

## CIGNA HEALTHCARE OF \_\_\_\_\_ SURVEY FORM FOR PRACTITIONER OFFICE SITE ASSESSMENT

Please Print

<b>PHYSICIAN'S NAME:</b> _____	<b>Date:</b> _____
<b>NAME OF GROUP:</b> _____	
<b>PRIMARY OFFICE ADDRESS:</b> _____ _____	<input type="checkbox"/> <b>PRIMARY CARE</b>
	<input type="checkbox"/> <b>OB/GYN</b>
<b>PHONE NUMBER:</b> _____	
<b>OFFICE FAX NUMBER:</b> _____	
<b>2<sup>nd</sup> OFFICE ADDRESS:</b> _____ _____	
<b>PHONE NUMBER:</b> _____	
<b>OFFICE FAX NUMBER:</b> _____	
<b>3<sup>rd</sup> OFFICE ADDRESS:</b> _____ _____	
<b>PHONE NUMBER:</b> _____	
<b>OFFICE FAX NUMBER:</b> _____	

**OTHER PRACTITIONERS AT THE PRIMARY ADDRESS**

- |          |          |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

**PLEASE ANSWER THE FOLLOWING QUESTIONS. IF THE QUESTION IS NOT APPLICABLE, PLEASE INDICATE N/A.**

A. GENERAL SITE INFORMATION	Primary Office			2 <sup>nd</sup> Office			3 <sup>rd</sup> Office		
	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
1. Is your office handicap accessible?	..	..		..	..		..	..	
2. Is there adequate seating space for the volume of patients being seen? (At least 5 chairs per physician for adults, 10 chairs for pediatrics. Reasonable limit: 25 chairs for large group practice)	..	..		..	..		..	..	
3. Is the following examination equipment readily accessible: Scale, blood pressure cuff, stethoscope, otoscope and ophthalmoscope?	..	..		..	..		..	..	
4. Do you have at least 1 examining room per physician during office hours in each location?	..	..		..	..		..	..	
B. PATIENT SAFETY	Primary Office			2 <sup>nd</sup> Office			3 <sup>rd</sup> Office		
	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
1. Briefly describe how controlled substances / samples / OTC medications, if dispensed, are monitored, secured and verified.  _____ _____ _____									

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<ul style="list-style-type: none"> <li>Is this the same for each office location?</li> </ul>	..	..	..	..	..	..	..	..	..
2. Where are prescription pads and "syringes / needles" are kept?  <hr/> <hr/>									
<ul style="list-style-type: none"> <li>Is this the same for each office location?</li> </ul>	..	..	..	..	..	..	..	..	..
3. Does each examining room have sharp containers properly mounted? 4. Are there safety policies and procedures implemented for: a. Disposal of hazardous waste materials? b. Disposal of sharp containers? 5. Is there at least one person in addition to the practitioner who is trained in Basic Life Support/CPR? 6. Do you have a patient chaperon policy?	..	..		..	..		..	..	
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## CIGNA HEALTHCARE OF \_\_\_\_\_ SURVEY FORM FOR PRACTITIONER OFFICE SITE ASSESSMENT

5. OB/GYN physicians – Can patients obtain appointments within the following time periods?									
• First trimester – within 14 days	..	..	..	..	..	..	..	..	..
• Second trimester – within 7 days	..	..	..	..	..	..	..	..	..
• Third trimester – within 3 days	..	..	..	..	..	..	..	..	..
• High-risk (urgent) – immediately	..	..	..	..	..	..	..	..	..
If no, please explain:									
6. Are laboratory tests performed in the office?	..	..		..	..		..	..	
If yes, please indicate expiration date of CLIA Certificate or waiver:									
7. Are radiology services performed in the office?	..	..		..	..		..	..	
If yes, are the services provided by State certified staff?	..	..		..	..		..	..	
Please indicate expiration date of license									
8. Is there a written Policy and Procedure for determining whether or not the patient has executed an advance directive? (adult)	..	..	..	..	..	..	..	..	..
9. Do you have a Policy and Procedure for addressing HIPAA compliance within each office?	..	..		..	..		..	..	
<b>D. STATE REQUIREMENTS</b>	Primary Office			2 <sup>nd</sup> Office			3 <sup>rd</sup> Office		
	YES	NO	N/A	YES	NO	N/A	YES	NO	N/A
1.	..	..	..	..	..	..	..	..	..
2.	..	..	..	..	..	..	..	..	..
3.	..	..	..	..	..	..	..	..	..
<b>E. MEDICAL RECORD KEEPING</b>	Primary Office			2 <sup>nd</sup> Office			3 <sup>rd</sup> Office		
	YES	NO	N/A						
1. Are there written Policies & Procedures for maintaining confidentiality for medical records and release of patient's medical information?	..	..							
2. Patient medical records are protected from public access?	..	..							
3. Patient's gender is indicated?	..	..							
4. Patient's date of birth is included?	..	..							
5. Patient's home address is included?	..	..							
6. Patient's home or work telephone number is included (Adult) or home/work telephone number of parent (Pediatrics)?	..	..							
7. Patient's occupation is included (Adult)?	..	..	..						
8. Patient's employer is included (Adult) or employer of parent (Pediatrics)?	..	..							
9. Patient's marital status is included (Adult)?	..	..	..						

**CIGNA HEALTHCARE OF \_\_\_\_\_**  
**SURVEY FORM FOR PRACTITIONER OFFICE SITE ASSESSMENT**

10. All pages in the record contain patient identification?	..	..							
11. Is there an individual medical record for each individual receiving care? If no, is there is an individual sheet for each family member in one medical record?	..	..							
12. Is the patient's medical record organized?	..	..							
13. Is each patient's medical record entry dated?	..	..							
14. Does each patient's entry in the record contain the practitioner's name or initials, and professional designation?	..	..							
15. Is the patient's medical record legible?	..	..							
16. <b>Do you maintain electronic medical records for patients?</b>	..	..							

**CERTIFICATION AND SIGNATURE**

**Certification and Signature**

This information is being submitted on behalf of Dr. \_\_\_\_\_.

I verify that the information provided in this form is accurate and complete. I understand that this information is part of the application process to participate with CIGNA and does not entitle me to participation with CIGNA. I also understand that the provision of false information is sufficient grounds to terminate the credentialing process.

Physician Name (Print) \_\_\_\_\_

Physician Signature \_\_\_\_\_

Date \_\_\_\_\_

Overall Score: \_\_\_\_\_