

- F. A written report prepared for each imaging study performed which must meet minimum documentation requirements.
- G. Current letter of state inspection, calibration report or physicist's report if equipment produces ionizing radiation.
- H. Established radiation safety program and "as low as (is) reasonably achievable" (ALARA) program.

Physicians at an office practice/freestanding site requesting to perform CT and/or MRI services must also meet the following criteria:

- A. Meet all credentialing/recredentialing criteria as a specialist in the HP provider network
- B. Be board certified by the American Board of Medical Specialties (ABMS) or the American Osteopathic Board in radiology or diagnostic radiology.

Exceptions to this policy will be granted only if access or geographical need can be demonstrated.



AN AFFILIATE OF
OSF HEALTHCARE 

DIAGNOSTIC IMAGING PROVIDER APPLICATION

Facility Name: _____

Telephone: _____ Fax: _____

Billing Address: _____

Provider Directory Addresses

Primary Address 1) _____

Secondary Addresses 2) _____

3) _____

Normal Business Hours:

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Federal Tax Identification Number: _____ (Please attach copy of your W-9)

State Licenses: (Please attach copies)

Number: _____ State: _____ Effective Date: _____

Number: _____ State: _____ Effective Date: _____

Malpractice/Professional Liability Insurance: **(Please attach copy of face page)**

Amount: _____ Policy Number: _____

Company Name: _____

Accreditation (please attach copy): JCAHO American College of Radiology

If not accredited, date applied for accreditation _____

Title 18 Certification # OR Provider # _____

Medicare Number: _____ Medicaid Number: _____

(Please attach a copy your Medicare letter of participation.)

RADIOLOGIC/DIAGNOSTIC IMAGING SERVICES PROVIDED

Indicate services available at your facility. (Minimum of 4 asterisked modalities required)

	Yes	No	Copy of State Inspection Enclosed	Calibration/Physicist Report Enclosed (if equipment produces ionizing radiation)	Sample Written Report of Imaging Study Enclosed
*CT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*DEXA Scan or Plain Films (circle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Digital Vascular Imaging	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Echocardiography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Fluoroscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Mammography	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*MRI / MRA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nuclear Medicine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
*Ultrasound (general or OB/GYN)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please list)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Hours diagnostic imaging services available (Minimum 40 hours per week required)

Mon	Tues	Wed	Thurs	Fri	Sat	Sun

Radiologist(s) on site during normal business hours **AND** during contrast enhanced procedures

Name	Contracted with OSFHP		Board Certified (Radiology or Diagnostic Radiology)	
	<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	<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

If no radiologists listed above,

Are procedures digitally transmitted to radiologist immediately following completion?

Yes No

Is another physician on site during contrast enhanced procedures?

Yes No

Physician(s) on site during contrast enhanced procedures

Name

Technologist(s) performing CT and/or MRI procedures:

Name(s)	Certification(s) (attach copies)	IL License # (attach copies)	Original Issue Date
	<input type="checkbox"/> ARRT <input type="checkbox"/> ARDMS <input type="checkbox"/> NMTCB		
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	<input type="checkbox"/> ARRT <input type="checkbox"/> ARDMS <input type="checkbox"/> NMTCB		

SAFETY PROGRAMS AT FACILITY (enclose copies)

	Yes	No
Radiation Safety Program	<input type="checkbox"/>	<input type="checkbox"/>
ALARA Program	<input type="checkbox"/>	<input type="checkbox"/>

Person completing application: _____

Title: _____ **Phone:** _____

Date Application Completed: _____