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.

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **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