This form is to be completed for all ancillary services where the IPA/MSO has established a contract directly with a facility or agency.

Directions: 1. Mark yes or no (Y or N) for each **Service** listed where your IPA/MSO has established a contract.

1. In the **CONTRACTED FACILITY/AGENCY** list the name of each contracting facility or agency.
2. In the **ACCREDITED BY** column, indicate if the facility or agency is accredited and by whom. In the **DELEGATED FUNCTION** column mark X in each row where your IPA/MSO has delegated any functions.

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| **ANCILLARY SERVICE REVIEW** |
| **Service** | **Y** | **N** | **Capitated Services** | **Contracted Facility/Agency** | **Accredited by** | **Date Accreditation Expiration** | **Delegated Function** | **Date License Expiration** |
|  1. Alcohol/Substance Abuse |  |  |  |  |  |  |  |  |
|  2. Home Health Agency |  |  |  |  |  |  |  |  |
|  3. DME, Orthotics, Prosthesis |  |  |  |  |  |  |  |  |
|  4. Mental Health |  |  |  |  |  |  |  |  |
|  5. Short-term Rehabilitation; P.T./O.T. |  |  |  |  |  |  |  |  |
|  6. Short-term Rehabilitation; Speech  |  |  |  |  |  |  |  |  |
|  7. Hospice |  |  |  |  |  |  |  |  |
|  8. Infusion Center |  |  |  |  |  |  |  |  |
|  9. Renal Dialysis |  |  |  |  |  |  |  |  |
| 10. Family Planning |  |  |  |  |  |  |  |  |
| 11. Chiropractor |  |  |  |  |  |  |  |  |
| 12. Skilled Nursing Facilities |  |  |  |  |  |  |  |  |
| 13. Tertiary Care Facility |  |  |  |  |  |  |  |  |
| 14. X-ray |  |  |  |  |  |  |  |  |
| 15. Ultrasound MRI/CT |  |  |  |  |  |  |  |  |
| 16. Laboratory |  |  |  |  |  |  |  |  |
| 17. Surgi-Centers |  |  |  |  |  |  |  |  |
| 18. Urgent Care Centers |  |  |  |  |  |  |  |  |
| 19. Transportation (ambulance, ambi-vans) |  |  |  |  |  |  |  |  |

**Note**: The Delegated Credentialing function is evaluated separately