# *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:** |
| **Attn:** Dear Provider | **Date:** 12/8/2015 |
| **From:** HOMELINK DME Credentialing | **Pages:** Page 1 of 9 |

Dear Provider:

Thank you for accepting a recent referral from HOMELINK.

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

**These companies require HOMELINK to credential providers that service their members/clients.**

Please review and complete the attached credentialing application. Upon completion fax or mail the completed materials to the number/address listed at the top of this page.

Thank you for your prompt attention to this matter and we look forward to directing more referrals to your company

HOMELINK Credentialing Team
1-866-575-8482

*The following document is not a contract*

# HOMELINK® DME Network Provider Credentialing Application

Are you **currently accredited?** Yes ☐ No ☐

If you marked **Yes**, please proceed and complete the information below.

**Accredited Providers**

Please circle the accreditation entity that applies to you.

JCAHO NCQA URAC CHAP ACHC HQAA Other: _____

**Proceed to the Three Easy Required Steps to finalize your HOMELINK Credentialing/Re-Credentialing Process**

1. Attach a copy of your current approved accreditation letter

2. Complete the Credentialing application and provide attachments

3. Mail or fax approved accreditation letter and signed HOMELINK Credentialing Application to:

HOMELINK
c/o Credentialing Team
PO Box 1860
Waterloo, IA 50704

OR

Fax it to:
855-863-7189
Attention: c/o Credentialing Team

**Thank you for your prompt attention to this request.**

Dave Kazynski - HOMELINK President

Teri Smith - Credentialing Officer

# HOMELINK® DME Network Provider Credentialing Application

December 08, 2015

Dear Provider:

HOMELINK® is a National Ancillary Provider Network that maintains a National Accreditation with "Accreditation Commission for Health Care, Inc." (ACHC). Achieving accreditation as well as developing programs and systems that meet Medicare standards, HOMELINK has grown to be the largest network of its kind in the United States and

In order to continue meeting our accreditation requirements and standards, please send us the following information as part of our credentialing requirements. Many of our referral sources require that we coordinate orders with credentialed providers, so your completion of this request is strongly encouraged.

- Completed VGM\HOMELINK Credentialing Application
- A list of current locations and hours of operation, including after hours coverage
- 2 copies of your W-9 and/or (W-8 signed, if applicable)
- A copy of your Medicare Acceptance letter and 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 coverage amount
- A copy of any Professional or General Liability Insurance adverse actions for the past five years
- A summary of any convictions and/or alleged crimes for the past five years (if applicable)
- A summary of any adverse sanctions or disciplinary actions (signed by owner) (if applicable)
- A copy of your most recent customer satisfaction survey with results and existing quality program (if applicable
- A copy of State required Worker's Compensation Certification/Training (if applicable)
- A copy of your HIPAA Compliance Policy/Privacy Statement form

If you have any questions, please call our Credentialing Team at **866-575-8482** or
Email: **HomelinkCredentialing@vgm.com.** We also have a website page to obtain a copy of the credentialing 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 credentialing requirements can be faxed to 855-863-7189 or mailed to:

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

Sincerely,

Dave Kazynski - HOMELINK President

Teri Smith - Credentialing Officer

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# HOMELINK® DME Network Provider Credentialing Application

HOMELINK is the Managed Care division of VGM Group Inc.. HOMELINK is nationally accredited by ACHC. **We have been appointed the delegated entity for credentialing our network providers by several contracted clients. As such, please complete this credentialing application and send to:**

**HOMELINK**
**c/o Credentialing Team**
**PO Box 1860**
**Waterloo, IA 50704**

**OR**

**Fax it to:**
**855-863-7189**
**Attention: c/o Credentialing Team**

## I. Demographic Information

**Legal Company Name:** _____

DBA: _____

**Physical/Standard Address:** _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt Phone: _____ Fax: _____

**Remit Address:** _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt Phone: _____ Fax: _____

**Key Contact Person:** _____

**Email Address:** _____ **Website Address:** _____

**National Provider Identifier (NPI):** _____

***Attach a list of current locations and hours of operation, including after hours coverage.*
***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 #:** _____

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

***Attach copy of Medicare Acceptance letter 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 ☐ None

Other Accreditation: _____

***Attach a current copy of each accreditation certificate including expiration dates.**

Are you required to have a state license or certifications 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 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. 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**

# 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

  ☐ Yes ☐ No

- Been excluded from participation in Medicare or any of the State health care programs, such as

  ☐ Yes ☐ No

- Had a direct or indirect ownership interest (or any combination thereof) of 5% or more in the

  ☐ 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 Contro 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 organization ☐ Yes ☐ No

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

# 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, 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***

*(Manufacturers/Distributors Only)*: Do you comply with Product 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

**Please check all services that you are accredited to provide:**

- ☐ 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
- ☐ Ostomy/Colostomy
- ☐ Wound Care
- ☐ Home Health Services
- ☐ Concentrators
- ☐ Liquid Oxygen
- ☐ Transfill On-Site Gas
- ☐ CPAP/Bi-Level
- ☐ Apnea Monitor
- ☐ Volume Ventilators
- ☐ Orthotics/Prosthetics
- ☐ IV Therapy
- ☐ Mastectomy
- ☐ Other specialty services-list below

_____

_____

_____

☐ Instruction provided on all above services

# VIII. Provider Confidentiality Statement

As a credentialed entity for HOMELINK®, Provider understands that their employees will routinely be handlin 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 information (PHI). Provider understands that the medical records, medical information, personal information an 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. Credentialing Application Agreement

**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:** _____

**Title:** _____ **Date:** _____

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

# HOMELINK® DME Network Provider
# Initial 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 o call **(866) 575-8482**. Please send your completed application to:

**HOMELINK**
**c/o Credentialing Team**
**PO Box 1860**
**Waterloo, IA 50704**

**OR**

**Fax it to:**
**855-863-7189**
**Attention: c/o Credentialing Team**

- ☐ Completed VGM\HOMELINK Credentialing Application
- ☐ A list of current locations and hours of operation, including after hours coverage.
- ☐ 2 copies of your W-9 and/or (W-8 signed, if applicable)
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- ☐ A copy of your most recent customer satisfaction survey with results and existing quality program (if applicable)
- ☐ A copy of State required Worker's Compensation Certification/Training, (if applicable)
- ☐ A copy of your current HIPAA Compliance Policy/Privacy Statement form.

**Thank you for your prompt attention to this important request.**