



PROCEDURES FOR APPLYING FOR RENEWAL LICENSURE OF SERVICE LINES FOR PHYSICIAN OFFICES

1. Please complete the entire application responding to each applicable field. All applications must be signed by an authorized representative. Incomplete or unsigned applications will be returned which may delay the processing of the application.
2. All applications will need to be emailed to hfc.service@tn.gov. An email will be sent to the applicant within two (2) business days of receipt verifying that the application was received.
3. If the application involves MRI and/or PET, please review HFC's Medical Equipment Registry to ensure information submitted on the licensure application is consistent with previously submitted data.
4. Upon receipt of the application, HFC staff will review the application for completeness. Once determined to be complete, an invoice will be sent to the listed Billing contact. The requested license fee will need to be submitted to Health Facilities Commission, following the invoice instructions, by listed due date on the invoice.

Licensing fee schedule is listed at the end of the application.

5. Once the license fees have been received, an approval letter will be sent to the listed CEO/Administrator.
 - a. The renewal license certificate will then be created and mailed to the licensee. You should receive the physical license in ten (10) to fourteen (14) days.

All applicable laws, rules, policies, and guidelines are available for viewing at <https://www.tn.gov/hfc/division-of-licensure-and-regulation/hfc-licensure/licensure-applications.html>. Please check this website periodically for updates.

Please note the licensure application does not take the place of the HFC Medical Equipment Registry. Medical Equipment Yearly submissions are still required.



State of Tennessee

Health Facilities Commission

502 Deaderick Street, Andrew Jackson Building, 9th Floor, Nashville, TN 37243

www.tn.gov/hfc

Phone: 615-741-2364

hsda.staff@tn.gov

**RENEWAL APPLICATION FOR LICENSE OF SERVICES
FOR PHYSICIAN OFFICES**

1. NAME AND PHYSICAL ADDRESS OF PHYSICIAN OFFICE OF SERVICE

Name

Address

City

State

ZIP

2. CEO/ADMINISTRATOR OF PROVIDER

Name

Title

Email Address

Company Name

Address

City

State

ZIP

Phone Number

3. BILLING INFORMATION FOR FACILITY

Name

Title

Email Address

Company Name

Address

City

State

ZIP

Phone Number

4. OWNERSHIP OF FACILITY

Name of Owner

Address

City

State

ZIP

Phone Number

Legal Entity:

☐ **Individual**

☐ **Limited Liability**

☐ **Corporation
(For Profit)**

☐ **Corporation
(Not for Profit)**

☐ **Government**

☐ **Limited Partnership**

☐ **Joint Venture**

☐ **Professional Limited
Liability Company**

☐ **Other** _____

List name(s) and addresses of individual owners, partners, directors of the corporation, or head of the government entity. (If more than two (2), please use ATTACHMENT – B.)

(1) Name

Address

City

State

ZIP

(2) Name

Address

City

State

ZIP

If a government/county owned facility, does the administrator have authority to act on behalf of the government/county as it relates to the operation of this facility? ☐ Yes ☐ No

If no, why:

Is this facility chain affiliated? ☐ Yes ☐ No

If a corporation, is there a holding company? ☐ Yes ☐ No

If yes, please complete the following information of the holding company.

Name of Owner

Address

City

State

ZIP

Phone Number

Are any owners of the disclosing entity also owners of other health care facilities in Tennessee and/or other states? ☐ Yes ☐ No

If yes, list their names and addresses of all facilities.:

Is there a contract with a management firm to operate this facility? ☐ Yes ☐ No

If yes, please specify the dates of the contract and complete the firm’s information.

Start Date: _____ End Date: _____

Name of Firm

Address

City

State

ZIP

Phone Number

5. LEGAL

If any of the items within this section (LEGAL), please identify, explain, and provide documentation of the item(s) noted if response is “yes”. Have either the licensed entity for any of the other health care facilities in Tennessee and/or other states listed, or the management firm listed been subjected to any of the following within the past five (5) years?

Licensure

- | | | |
|---|------------------------------|-----------------------------|
| ➤ Denied a License | ☐ Yes | ☐ No |
| ➤ Had a license suspended or revoked by any state licensure agency? | ☐ Yes | ☐ No |
| ➤ Been subject to a final order or judgement in a state licensure action? | ☐ Yes | ☐ No |

Convictions

- | | | |
|--|------------------------------|-----------------------------|
| ➤ If convicted of a criminal offense related to that person’s involvement in any program under any state or federal health care program – including Medicare, Medicaid, and TriCare? | ☐ Yes | ☐ No |
|--|------------------------------|-----------------------------|

Exclusion

➤ Excluded from participation in federal health care programs – Medicare, Medicaid, CHIP, or TriCare – in the past? ☐ Yes ☐ No

(Excluded is defined as a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS-OIG) that they may no longer be a provider for any federally funded healthcare.) ☐ Yes ☐ No

Termination/Suspension

➤ Suspended or terminated from participation in Medicare or Medicaid/TennCare programs? ☐ Yes ☐ No

Fraud and Abuse

➤ Paid through settlement, or civil or criminal fines, any monies to the federal government or any state as a result of any administrative or judicial proceeding based on allegations of fraud or abuse involving claims related to the provision of health care items and services? ☐ Yes ☐ No

Corporate Integrity Agreement

➤ Is presently an entity covered by and subject the terms of a corporate integrity agreement? ☐ Yes ☐ No
(If yes, please provide a copy of CIA.)

Bankruptcy

➤ Filed bankruptcy under any provision of the United States Bankruptcy Code: ☐ Yes ☐ No

Civil Monetary Penalty (CMP)

➤ Paid to the Centers for Medicare and Medicaid Services or any state Medicaid agency a civil money penalty equal to or greater than \$250,000 as a result of an enforcement action during a survey? ☐ Yes ☐ No

6. On the following items, check all appropriate services to be licensed.

☐ **ESTABLISHING MRI UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: _____

Name Brand of Unit _____

Tesla _____

Type (i.e. Close, Short Bore, etc.) _____

Unit's Serial Number _____

Will the MRI Unit be Accredited?: ☐ Yes ☐ No

If MRI Unit will be Accredited, is it ☐ PENDING ☐ ACCREDITED

If ACCREDITED, What Organization? _____
(Attach certificate or proof of accreditation.)

If no, why:

The MRI unit will be registered with the Health Facilities Commission. ☐ Yes ☐ No

☐ **ESTABLISHING PET UNIT/SERVICE:** *(If more than one unit, use ATTACHMENT – A.)*

Physical Address of Service: _____

Name Brand of Unit _____

Type (i.e. PET Only, PET/CT, PET/MRI) _____

Unit's Serial Number _____

Will the PET Unit be Accredited?: ☐ Yes ☐ No

If PET Unit will be Accredited, is it ☐ PENDING ☐ ACCREDITED

If ACCREDITED, What Organization? _____
(Attach certificate or proof of accreditation.)

If no, why:

The PET unit will be registered with the Health Facilities Commission. ☐ Yes ☐ No

Pursuant to Tennessee Rule of Civil Procedure 72, I hereby declare under perjury that the information provided in this application is true and correct. Signee for this application certifies that he or she is of responsible character and able to comply with the minimum standards and regulations established by Tennessee pertaining to the type of facility or services for which application for licensure is made and with the rules promulgated under Tennessee Code Annotated §68-11-201 and Rules 0720-.14, 0720-36, and 0720-47 adopted by the Commission effective December 1, 2025. Signee also certifies that a policy has been implemented to inform all employees of their obligation under TCA §71-6-103 to report incidents of abuse or neglect.

Signature	Date
Printed Name	

Non-Refundable Licensing Fees for Listed Licensed Services

An invoice will be sent to the contact for Billing for total payment of fees.

MRI:

Hospital: \$500 per MRI unit
Outpatient Diagnostic Center: Included with ODC License
Physician Office: \$500 per MRI unit

PET:

Hospital: \$500 per MRI unit
Outpatient Diagnostic Center: Included with ODC License
Physician Office: \$500 per MRI unit

(as of December 1, 2025)