HOMELINK DME Credentialing

PO Box 1860 · Waterloo, IA 50704
Main Phone 800-482-1993 · Credentialing Phone 866-575-8482 · Fax 855-863-7189

To:	Provider	**Fax:**	Fax
Attn:	Dear Provider	**Date:**	08/31/2017
From:	HOMELINK Credentialing	**Pages:**	Page 1 of 9
Re:	HOMELINK Provider Credentialing		

Dear Provider:

HOMELINK® is a National Provider Network that currently has contracts with multiple insurance companies and other payer sources to provide in-network services to their clients.

HOMELINK contracts with a wide variety of insurance companies to arrange for the medically needed products and services. Providing superior quality service to these patients is a cornerstone of our business.

These companies require HOMELINK to credential providers that provider goods and/or services to their members/clients.

Please review each section prior to signing this application and contact our Credentialing/Certification Team by phone at **866-575-8482** or Email: **HomelinkCredentialing@vgm.com** if you have any questions**.** We also have a website page to obtain a copy of the certification application at **www.HomelinkCredentialing.com.**

Thank you for your prompt attention to this matter; your cooperation is greatly appreciated. Please respond with your completed information within 15 business days of receipt.

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

HOMELINK ATTN:
CREDENTIALING/CERTIFICATION TEAM
PO BOX 1860
WATERLOO, IA 50704

Sincerely,

Dave Kazynski - HOMELINK President

Teri Smith - Credentialing/Certification Officer

The following document is not a contract

Notice of Confidentiality: The document accompanying this electronic transmission contains confidential information belonging to the sender, which is legally and/or medically privileged. The information is intended only for the use of the individual or entity named above. If you are the intended recipient, you are hereby notified that any disclosure, copying, distribution, or taking of the contents of the information is strictly prohibited. If you have received this electronic transmission in error, please immediately notify us by telephone to arrange a return of the document to us.

HOMELINK DME Credentialing

I. Demographic Information

Legal Company Name: ____________________

DBA: ____________________

Physical/Standard Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Phone: ____________________ Alt Phone: ____________________ Fax: ____________________

Central Intake Number: ____________________

Web Referral Email Address: ____________________

Website Address: ____________________

Remit Address: ____________________

City: ____________________ State: __________ Zip Code: __________

Phone: ____________________ Alt Phone: ____________________ Fax: ____________________

Billing Contact ____________________

Billing Email Address ____________________

National Provider Identifier (NPI): ____________________

*****Additional Locations may be attached - please include hours of operation and NPI for each.***

Weekdays	Hours of Operation	Weekend	Hours of Operation
Monday		Saturday	
Tuesday		Sunday	
Wednesday		Holiday Hours of Operation	
Thursday			
Friday			
24 hour on-call/after hours policy: ☐ Yes ☐ No			

Federal Tax ID: ____________________ ☐ Corporate-Wide ☐ By Location

*****Attach 2 copies of W-9***

Medicare #: ______________ **Medicaid #:** ______________

Business License #: ______________ **State Sales Tax #:** ______________

*****Attach copy of Medicare Certification letter, CMS Disclosure of Ownership form and Copy of Sales Tax Certificate.***

Is your company minority owned? ☐ Yes ☐ No

Is your company owned by a woman? ☐ Yes ☐ No

II. General Information

Accreditation Status - mark the box that applies

☐ JCAHO ☐ NCQA ☐ URAC ☐ CHAP ☐ ACHC ☐ ABC ☐ BOC

Other Accreditation: ____________________

***Attach a current copy of your letter of acceptance and the accreditation certificate including expiration dates.*

If you are not accredited by one of the above bodies, please confirm that you provide ongoing educational opportunities and training to your employees. ☐ Yes ☐ No

***Attach the most current copy of your CMS or State Agency survey/site visit results.*

Frequency of training: Monthly Quarterly Bi-Annually Annually Other:____________________

Are you required to have a state license/certification to provide services? ☐ Yes ☐ No

***Attach a current copy of each license with expiration dates.*

Have you or your organization now or ever been on the state Medicaid Exclusion list or the OIG/SAM Exclusion lists? This information will be verified. ☐ Yes ☐ No

Do you submit performance data as required by CMS? ☐ Yes ☐ No ☐ N/A

Do you do monthly OIG/SAM/Medicaid exclusion checks on all subcontracted providers and on your employees? (You may be asked to provide verification of this at any time.) ☐ Yes ☐ No

Do you complete employee background checks? ☐ Yes ☐ No

Are you surety bonded? ☐ Yes ☐ No

(if yes, include a copy with dollar amount)

(if no, are you hands on with patients?) ☐ Yes ☐ No

***Attach a copy of your Human Resources Hiring Policy & Procedure.*

Do you currently possess any Foreign Assets/Companies/Offices? ☐ Yes ☐ No

***If yes, attach a copy of your W-8.*

Our company's policy is not to engage in any services or financial activity with any individual or organization that has or has been suspected to have direct or indirect ties with terrorism.

III. Insurance Information

General Liability Insurance? ☐ Yes ☐ No

Professional Liability Insurance? ☐ Yes ☐ No

***Attach a copy of your General and Professional Liability Proof of Insurance including amount of coverage and listing HOMELINK as an additional insured on the policy.*

***If you have separate Professional Liability & General Liability policies, it is recommended that you have a minimum of $1 million in coverage with $2 million aggregate ($1m/$2m) and the minimum occurrence limit of $1 million for each. If you have a combined Professional Liability & General Liability policy, we recommend $1m/$2m limits.*

***Please send us an updated copy of your Proof of Insurance when it is renewed each year.*

Has your General Liability Insurance or coverage been denied, suspended, canceled, lapsed, or not renewed within the last five years? ☐ Yes ☐ No

***If Yes, attach a copy of any General Liability Insurance adverse actions for the past five years.*

Has your Professional Liability Insurance or coverage been denied, suspended, canceled, lapsed, or not renewed within the last five years? ☐ Yes ☐ No

***If Yes, attach a copy of any Professional Liability Insurance adverse actions for the past five years.*

IV. Disclosure Info.

Have you been convicted of a crime or are you under indictment for an alleged crime within the last five years? ☐ Yes ☐ No

*****If Yes, attach a summary of any convictions and/or alleged crimes for the past five years, if applicable.***

Have you or your organization:

Been convicted of a criminal offense as described in sections 1128(a) and 1128(b)(1), (2), or (3) of the Social Security Act? ☐ Yes ☐ No

Had any civil monetary penalties or assessments imposed under section 1128A of the Social Security Act? ☐ Yes ☐ No

Been excluded from participation in Medicare or any of the State health care programs, such as Medicaid? ☐ Yes ☐ No

Had a direct or indirect ownership interest (or any combination thereof) of 5% or more in the organization? ☐ Yes ☐ No

Has any person in your organization with a ≥ 5% indirect or direct ownership or control interest in the organization (or any combination thereof), or who is an agent or managing employee of the organization, been convicted of a criminal offense related to that person's involvement in any Medicare or Medicaid program? ☐ Yes ☐ No

If you or your organization is an Iowa Medicaid Provider, have you completed the online Ownership and Control Disclosure form as part of the Iowa Medicaid Universal Provider Enrollment Application process? ☐ Yes ☐ No

Do you have a history of sanctions or disciplinary actions within the last five years with any of the following?

- State License/Certification/Registration ☐ Yes ☐ No
- Medicare, Medicaid, or any other government health program ☐ Yes ☐ No
- HMO, PPO, PHO, IPA or any prepaid health plan or managed care participation ☐ Yes ☐ No

****If marked "yes" to any of the above please attach a summary of any adverse sanctions or disciplinary actions (Signed by owner)**

Does your organization have a formal program or process for the maintenance of a drug free working environment? ☐ Yes ☐ No

If no, please provide explanation:____

Other Attestations

Provider attests to compliance with the standards of Title 45, Section 156.705 (Maintenance of Records for Federally-Facilitated Exchanges) and Section 156.715 (Compliance Reviews of QHP Issuers in Federally-Facilitated Exchanges) in the Code of Federal Regulations? ☐ Yes ☐ No ☐ N/A

Provider attests to compliance with the Section 1557 of the Affordable Care Act of 2010, in regards to ensuring that individuals with disabilities and/or limited English proficiency have access to its applicable materials and services? ☐ Yes ☐ No

V. Quality Program and Patient Satisfaction

*****Attach a copy of your Patient Satisfaction Survey***
*****Attach a copy of your Quality Program***
*****Attach a copy of State required Worker's Compensation Certification/Training, if applicable.***

Do you subcontract any of your services? ☐ Yes ☐ No

**If Yes, please provide a list of agencies or individuals that you subcontract with along with a list of services these agencies or individuals are subcontracted for.

If yes, who credentials these subcontractors? ______________________________

Do you have a process in place to verify professional licensures are current? ☐ Yes ☐ No

*****If Yes, please attach a copy of your policy***

Provider agrees that any employed or subcontracted Physical Therapy Assistant (PTA's) and Certified Occupational Therapist Assistant (COTA's) will hold a current, unrestricted license or certification in the appropriate state of jurisdiction prior to rendering services. ☐ Yes ☐ No

(Manufacturers/Distributors Only): Do you comply with Product Information and Patient Information Standards? ☐ Yes ☐ No

VI. HIPAA/Privacy Statement Form

Are you compliant with the current HIPAA policies and procedures? ☐ Yes ☐ No

*****Attach a copy of your HIPAA/Privacy Statement.***

VII. Products & Services

Check all that apply:

☐ Manual Wheelchairs
☐ Electric Wheelchairs
☐ Custom Rehab
☐ Ramps and Lifts
☐ Vehicle Modifications
☐ Beds
☐ Low Air Loss Therapy
☐ Patient Supports
☐ Patient Lifts
☐ Enteral Nutrition
☐ CPMs
☐ Phototherapy
☐ Diabetics
☐ Retail Pharmacy

☐ Lymphedema Pumps
☐ Ostsomy/Colostomy
☐ Wound Care
☐ Home Health Services
☐ Concentrators
☐ Liquid Oxygen
☐ Transfill On-Site Gas
☐ CPAP/Bi-Level
☐ Apnea Monitor
☐ Volume Ventilators
☐ Orthotic/Prosthetics
☐ IV Therapy
☐ Mastectomy

☐ Hearing Aids
☐ Hearing Supplies/Batteries
☐ Custom Ear Molds
☐ Hearing Eval/Test

Other Services: ______________________________
____
____

☐ Instruction provided on all above services

VIII. Provider Confidentiality Statement

As a credentialed entity for HOMELINK®, Provider understands that their employees will routinely be handling and in receipt of sensitive patient information 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 patient health information (PHI). Provider understands that the medical records, medical information, personal information and financial data are the property of HOMELINK and that the information contained within is property of the patient and HOMELINK.

By signing this agreement, Provider agrees to conform with the release of information policies and the confidentiality of the information about the patients with whom both parties are engaged in providing services. Provider understands that both Federal and State laws 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 understands that violation of the privacy policies, initiates immediate termination of this agreement between HOMELINK and Provider and/or legal action.

IX. Signature to complete credentialing

By signing below, I attest that the information on this application is correct and complete.

I agree to notify HOMELINK in a timely manner not to exceed 30 - 60 days of any change in the information contained in this application.

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

By: ______________________________ **(Print)**

Signature: ______________________________ **Date:** ______________

Title: ______________________________ **Phone:** ______________________________

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

2016 HOMELINK Medicare Compliance Program Guidelines Attestation

I certify, as an authorized representative of my organization, that the statements made are true and correct to the best of my knowledge and that our organization is and has been in compliance with First Tier, Downstream and Related Entity ("FDR") Medicare Compliance Program Guide per 42 CFR § 422.500 and §423.501 during the three (3) year HOMELINK credentialing cycle. It also confirms our commitment to comply with the Centers for Medicare & Medicaid Services ("CMS") requirements [1]. These requirements are listed below and apply to all services our organization, as Homelink's Downstream Entity [3], provides for Homelink Medicare business[2]. Also, my organization agrees to maintain documentation supporting the statements made. We will maintain this documentation in accordance with federal regulations and our contract Homelink, which is no less than ten (10) years. My organization will produce this evidence, within two (2) business days. My 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. **CMS' Fraud, Waste and Abuse ("FWA") Training**
   My organization's employees either completed CMS' *Combating Medicare Parts C & D Fraud, Waste, and Abuse Training* module within 90 days of hire and annually thereafter **OR** they were "deemed" to have met the FWA training requirement. [Deeming status is acquired through our enrollment in Parts A or B of the Medicare program or through our accreditation as a supplier of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)]. If not "deemed" the training was completed on Medicare Learning Network (MLN) or was incorporated, unmodified, into our existing training materials/systems.
3. **CMS' General Compliance Training**
   My organization's employees completed CMS' *Medicare Parts C & D General Compliance Training* module within 90 days of hire and then annually thereafter. The training was completed on the Medicare Learning Network (MLN) or was incorporated, unmodified, into our existing training materials/systems.
4. **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.
5. **Reporting Mechanisms**
   My organization communicated 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.
6. **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.

7. **Downstream Entity Oversight**
   My organization either doesn't use Downstream Entities, or uses Downstream Entities for Homelink Medicare business and conducts robust oversight to ensure that they comply with all the requirements described in this attestation (e.g. FWA training, OIG and GSA's SAM exclusion screening, etc.) and any applicable laws, rules and regulations.
8. **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. Also, my organization agrees to maintain documentation supporting the statements made above. We'll maintain this documentation in accordance with federal regulations and our contract Homelink, which is no less than ten (10) years. My organization will produce this evidence, upon request. My 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.

____
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)

[1] 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.

[2] For purposes of this attestation, "Homelink Medicare business" includes Medicare Advantage HMO and PPO plans 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.

[3] 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)

HOMELINK®
Credentialing Checklist

To facilitate prompt processing, please return only the forms and documents requested below. It is not necessary to provide us with costly booklets or binders as extraneous material may delay processing. If you need assistance completing this application, please contact the HOMELINK Credentialing Team 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 TEAM
PO BOX 1860
WATERLOO, IA 50704

- ☐ Completed HOMELINK Credentialing Application
- ☐ A list of locations, hours of operation (including after hours coverage) and NPI for each location (if applicable)
- ☐ **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.)
- ☐ 2 copies of your W-9
- ☐ W-8 signed (if applicable)
- ☐ A copy of your Medicare Certification Letter
- ☐ A copy of your CMS Disclosure of Ownership Form
- ☐ A copy of your Sales Tax Certificate
- ☐ A copy of your business certificates/licensures, and personnel licensures of employees or contracted professionals with expiration dates
- ☐ A copy of your Human Resource Hiring Policy and Procedures.
- ☐ A copy of your General and 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 years.
- ☐ A summary of any convictions and/or alleged crimes for the past five years
- ☐ A summary of any adverse sanctions or disciplinary actions (signed by owner)
- ☐ A copy of your most recent customer satisfaction survey with results and existing quality program
- ☐ A copy of State required Worker's Compensation Certification/Training (if applicable)
- ☐ A copy of your current HIPAA Compliance Policy/Privacy Statement form.
- ☐ A copy of your letter of acceptance and the accreditation certificate including expiration dates (if applicable)
- ☐ A copy of your current CMS or State Agency survey/site results, including deficiencies and corrective action plans (if you have a Medicare PTAN and are NOT accredited)

Thank you for your prompt attention to this important request.