Healthcare Delivery Organization (HDO) Application

INSTRUCTIONS

If your organization has multiple physical locations/businesses, please include a separate full application for any facility grouping for which there is an independent facility survey and/or facility license. (i.e Separate NPI numbers and Facility Licenses)

This application must be fully completed with all questions answered. If a particular section (1-4) is not applicable to you, mark that section with N/A. Section 5 must be completed by all applicants, and Section 6 may not be applicable to all applicants.

CHECKLIST – DOCUMENTS BELOW MUST ACCOMPANY THIS COMPLETED APPLICATION PLEASE	
☐	State Medical Facility License(s)/Registration(s) (if applicable)
☐	Facility DEA certificate(s), if applicable
☐	Current Professional Liability Insurance and General Liability face sheet, which lists amounts and coverage dates (and any other insurance face sheets for the facility)
☐	W-9 Form (TIN Number Identification)
☐	Copy of Accreditation Letter and Accreditation Decision Grid, (or, if not accredited)
☐	Copy of the most recent survey results from CMS or State Department of Health survey, including your corrective action plan if deficiencies were cited, or cover letter from CMS or the State Department of Health stating facility is in substantial compliance. Not required if facility/organization is accredited.
☐	Copy of Medicare Certification Letter

Please return application and attachments to:

Healthcare Highways
Attn: Credentialing
3001 Dallas Pkwy., Ste. 700
Frisco, TX 75034
Phone: (866) 945-2292
Fax: (469) 574-5566
credentialing@healthcarehighways.com

Please contact HCH Credentialing should you have any questions regarding this application.

SECTION 1: CONTACT AND ORGANIZATION INFORMATION

ORGANIZATION INFORMATION (PROVIDE PHYSICAL LOCATION INFORMATION ON THE FOLLOWING PAGE)			
Legal Name of Organization: (Legal Name Listed with IRS)			
DBA Name of Organization: (if applicable)			
Organization Owner:			
Organization Administrator:			
Select Appropriate Choice(s):	☐ Privately Owed ☐ Corporation Owed	☐ City or County Owned ☐ Other _____	**Select One**: ☐ For Profit ☐ Not for Profit

MAILING ADDRESS		
Street Address:		
Address Line 2:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	

BILLING ADDRESS		
Street Address:		
Address Line 2:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	

CONTACT INFORMATION		
Credentialing Contact Name:		
Phone:	**Fax:**	**E-mail:**
Billing Contact Name:		
Phone:	**Fax:**	**E-mail:**

SECTION 2: PLEASE INCLUDE THE BELOW INFORMATION FOR EACH NPI/PRACTICE LOCATION

Only include information for locations that you wish to be listed with Healthcare Highways

PHYSICAL LOCATION INFORMATION: (INCLUDE ANY ADDITIONAL INFORMATION RELEVANT TO THIS LOCATION ON A SEPARATE SHEET)		
Specific Location DBA (if different than the Organization DBA):		
Is this location Medicare Certified?	☐ Yes ☐ No	Is this the Primary Address? ☐ Yes ☐ No
Site-Specific Medicare #:		
Site-Specific Medicaid #:		
Federal TIN:		
NPI #:		

PHYSICAL PRACTICE LOCATION		
Street Address:		
Address Line 2:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	
Is this location wheelchair accessible?	☐ Yes ☐ No	
Describe your service area: (states, counties, cities, etc.)		
Please list any languages spoken by office personnel:		
Practice Limitations: (e.g., age, gender, etc.)		
Office Hours: (open to close)	Monday: Tuesday: Wednesday: Thursday: Friday: Saturday: Sunday:	

LICENSE(S) – ATTACH A COPY OF ALL LICENSES / DO NOT INCLUDE PRACTIONER LICENSES IF THIS LOCATION IS NOT REQUIRED TO BE "LICENSED" BY AN APPROPRIATE STATE AGENCY, PLEASE CHECK HERE: ☐	
State of Licensure:	
Type of License:	
License Number:	
Date of Most Recent Licensure Survey:	Click or tap to enter a date.
License Expiration Date:	Click or tap to enter a date.
State of Licensure:	
Type of Licensure:	
License Number:	
Date of Most Recent Licensure Survey:	Click or tap to enter a date.
License Expiration Date:	Click or tap to enter a date.

REGISTRATION(S), CERTIFICATE(S), ETC. – ATTACH A COPY OF ALL REGISTRATIONS, CERTIFICATES, ETC.		
DEA Number:	Issue Date: Click or tap to enter a date.	Expiration Date:Click or tap to enter a date.
CSR/CDS Number:	Issue Date: Click or tap to enter a date.	Expiration Date:Click or tap to enter a date.
CLIA Number:	Issue Date: Click or tap to enter a date.	Expiration Date:Click or tap to enter a date.
Other Certificates, Registrations, and/or Licenses:		

SECTION 3: ORGANIZATION'S SPECIALTY & TAXONOMY INFORMATION

PRIMARY CONTRACTED SPECIALTY AND TAXONOMY (IF EACH LOCATION OFFERS DIFFERENT SERVICES, PLEASE INDICATE THIS ON A SEPARATE SHEET OR ATTACHMENT; FOR MULTIPLE PRIMARY CONTRACTED SPECIALTIES, PLEASE CHECK ALL THAT APPLY BELOW)	
Hospital Specialties: ☐ General Acute Care ☐ Psychiatric ☐ Rehabilitation	**Physical Rehabilitation Specialties:** ☐ Outpatient Rehab Facility - CORF ☐ Rehabilitation Clinic – PT/OT/SLP ☐ Occupational Therapy Clinic ☐ Physical Therapy Clinic ☐ Speech Therapy Clinic
Other Specialties: ☐ Home Infusion Therapy ☐ Infusion Therapy Clinic ☐ Laboratory – Clinical Laboratory ☐ Laboratory – Independent Diagnostic Testing Facility (IDTF)	**Medical Supplier Specialties:** ☐ Durable Medical Equipment ☐ Respiratory DME Equipment ☐ Emergency Response Services ☐ Minor Home Modifications ☐ Portable X-Ray Supplier ☐ Prosthetic/Orthotic Supplier
Custodial Care Specialties: ☐ Assisted Living Facility ☐ Adult Care Home ☐ Adult Foster Care Agency ☐ Day Training and Health Services ☐ Home Health Agency ☐ Hospice Facility ☐ In Home Supportive Care/P.A.S. ☐ Skilled Nursing Facility	**Ambulatory Specialties:** ☐ Adult Day Care ☐ Ambulatory Surgery Center ☐ Dialysis (ESRD) Center ☐ Federally Qualified Health Center ☐ Radiology Clinic ☐ Radiology Clinic - Mobile ☐ Urgent Care Clinic
Other Specialty:	**Taxonomy (if applicable):**
Any additional notes on Specialty Designation:	

SECTION 4: INSURANCE COVERAGE INFORMATION

CURRENT INSURANCE – ATTACH A COPY OF YOUR CURRENT FACILITY LIABILITY INSURANCE FACE SHEET IF YOUR FACILITY IS NOT INSURED, PLEASE CHECK HERE: ☐	
Current Carrier Name:	
Policy Number:	
Policy Start Date:	Click or tap to enter a date.
Policy End Date:	Click or tap to enter a date.
Policy Type: (malpractice, general, etc.)	
Broker/Agent Name:	
Agency Phone Number:	
Type of Coverage:	
Occurrence Based; Claims Based:	
If Claims Based, does Facility have Tail Coverage:	☐ Yes ☐ No
Coverage Amount per Occurrence:	$
Coverage Amount Aggerate:	$

SECTION 5: ACCREDITATION AND/OR CERTIFICATION

ACCREDITATION/CERTIFICATION – ATTACH A COPY OF YOUR MOST RECENT ACCREDITATION CERTIFICATE FOR EACH ACCREDITING BODY	
Step 1 Specify agency of current facility accreditation (if any). At least one box must be checked:	☐ Accreditation Association for Ambulatory Health Care (AAAHC) ☐ Accreditation Commission for Health Care (ACHC-HFAP) ☐ American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) ☐ American Board for Certification in Orthotics, Prosthetics, & Pedorthics (ABCOP) ☐ American Society for Histocompatibility and Immunogenetics (ASHI) ☐ Board of Certification/Accreditation (BOC) ☐ College of American Pathologists (CAP) ☐ Commission on Accreditation of Rehabilitation Facilities (CARF) ☐ Committee of Laboratory Accreditation (COLA) ☐ Community Health Accreditation Program (CHAP) ☐ Det Norske Veritas (DNV) ☐ Healthcare Quality Association on Accreditation (HQAA) ☐ Joint Commission (JC) ☐ National Association of Boards of Pharmacy (NABP) ☐ National Board of Accreditation for Orthotics Suppliers (NBAOS) ☐ National Commission for Quality Assurance (NCQA) ☐ The Compliance Team ☐ Utilization Review Accreditation Commission (URAC) ☐ **Non-accredited – Refer to Section 6 Non-Accredited/Site Visit**
Step 2 Date of Initial Accreditation:	Click or tap to enter a date.
Step 3 Date of Last Full Survey:	Click or tap to enter a date.

SECTION 6: NON-ACCREDITED / SITE VIST

This Section only applicable if "non-accredited" was checked in Section 5, Step 1

SITE VISIT REQUIREMENT – ATTACH A COPY OF MOST RECENT ON-SITE SURVEY (INCLUDING CORRECTIVE ACTION PLAN, IF CITATIONS WERE ISSUED), OR ATTACH COVER LETTER FROM GOVERNMENT AGENCY STATING FACILITY IS IN SUBSTANTIAL COMPLIANCE
Has Facility had a post-licensing on-site visit by a government agency, such as the Department of Health or CMS within the past 36 months?
☐ YES – Date of most recent standard survey: Click or tap to enter a date.
☐ NO – Successful completion of a health plan on-site visit will be required to complete credentialing.
Were any deficiencies cited during the last full survey?
☐ YES ☐ NO ☐ N/A – No recent survey
If yes, have all deficiencies been corrected?
☐ YES. Please provide evidence of state acceptance of your Corrective Action Plan (CAP). ☐ NO. Please provide explanation and your plan to correct all deficiencies.
If no deficiencies were cited during the last full survey, please submit verification of having no deficiencies.

SECTION 7: ORGANIZATION'S CREDENTIALING PROGRAM

CREDENTIALING PROGRAM QUESTIONS	
1. Do you verify the credentials of all **licensed and non-licensed** staff that you employ?	☐ Yes ☐ No
For Yes, please check method(s) of verification for **Licensed** Staff:	☐ Online directly with appropriate State Board ☐ Obtaining a current copy of the license ☐ Other:
For yes, please check method(s) of verification for **Non-Licensed** Staff:	☐ Background Check agency ☐ Previous employers ☐ Other:
2. Do you ensure that each of the licensed staff practicing at your facility renews his/her State License *before* it expires?	☐ Yes ☐ No
3. Do you perform background checks on all your staff before hiring?	☐ Yes ☐ No
For yes, please check method(s) you utilize:	☐ Federal and/or State Criminal Background Check(s) ☐ Background Check agency ☐ Search a State "Misconduct Registry" or equivalent ☐ Other:
4. Has the entity, any employee of the entity or other party with a controlling interest in the entity ever been convicted of, pled guilty to or no contest to, or been sanctioned for any offense or action involving Medicare, Medicaid or other governmental or private third-party payer fraud or abuse program?	☐ Yes ☐ No
5. Have there ever been any limitations, restrictions, terminations or other disciplinary actions taken or initiated against the entity, or its employees or agents by any other agency?	☐ Yes ☐ No
6. Has the entity, any employee of the entity or party with a controlling interest in the entity ever been sanctioned, debarred, excluded or precluded from participation in Medicare or Medicaid programs?	☐ Yes ☐ No
7. Has the entity, any employee of the entity or other party with controlling interest in the entity ever been indicted or convicted of, pled guilty to or no contest to, a felony, any offense involving moral turpitude or fraud, or any offense related to the provision of health services, other health care related matters, third-party reimbursement, controlled substances violations, child or adult abuse?	☐ Yes ☐ No

8. Is there any reason that the provider, for the long term, does not possess the financial resources to provide health care services to Healthcare Highways members?	☐ Yes ☐ No
9. Is the entity restricted from participating in the provider network of Healthcare Highways by an exclusive or other arrangement with any person or entity other than Healthcare Highways?	☐ Yes ☐ No

Attestation and Authorization

As part of the application process and for the purpose of verifying any information provided on this application, I, the undersigned authorized agent of the applicant facility/organization, grand permission to Healthcare Highways, its affiliates and employees, agents and representatives thereof to obtain information about the licensing, competence, ethics, and other qualifications of the applicant facility/organization. I, the undersigned authorized agent, consent to the release of such information, whether in the form of transcripts, records, tapes, letters, photocopies/duplications of any of the foregoing, or verbal statements state licensing boards or regulatory bodies (by whatever name known in their respective jurisdiction) or other individuals or organizations who or which possess information about the applicant facility/organization. Such information may be released to Healthcare Highways and its affiliates or to representatives of Healthcare Highways and its affiliates.

On behalf of the applicant facility/organization, I, the undersigned authorized agent, hereby release from liability and agree to hold harmless any person or entity who or which provides the above information as authorized herein.

I, the undersigned authorized agent, hereby release from liability and agree to hold harmless all employees, agents and representatives of Healthcare Highways and its affiliates for their acts performed and statements made in connection with obtaining, reviewing, and evaluating the applicant facility/organization credentials and qualifications. The determination of whether the applicant facility/organization is qualified to serve as a provider of services is the reason such information is needed for review and evaluation by Healthcare Highways and their representatives.

I hereby affirm and attest that all statements, answers and information contained in this application are true to the best of my knowledge, information and belief. I understand that falsification, misrepresentation, or omission of any fact(s) requested would be sufficient cause for denial of this application and/or subsequent termination of any participating privileges granted upon basis of this application.

Further, I understand that acceptance of this application does not constitute approval or acceptance of participating status with Healthcare Highways and grants this applicant facility/organization no rights or privileges of participation until such time as a contract is executed and written notice of participating status is issued to the applicant facility/organization by Healthcare Highways. I acknowledge that action on this application will be delayed until all required information is received an/or verified.

This applicant facility/organization complies with all federal, state, and local handicapped access requirements as well as the standards required by the 1992 Federal Americans with Disabilities Act.

I hereby certify that the on-line exclusion lists for the Health and Human Services, Office of Inspector General (OIG) and General Services Administration (GSA) are checked for all new hires and monthly for existing employees to ensure that no excluded employees work on any jobs related to any Federal health care programs. I also hereby certify that I will remove any employee found on one of the above referenced lists from any work related to a Federal health care program. The OIG exclusion list can be found at: http://exclusions.oig.hhs.gov/. The GSA exclusion list can be found at: https://www.sam.gov/.

The individual executing this Attestation is duly authorized and has the proper authority and proper authorization to execute this Attestation and does so with the intent to fully bind Facility to the truthfulness of its answers.

Print Name:	**Title:**
Signature:	**Date:**