apply)	☐ North America ☐ South America ☐ Central America ☐ Europe ☐ Australia ☐ Asia	☐ Mexico ☐ Caribbean ☐ Canada ☐ Middle East ☐ Africa ☐ Others: _____
Geographic Limitation/Restrictions (List all that apply)		
Licensure/Certification (Check all that apply and submit copy)		
CAMTS (Please indicate which level of care you are accredited for (BLS, ALS, Critical Care and Mode of Transport)		
ARG/US	☐ Gold	☐ Gold Plus ☐ Platinum
IS-BAO	☐ Stage I	☐ Stage II ☐ Stage III
NAAMTA	☐ YES	
WYVERN	☐ YES	
EURAMI	☐ YES	
*If none of the certifications above are held, please provide documentation of Policies and Procedures for the following: Training protocols for clinicians, Safety Program		
Air Ambulance State Licenses (please list state and attach copies)		
International Certificates (please list all and attach copies)		

States Licensed In (Check all that apply)	☐ Alabama	☐ Nevada
	☐ Arizona	☐ Oklahoma
	☐ Arkansas	☐ New Mexico
	☐ Colorado	☐ South Dakota
	☐ Georgia	☐ Tennessee
	☐ Kansas	☐ Texas
	☐ Louisiana	☐ Wyoming
	☐ Michigan	
	☐ Other: _____	
If license/cert/award is county specific, please list state and county		

Liability Insurance Information (please provide copies of each current insurance policy)

Type of Insurance	Coverage Limits	Coverage Dates
Commercial General Liability *requirement $1M/$2M		
Aircraft Liability (include bodily injury for patients) *requirement $5M/seat or $25M/occurrence		
Automobile Liability *requirement $1M/occurrence		
Professional Liability for Company & Personnel (include bodily injury for patients) *requirement $1M/$3M		
Worker's Comp *requirement $1M/acc, $100k/disease/emp, $500k/disease		

Payor Affiliation Information

In order to facilitate additional referrals, please provide the information on this page.
This will be added into your records for reference only.
Should we receive a transport request that does NOT have coverage through one of our payor clients, we would like to turn those over to our network providers, but keeping with our mission to help patients by keeping them with in-network providers whenever possible.
In these cases, we are acting strictly as a Transfer Center and will not be involved with billing or payments.

	Payor	ID	Commercial Plans (In-network Contract)	Geographic Area (If Limited)
1				
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Fixed Wing (Aircraft) Fleet Information

alacura
Medical Transportation Management

	Model	Serivce Type	Tail #	Range (Miles) MIN	Range (Miles) MAX	MAX PAX	Max Weight (Patient)	Base Location or Roaming	If Base: Address	City	State	County	Zip Code
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Ground Ambulance Fleet Information

alacura
Medical Transportation Management

	QTY	Type	Service	Range (Miles) MIN	Range (Miles) MAX	MAX PAX	Max Weight (Patient)	Base Location or Roaming	Base Address	City	State	County	Zip Code
1													
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Rotor (Helicopter) Fleet Information

	Model	Serivce Type	Tail #	Range (Miles) MIN	Range (Miles) MAX	MAX PAX	Max Weight (Patient)	Base Location or Roaming	If Base: Address	City	State	County	Zip Code
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ATTESTATIONS

Have you and/or any facility or staff member ever had any adverse action taken or is any adverse action pending with respect to any of the following items?

State License /Certification/ Registration	☐ YES	☐ NO
Medicare, Medicaid, or other government health program participants.	☐ YES	☐ NO
HMO, PPO, PHO, IPA, or any prepaid health plan or managed care participation	☐ YES	☐ NO
Are you and/or a facility or staff member now or have you been involved in any malpractice action(s), including litigation, arbitration, or mediation, regardless of the method or amount of the outcome that	☐ YES	☐ NO
Has payment to resolve or avoid any allegation(s) concerning your competence, conduct, or quality of care (not involving litigation, arbitration, or mediation) ever been paid by or on your	☐ YES	☐ NO

If ***YES***, please attach a detailed explanation for each allegation, claim, suit, action or settlement, whether open or closed, regardless of

Please be sure to include:

Date of the incident(s) leading to the allegation, claim, suit, action, or settlement
Dates of filing, resolution, and outcome
Professional liability insurer involved

Has your professional liability insurance or coverage been denied, suspended, canceled, lapsed, not renewed, special rated, or experienced gaps?	☐ YES	☐ NO
Have you and/or your facility or a staff member been the subject of an administrative, civil, or criminal complaint or investigation?	☐ YES	☐ NO

If YES, please attach an explanation with full details (including the plaintiff and courtcaption of any pending lawsuit)

Are you and/or a facility or staff member presently a defendant in a malpractice, discrimination, or professional liability lawsuit or proceeding, or have you been placed on notice of such a potential lawsuit or proceeding yet to be filed?	☐ YES	☐ NO

RELEASE AND AUTHORIZATION

I consent to the release to Alacura of all information that may be relevant to an evaluation of credentials and qualifications, including information about
I understand that I need to provide adequate information to Alacura to demonstrate the organization's qualifications. I understand that any misstatement or
I attest that the information contained in this application is correct and complete.

Signature:_____ Title:_____ Date:_____

Submittal

Please submit your completed application by clicking "Submit." Attach any needed documentation to the email, and send it to providers@alacura.com. We will provide confirmation of received application within 48 business hours.

You may also click print and attach a copy to an email.

Print Form Submit Form

Non-Disclosure of Confidential Information Each party agrees not to use any Confidential Information of the other party for any purpose except to evaluate and engage in discussions concerning a potential business relationship between the parties. Each party agrees not to disclose any Confidential Information of the other party to third parties or to such party's employees, except to those employees of the receiving party who are required to have the information in order to evaluate or engage in discussions concerning the contemplated business relationship.

Document Checklist

Attach a copy of the following	
	☐ W-9(s)
	☐ Additional Facility Information
	☐ General Liability Policy
	☐ Aircraft Liability Policy
	☐ Automobile Liability Policy
	☐ Professional Liability Policy
	☐ Worker's Comp Policy
	☐ Air Ambulance State Licenses
	☐ Medicare Certificate
	☐ Ground Ambulance State/County/City Licenses (for all bases + any additional covered areas)
	☐ CAMTS, NAAMATA, CAAS, or other industry accreditation certs
	☐ International Certificates
	☐ Explanation of aircraft incidents/accidents (if applicable)
	☐ Details of any adverse reaction, settlement, or sanctions
	☐ Policies and Protocols if required by answers
	☐ Standard equipment list for each aircraft