



HOMELINK Credentialing

PO Box 1860 · Waterloo, IA 50704
Main Phone 800-482-1993 · Credentialing Phone 866-575-8482 · Fax 800-357-4636

To: Provider

Fax:

Attn: To Whom It May Concern

Date:

From: HOMELINK Credentialing

Pages: Page 1 of 8

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

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® Network Provider Credentialing/Re-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 following:
 - Section I-Demographic Information
 - Signed HOMELINK Credentialing Application

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:
800-357-4636
Attention: c/o Credentialing Team

Thank you for your prompt attention to this request.

Dave Kazynski - HOMELINK President

Sherry Gribble - Credentialing Officer



Dear Provider:

HOMELINK® is a National Ancillary Provider Network that maintains a National Accreditation with ACHC and adheres to the National Committee on Quality Assurance (NCQA), the Utilization Review Accreditation Commission (URAC) and Medicare standards in the homecare industry. Achieving accreditation as well as developing programs and systems that meet NCQA, URAC, and Medicare standards, HOMELINK has grown to be the largest network of its kind in the United States and Canada.

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 expect that we coordinate orders with credentialed providers, so your completion of this request is strongly encouraged.

Please send all of the following:

- Completed VGM\HOMELINK Credentialing Application **AND/OR** a copy of your **current accreditation acceptance letter** (if applicable)
- 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 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 800-357-4636 or mailed to:

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

Sincerely,

Dave Kazynski - HOMELINK President

Sherry Gribble - Credentialing Officer



VGM HOMELINK® Provider Credentialing Application

HOMELINK is the Managed Care division of Van G. Miller and Associates. HOMELINK is nationally accredited by ACHC and also complies with NCQA, URAC, and Medicare standards. **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:
800-357-4636
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: <input type="checkbox"/> Yes <input type="checkbox"/> No			

Federal Tax ID: _____ Corporate-Wide By Location

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

Medicare #: _____ **Medicaid #:** _____

****Attach copy of Medicare Acceptance letter.**

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

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.

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 to provide services? Yes No

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

Do you complete employee background checks? Yes No

Are you bonded? Yes No (if yes, include a copy with dollar amount)

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

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.**

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.**

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.**

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

****Attach a summary of any adverse sanctions or disciplinary actions (Signed by owner)**

IV. 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

V. HIPAA/Privacy Statement Form

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

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

VI. Products & Services

Check all that apply:

- | | |
|--|--|
| <input type="checkbox"/> Manual Wheelchairs | <input type="checkbox"/> Lymphedema Pumps |
| <input type="checkbox"/> Electric Wheelchairs | <input type="checkbox"/> Ostomy/Colostomy |
| <input type="checkbox"/> Custom Rehab | <input type="checkbox"/> Wound Care |
| <input type="checkbox"/> Ramps and Lifts | <input type="checkbox"/> Home Health Services |
| <input type="checkbox"/> Vehicle Modifications | <input type="checkbox"/> Concentrators |
| <input type="checkbox"/> Beds | <input type="checkbox"/> Liquid Oxygen |
| <input type="checkbox"/> Low Air Loss Therapy | <input type="checkbox"/> Transfill On-Site Gase |
| <input type="checkbox"/> Patient Supports | <input type="checkbox"/> CPAP/Bi-Level |
| <input type="checkbox"/> Patient Lifts | <input type="checkbox"/> Apnea Monitor |
| <input type="checkbox"/> Enteral Nutrition | <input type="checkbox"/> Volume Ventilators |
| <input type="checkbox"/> CPMs | <input type="checkbox"/> Orthotics/Prosthetics |
| <input type="checkbox"/> Phototherapy | <input type="checkbox"/> IV Therapy |
| <input type="checkbox"/> Diabetics | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Retail Pharmacy | <input type="checkbox"/> Other specialty services-list below |

Instruction provided on all above services



VGM HOMELINK®

Provider Confidentiality Statement

As a contracted entity or sub-contractor 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 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.

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.



VGM HOMELINK® Provider 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. Please send your completed application to:

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

OR

Fax it to:
800-357-4636
Attention: c/o Credentialing Team

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Please attach the following documents to your Credentialing Application:

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- A copy of your Human Resource Hiring Policy and Procedures.
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- A copy of your current HIPAA Compliance Policy/Privacy Statement form.

Thank you for your prompt attention to this important request.