

**HEALTHPLUS IMAGING MANAGEMENT PROGRAM
FACILITY ASSESSMENT TOOL
NEW HEALTHPLUS PHYSICIANS**

Physician Name(s): _____

Practice Name: _____

Physician Address: _____

Physician City, St, Zip: _____

Please check the correct response and send this form back with your HealthPlus of Michigan Application:

I do not perform X-rays in my office and will not be submitting a facility assessment tool

I am joining an existing physician practice that has submitted a facility assessment form

Please indicate practice/physician name: _____

I have completed and have/will submit/ed the Facility Assessment Form

Signature: _____ **Date:** _____

Please submit form to HealthPlus with your application or fax directly to:

**HealthPlus QM/Credentialing
810.230.2106**