HOMELINK Hearing Healthcare Credentialing Application

HOMELINK Hearing Healthcare
1111 West San Marnan Drive
Waterloo, Iowa 50701

Fax: HOMELINK Hearing Healthcare (HHC) Credentialing Application

To:	HHC Provider	Control #:	**Fax:**	
From:	HHC Credentialing		**Date:**	
Re:	HHC Credentialing Application		**Pages:**	Nine (9)

Dear Provider:

HHC contracts with a variety of payers who look to HHC to coordinate high quality hearing aids, supplies and services on their behalf. These payers require HHC to credential all providers providing services to their patients.

Included with this fax is the HHC Credentialing Application. Please complete the application and return all requested documents by email or fax.

HHC is committed to providing prompt payment for your services. Your credentialing information is essential for this to occur. **Failure to submit a complete application and all supporting documents will result in a loss of referrals and/or payments being held.**

If you have any questions please feel free to call 855-874-6940.

Please send your completed application and required documents to:

Email: homelinkcredentialing@vgm.com
Fax: 855-863-7189

Please respond with you completed information within fifteen (15) business days of receipt. Thank you for your prompt attention and cooperation!

The following document is not a contract

I. Demographic Information

☐ Audiologist – ENT Practice ☐ Audiologist Private Practice

☐ Hearing Instrument Dispenser ☐ Other:_____

Legal Company Name:_____

Practice/DBA:_____

Physical/Standard Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Alt Phone: _____ Fax: _____

Website Address:_____

Remit Address:_____

City:_____ State:_____ Zip Code:_____

Phone:_____ Alt Phone:_____ Fax:_____

Company Contacts:

Owner Name:_____ Phone:_____

Owner Email Address: _____

Credentialing Contact: _____ Phone: _____

Credentialing Contact Email Address: _____

Organizational National Provider Identifier (NPI):_____

Practice Tax ID: _____ ***Attach a copy of W-9*

II. Insurance Information

Commercial General Liability Coverage (CGL)?	☐ Yes ☐ No
Professional Liability Coverage?	☐ Yes ☐ No
Provider agrees to keep in full force and effect and maintain at its sole cost and expense the following policies of insurance: ***a. Commercial General Liability Coverage (CGL) - $1 million per occurrence / $3 million aggregate*** ***b. Professional Liability/E&O – $1 million per occurrence / $3 million aggregate*** ***c. CGL policy must name HOMELINK as additional insured and include product liability/complete operations coverage***	
The coverage limits referenced above can be satisfied through a combination of primary, umbrella or excess liability policies. All such insurance provided shall be with such insurance companies and in such form as shall be acceptable to HOMELINK.	
Provider shall, except where a new policy is secured and no lapse in coverage occurs, provide HOMELINK with written notification of any cancellation, termination, expiration or alteration of any such policy(ies) within twenty-four (24) hours after participating provider receives notice of such change in policy(ies).	
Attach a copy of your CGL and Professional Liability Proof of Insurance (if applicable) including amount of coverage and listing HOMELINK as an additional insured on the policy.	
Please send us an updated copy of your Proof of Insurance when it is renewed each year.	
Has your CGL coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years?	☐ Yes ☐ No ***If yes, attach a copy of any CGL adverse actions for the past five (5) years.***
Has your Professional Liability coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years?	☐ Yes ☐ No ***If yes, attach a copy of any Professional Liability adverse actions for the past five (5) years.***

III. Professional Licensure

Do you have procedures in place to verify the professional licensure, certification, and/or registration status (i.e., current and in good standing) of staff and contractors as required by state law? ☐ Yes ☐ No

IV. Owner Attestation & Disclosure Questionnaire

(Must be completed in its entirety)

Provider attests that they have HIPAA Privacy and Security policies and procedures and conduct employee and subcontractor training as required by state and federal law.
☐ Yes ☐ No ☐ NA

Does your company perform criminal background checks on all new employees and contractors and have an established policy outlining the screening procedures?
☐ Yes ☐ No

Is your facility currently or ever been on the OIG's LEIE, SAM, and/or State Medicaid exclusion lists? (This information will be verified.) ☐ Yes ☐ No

Do you perform monthly OIG LEIE, SAM, and/or Medicaid exclusion verification checks on your employees and subcontractors? (You may be asked to provide verification of this at any time.) ☐ Yes ☐ No

Do you subcontract any of your services? ☐ Yes ☐ No
***If yes, please provide a list of individuals and/or entities that you subcontract with along with a list of services these individuals and/or entities are subcontracted for.*
If Yes, who credentials these subcontractors?_____

Do you have procedures in place to verify the professional licensure, certification, and/or registration status, including any professional disciplinary or legal actions, of employees and subcontractors as required by state law? ☐ Yes ☐ No
****If yes, you agree to provide proof of the above as required by state law, upon request, within two (2) business days or sooner if required by a payer or accreditation organization.**

If you respond Yes to any of the following questions below in section IV., please attach a summary of any legal actions, adverse sanctions, disciplinary actions, etc.

Has your current business ever been subject to fine, reprimand, consent order, probation or any conditions or limitations by any state or professional licensing, registration or certification board? ☐ Yes ☐ No ☐ NA

Has your current business ever been refused participation from, not renewed or terminated for cause, or been subject to disciplinary action, by any managed care or provider organizations (including HMO's, PPO's, IPA's or PHO's)? ☐ Yes ☐ No ☐ NA

Has your current business ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted from participation in federal or state government healthcare plans or programs including Medicare and/or Medicaid? ☐ Yes ☐ No ☐ NA

Have you ever had any professional liability actions settled, arbitrated, mediated or litigated?
☐ Yes ☐ No ☐ NA

Has your general or professional liability coverage ever been cancelled, restricted, declined or not renewed by a carrier based on your liability history? ☐ Yes ☐ No ☐NA

Have you or any member of your Board of Directors or current employees/members ever been convicted of a felony or misdemeanor other than minor traffic violations?
☐ Yes ☐ No ☐ NA

Has your business license ever been voluntarily or involuntarily relinquished, denied, suspended, revoked or restricted? ☐ Yes ☐ No ☐ NA

V. Clinic Locations

☐ CHECK BOX if adding additional locations on a separate roster of Clinics and/or Providers

Physical Address:_____

City/State/Zip + 4:_____ County:_____

Location Email:_____

Phone:_____ Fax:_____ Organizational NPI:_____

Population Served: ☐ Adults ☐ Pediatrics ☐ Infants ☐ Cochlear Implants

Hearing Aid Brands: ☐ Oticon ☐ Phonak ☐Resound ☐Signia

☐ Starkey ☐ Unitron ☐ Widex ☐ Other:_____

Provider Information:

Provider Full Name:_____

Provider Email:_____ AuD, HAD/HIS:_____

Medicare #:_____ Medicaid #:_____ CAQH ID:_____

Provider Full Name:_____

Provider Email:_____ AuD, HAD/HIS:_____

Medicare #:_____ Medicaid #:_____ CAQH ID:_____

VI. Provider Confidentiality Statement

As a credentialed entity for HOMELINK®, Provider understands that their employees and/or subcontractors will routinely be handling and in receipt of sensitive Protected Health Information (PHI) and/or financial data. Provider agrees to hold said information about patients and their needs in confidence and not disclose any information without contacting HOMELINK to review privacy and security policies and procedures (HIPAA) surrounding the release of any PHI. Provider understands that the medical records, medical information, PHI, and financial data are the property of HOMELINK and that the information contained within is property of the patient and HOMELINK.

By signing this application, Provider agrees to conform to the release of information policies and the confidentiality of the information about the patients with whom both parties are engaged in coordinating and/or providing services. Provider understands that both federal and state privacy and security laws, including HIPAA, apply to some parts of the release of information and any violation of HOMELINK's policies will be a violation of these laws.

Provider accepts complete responsibility for the actions of their employees and subcontractors and understands that violation of the privacy and security policies may initiate immediate termination of any applicable agreement between HOMELINK and Provider and/or legal action.

VII. Signature

By signing below, I certify that the information provided is complete and accurate to the best of my knowledge. I acknowledge that my eligibility for continued participation as a business entity is contingent upon the approval of the information provided within this application. I understand that my application may require review of information related to me on file with third-party entities, including but not limited to, state Medicaid and licensing boards, malpractice carriers, the Office of Inspector General's (OIG's) List of Excluded Individuals and Entities (LEIE), and the System for Award Management (SAM) administered by the US Government. I consent and authorize the release of such information.

I agree to notify HOMELINK in a timely manner, not to exceed sixty (60) days, of any changes in the information contained in this application.

Name of Company:_____**(Print)**

By:_____**(Print)**

Signature:_____ **Date:**_____

Title:_____ **Phone:**_____

The information requested in this application will be used in HOMELINK's credentialing process. All information will be treated as confidential information. Thank you for completing this credentialing application.

Medicare Compliance Program Guidelines Attestation

(Only complete & sign below if you have a Medicare PTAN)

This attestation confirms your organization is in compliance with *First Tier, Downstream and Related Entity ("FDR") Medicare Compliance Program Guidelines per 42 CFR § 422.500 and §423.501*. It also confirms your commitment to comply with the Centers for Medicare & Medicaid Services ("CMS") requirements[i]. These requirements are listed below and apply to all services your organization, as HOMELINK's Downstream Entity[iii], provides for HOMELINK Medicare business[ii]. The requirements also apply to any of the Downstream Entities, you use for HOMELINK Medicare business. Also, your organization agrees to maintain documentation supporting the statements made. You will maintain this documentation in accordance with federal regulations and your contract with HOMELINK, which is no less than ten (10) years. Your organization will produce this evidence, within two (2) business days. Your organization understands that the inability to produce this evidence may result in a request by HOMELINK for a Corrective Action Plan (CAP) or other contractual remedies such as contract termination.

1. **Code of Conduct ("COC") and/or Compliance Policies**
   My organization has adopted a COC and/or Compliance Program policies which were distributed to all employees within 90 days of hire, upon revision, and annually thereafter.

2. **General Compliance Training**
   My organization's employees completed a general compliance training program within 90 days of hire and then annually thereafter.

3. **US Department of Health & Human Services Office of Inspector General (OIG) and General Services Administration's System for Award Management (SAM) exclusion screening**
   My organization screens the US Department of Health & Human Services Office of Inspector General (OIG) and the General Services Administration's System for Award Management (SAM) exclusion lists prior to hire or contracting, and monthly thereafter, for all of our employees and Downstream Entities. My organization removes any person/entity from work on HOMELINK Medicare business if found on these lists.

4. **Reporting Mechanisms**
   My organization communicates to employees how to report suspected or detected non-compliance or potential FWA, and that it is their obligation to report without fear of retaliation or intimidation against anyone who reports in good faith. My organization either requests employees report concerns directly to payers or carriers or maintains confidential and anonymous mechanisms for employees to report internally. In turn, we report these concerns to payers or carriers, when applicable.

5. **Offshore Operations**
   For any work my organization performs that involves the receipt, processing, transferring, handling, storing or accessing of Protected Health Information ("PHI"), my organization either doesn't do the work offshore, doesn't have Downstream Entities that do the work offshore, or does the work offshore (ourselves or through a Downstream Entity) but has obtained approval from an authorized HOMELINK representative to do so.

6. **Downstream Entity Oversight**
   My organization either doesn't use Downstream Entities, or uses Downstream Entities for HOMELINK Medicare business and conducts oversight to ensure that Downstream Entities comply with all the requirements described in this attestation (e.g., OIG and GSA's SAM exclusion screening, etc.) and any applicable laws, rules and regulations.

7. **Operational Oversight**
   My organization conducts internal oversight of the services that we perform for any HOMELINK Medicare business to ensure that compliance is maintained with applicable laws, rules, and regulations.

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge.

_____

First Tier/Downstream Organization's Authorized Representative Printed Name and Title

_____ _____

Signature of First Tier/Downstream Organization's Authorized Representative Date

_____

First Tier/Downstream Organization Name Printed

_____

First Tier/Downstream Organization Mailing Address

_____

Tax ID# (TIN)/Employer ID# (EIN)

i CMS's guidance for Medicare Advantage organizations and Part D sponsors are published in both, Pub. 100-18, Medicare Prescription Drug Benefit Manual, Chapter 9 and in Pub.100-16, Medicare Managed Care Manual, Chapter 21, and are identical in each. Other applicable CMS regulatory/sub-regulatory guidance includes, but is not limited to CY 2019 Final Rule CMS-4182-F published April 16, 2018; 42C F.R. §§ 422 & 423; and associated CMS Manuals and HPMS memos.

ii For purposes of this attestation, "HOMELINK Medicare business" includes Medicare Advantage HMO and PPO plans, Medicare-Medicaid Plans (MMPs), and standalone Medicare prescription drug plans (PDPs) offered by payers/carriers under contract with CMS. Within the attestation, the terms "employee" and "Downstream Entity" refer only to those supporting HOMELINK's Medicare business. For the sake of clarity, the references in the attestation to the Medicare Advantage or Medicare Advantage organization(s), program(s), or benefit(s), or to Part D or Part D sponsor(s), program(s), or benefit(s), shall expressly include and encompass Medicare-Medicaid Plans (MMPs). Within the attestation, the terms "applicable employee" and Downstream Entity" refer only to those providing administrative or health care services for HOMELINK Medicare business.

iii Downstream Entity is any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit or Part D benefit, below the level of the arrangement between a Medicare Advantage Organization or applicant or a Part D plan sponsor or applicant and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services. (See, 42 C.F.R. §§ 422.500 & 423.501)

Credentialing Application Checklist

The credentialing process evaluates the qualifications of licensed providers. Credentialing includes verification of business ownership, location demographic information, and professional credentials.

HOMELINK is required by agreements with our payers that all provider locations are credentialed and in good standing prior to sending you approval for referrals.

To facilitate prompt processing of your credentialing application, please return only the forms and documents requested below. It is not necessary to provide us with booklets or binders as extraneous material may delay processing. If you need assistance completing this application, please contact the HOMELINK Credentialing Department at HomelinkCredentialing@vgm.com or call 866-575-8482.

Your completed application can be faxed to 855-863-7189 or mailed to:

HOMELINK
ATTN: Credentialing Department
PO Box 1860
Waterloo, IA 50704

☐ Completed HOMELINK Credentialing Application

☐ Servicing Counties: Please attach a list of all servicing counties by state; only a listing of specific counties will be accepted; do not submit maps and/or regional designations (e.g., southeast Iowa, etc.)

☐ Copy of signed W-9

☐ A copy of your General and/or Professional Liability proof of insurance including amount of coverage and listing HOMELINK as an additional insured on the policy.

☐ A copy of any General or Professional Liability Insurance adverse actions for the past five (5) years

Thank you for your prompt attention to this important request.