# *HOMELINK Hearing Health Care Credentialing & Provider Network Participation Agreement*

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**: | 11/22/2017 |
| **From:** | HOMELINK Credentialing Team | **Pages:** | Page 1 of 8 |

**Re:** HOMELINK Hearing Health Care Credentialing & Provider Network Participation Agreement

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. **Failure to submit a complete application and all supporting documents will result in a loss of referrals and/or payments being held.**

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.

The enclosed HOMELINK Hearing Health Care Credentialing & Provider Network Participation Agreement contains the terms and process requirements to become part of our Network.

Please review each section prior to signing this agreement and contact our Credentialing Team by phone at **866-575-8482** or Email: **HomelinkCredentialing@vgm.com** if you have any questions**.**

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 emailed to HomelinkCredentialing@vgm.com or 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 - Director, Credentialing

# *HOMELINK Hearing Health Care Credentialing & Provider Network Participation Agreement*

## Frequently Asked Questions

**What is Credentialing and why do we need to complete the process?**
The credentialing process evaluates the qualifications of licensed providers. Credentialing includes verification of business ownership, location demographic information, and professional credentails.

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

**What is the Provider Network Participation Agreement and why do we need to complete the process?**
The Provider Network Participation Agreement outlines the responsibilities, terms and conditions of HOMELINK and you as an in-network provider.

**What are the next steps?**
1. Complete the HOMELINK Hearing Health Care Credentialing Application.
2. Complete the HOMELINK Hearing Health Care Provider Network Participation Agreement.
3. Submit a current copy of your General and Professional Liability insurance coverages.

**How do I complete the Credentialing Application and Provider Network Participation Agreement?**
1. Fill out the information requested within the application, in its entirety.
2. Business Owner or owner equivalent signs and dates the application and the W-9 (last page of the application).

**How long does the Credentialing process take?**
The process takes 7-10 business days upon receipt of a fully completed application. Once the application is approved, please allow a minimum of 10 business days to receive your welcome packet, including information to access the Provider Portal, www.vgmhomelink.com.

If an application is deficient, a HOMELINK Credentialing Team member will contact you via email and/or phone within 3-5 business days from receipt of the application.

**How do I submit the completed application?**
- Email - HomelinkCredentialing@vgm.com
- Fax - 855-863-7189
- Mail -

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

* All information will be treated as confidential information.

# I. Demographic Information

☐ Audiologist ENT/Medical Practice ☐ Audiologist Private Practice

☐ Hearing Instrument Dispenser Only ☐ Other:_____

**Legal Company Name:** _____

Practice/DBA: _____

**Physical/Standard Address:** _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Alt Phone: _____ Fax: _____

**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 NPI:** _____ **Practice TIN:** _____

## II. Owner Attestation & Disclosure Questionnaire **(Must be completed in its entirety)**

Is your current business compliant with all current HIPPA/HITECH rules and regulations?

☐ Yes ☐ No ☐ N/A

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 ☐ N/A

Has your current business ever been refused participation from, not renewed or terminated for cause, from participation, 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 ☐ N/A

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 ☐ N/A

Have you ever had any professional liability actions settled, arbitrated, mediated or litigated?

☐ Yes ☐ No ☐ N/A

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 ☐ N/A

Has the business owner(s) ever been convicted of or pled guilty to a felony?

☐ Yes ☐ No ☐ N/A

Has your business license ever been voluntarily or involuntarily relinquished, denied, suspended, revoked or restircted?

☐ Yes ☐ No ☐ N/A

*If any of the above are marked as "Yes", please attach a summary of any adverse sanctions, disciplinary actions, etc.

**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 by any**

**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 application.***

# III. Clinic Locations & Providers

**CHECK BOX if adding additional locations on a separate roster ☐**

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 Information:**

Provider Full Name: _____

Provider Email: _____ AuD, HAD/HIS: _____

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

**Provider Information:**

Provider Full Name: _____

Provider Email: _____ AuD, HAD/HIS: _____

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

# 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**.

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

- ☐ Completed HOMELINK Credentialing Application
- ☐ 2 copies of your W-9
- ☐ A copy of your General and Professional Liability Insurance Certificates with coverage amounts listed
- ☐ A copy of your Workers' Compensation Insurance Certificate with coverage amounts listed
- ☐ **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.)
- ☐ A copy of your professional licensures, personnel licensures of employees or contracted professionals with expiration dates (if applicable)
- ☐ A copy of any General or Professional Liability Insurance adverse actions for the past five (5) years
- ☐ A summary of any convictions and/or alleged crimes for the past five (5) years
- ☐ A summary of any adverse sanctions or disciplinary actions (signed by owner)

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

# *HOMELINK Hearing Health Care Provider Network Participation Agreement*

This Hearing Health Care Provider Network Participation Agreement ("Agreement") dated, _____ ("Effective Date") is between HOMELINK® and _____ _____("Participant").

HOMELINK contracts with multiple workers' compensation payers and group health insurance companies, including Medicare Advantage Plans, ("Payers") to provide hearing care products and services for claimants and members ("Members").

HOMELINK Hearing Health Care ("HHC") maintains a network ("HHC Network") of hearing health care providers to provide audiology diagnostic services and hearing aid fitting, evaluation and dispensing services ("Covered Services").

Participant employs or contracts with hearing health care professionals ("Providers") to provide hearing health care services and products to patients and requests to join the HHC Network to provide these services and products to HOMELINK Members as outlined in this Agreement.

**1.0 PARTICIPANT RESPONSIBILITIES**

**1.1** Program Participation. Participant agrees to provide Covered Services to HOMELINK Members in accordance with the terms and provisions of this Agreement and HHC Resource Manual.

**1.2** Hearing Aid Dispensing/Audiology Obligations. Participant acknowledges and agrees that it shall be solely responsible for ensuring that all hearing aid products dispensed to Members by Participant or Participant's Providers are dispensed in accordance with applicable federal and state laws and regulations governing hearing aid dispensing and audiology, including, without limitation, laws and regulations requiring medical examinations and/or medical examination waivers prior to dispensing, use of appropriate equipment, hearing aid product purchase agreements and receipts, and notification of return rights.

**1.3** Member Records. Participant shall maintain detailed and accurate records of all services performed for and all products sold or supplied to Members.

**1.4** Insurance. Participant shall carry and retain malpractice and professional liability insurance in the amount of at least $1 million per occurrence/$3 million in the aggregate for each of its participating Providers.

**1.5** Compliance with Laws and Rules. Participant acknowledges that certain Payers contracted with HHC are obligated under Medicare Advantage Plans to oversee and be accountable to the Centers for Medicare and Medicaid Services ("CMS") for the services provided and activities performed by Participant pursuant to this Agreement.

**2.0 HHC RESPONSIBILITIES**

**2.2** Payment to Participant. HOMELINK will pay Participant for Covered Services in accordance with rates established in the HHC Resource Manual. Payment will occur after HOMELINK is paid by a third party or the Member. It may be required that HOMELINK collect all Member portions due directly from the Member. In no event may Participant or Providers bill the Member for the difference between normal billed charges and agreed upon HOMELINK reimbursement.

**3.0 CLAIMS AND PAYMENTS**

**3.1** Claims Submission. Participant is responsible for initiating the payment process by completing and submitting claim and authorization forms to HHC.

**3.2** Payment for Covered Services. Participant shall be compensated for Covered Services as described in the HHC Resource Manual.

**3.3** Billing Members. Participant may bill or charge Members only those amounts detailed in the HHC Resource Manual.

**4.0 TERM AND TERMINATION**

**4.1** Term. This Agreement shall be in effect for one (1) year beginning on the Effective Date and shall remain in effect until terminated under the terms of this Section 4.

**PARTICIPANT**

_____
Signature

_____
Printed Name

_____
Title

_____
Address

_____
City, State, Zip Code

_____
Phone

**HOMELINK**

_____
Signature

_____
Printed Name

_____
Title