Humana.

Humana Recertification Organizational Provider Form

Organization Information	**Service Location_____ of _____** (If applicable) Copy pages for each additional location
Legal Name of Organization:	
DBA Name of Organization: (If applicable)	
Organization Type:	
Organization Medicare Number:	Organization Medicaid Number:
Organization Tax Identification Number (TIN):	Organization National Provider Identifier (NPI):
Organization Physical Address:	
City, State ZIP	
Organizational Contact Name:	Organizational Contact Email:
Organizational Contact Phone Number:	Organizational Contact Fax Number:

License and Credentials

☐ Check here if this location is not required to be licensed, certified or registered by a state agency.
(Attach a copy of all)

Type of Credential	**State**	**Number**	**Additional Notes/Info**
State License:			
State Registration:			
State Certification:			
DEA:			
CLIA:			
Other:			

Liability Insurance

(Attach a copy of the facility professional/general liability insurance face sheet.)

Professional Liability Insurance

Current Carrier Name:	
Policy Type: (malpractice, general, standard, etc.)	
Policy Number:	
Policy Start Date:	Policy End Date:
Coverage Amount Per Occurrence:	Coverage Amount Aggregate:

Accreditation/Certification

☐ Check here if the facility is NOT accredited.

List Accreditation/Certification Organization and Attach Copies of Current Certification:_____
_____
_____
_____

DBA: Doing business as; DEA: Drug Enforcement Agency; CLIA: Clinical Laboratory Improvement Amendment

Site Visit

(Attach a copy of your most recent on-site visit or a cover letter from government agency stating the facility is in substantial compliance.)

1. Has the 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: _____
   - ☐ No – Successful completion of a health plan on-site visit may be required to complete credentialing.
2. Were any deficiencies cited during the last full survey?
   - ☐ Yes (If yes, attach documents defining deficiencies.)
   - ☐ No
   - ☐ N/A – no recent survey

Organizational Service Provider Screening

1. Please select the method used to verify the license/certification of individuals rendering services for your organization:
   - ☐ Online directory with the appropriate state and/or federal licensure or certification board
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain):_____
2. Please indicate the method used to ensure that each license/certification (and all other credentials) of individuals rendering services for your organization is renewed before expiration:
   - ☐ Online directly with the appropriate state and/or federal licensure or certification board
   - ☐ Obtaining a current copy of the license/certification
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe): _____
   - ☐ No process (please explain):_____
3. Please indicate the method used to verify the <u>identity</u> of individuals rendering services for your organization:
   - ☐ Verification of a state driver's license or other government identification
   - ☐ Background check agency, contacted organization or vendor
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain): _____
4. Please indicate the method used to ensure that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service, and that no individuals convicted of a felony for a healthcare-related crime (including but not limited to healthcare fraud; patient abuse; and the unlawful manufacture, distribution, prescription or dispensing of controlled substance) are rending services:
   - ☐ Federal and/or state criminal background check(s)
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Search a state "misconduct registry" or equivalent
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain): _____
5. Has your organization or any of its authorized representatives ever been convicted of, pleaded guilty to or pleaded nolo contendere to any legal actions (excluding medical malpractice and misdemeanors)?
   - ☐ No ☐ Yes (provide an explanation):_____
     _____
     _____
6. Does your organization or any of its authorized representatives currently have any pending legal actions (excluding medical malpractice and misdemeanors)?
   - ☐ No ☐ Yes (provide an explanation):_____
     _____
     _____

7. Has your organization ever been the subject of an investigation or ever been terminated, suspended, sanctioned or otherwise restricted from participating in any private or public program including, but not limited to, Medicare, Medicaid, military or state Department of Health program?
   - ☐ No ☐ Yes (provide an explanation):_____
     _____
     _____

8. At any time, has any third-party payer ever revoked, reduced, denied or suspended your organization's participation due to inappropriate utilization management or quality-of-care issues?
   - ☐ No ☐ Yes (provide an explanation):_____
     _____

9. At any time, has any license or certification held by the organization or its branch locations ever been revoked, denied, or suspended, or has the organization or its branch locations ever voluntarily surrendered any license or certification while under investigation, or are any actions or investigations underway that may lead to one of these outcomes?
   - ☐ No ☐ Yes (provide an explanation):_____
     _____

10. Has your organization's liability insurance coverage ever been restricted, limited, denied, not renewed or special-rated for any reasons other than the carrier's termination of operations in your state?
    - ☐ No ☐ Yes (provide an explanation):_____
      _____

11. At any time, has any third-party payer ever revoked, reduced, denied or suspended your organization's participation due to inappropriate utilization management or quality-of-care issues?
    - ☐ No ☐ Yes (provide an explanation):_____
      _____

12. Does your organization currently employ any person who has been or is currently excluded from participation in a government program (e.g., Medicare, Medicaid)?
    - ☐ No ☐ Yes (provide an explanation):_____
      _____

13. Has the facility been denied accreditation by its selected body (e.g., TJC), or has its accreditation status been reduced, suspended, revoked, or in any way revised by the accrediting body?
    - ☐ No ☐ Yes (provide an explanation):_____
      _____

14. Does each service location associated with the facility follow the policies and procedures as defined by the facilities service location?
    - ☐ No ☐ Yes (provide an explanation):_____
      _____

Restrictions

Provide any additional explanation or attach documents as needed for screening questions:

ATTESTATION AND RELEASE OF INFORMATION FORM

Modifications Will Not Be Accepted

RELEASE OF INFORMATION:
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, grant the Managed Care Organization permission to contact any individual, institution, facility or agency identified on, or relative to, this application. Further, I hereby consent and authorize the Managed Care Organization to request, receive and inspect any and all records pertinent to consideration of this application.

As a health organizational facility/organization applicant, I, the undersigned authorized agent, acknowledge that I am required to supply the Managed Care Organization with verification of current malpractice coverage and any additional documentation necessary and relevant to the review of this application.

SITE REVIEW AUTHORIZATION:
I hereby grant permission for the Managed Care Organization to conduct on-site and medical record reviews as necessary. I further agree that this facility will participate in and support the Managed Care Organizations quality improvement and utilization review programs.

ATTESTATION:
I certify the information on this entire application is complete, accurate and current. I acknowledge that any misstatements in or omissions from this application constitute grounds for denial or summary dismissal. A copy of this application has the same force and effect as the original. I have reviewed this information as of the most recent date listed below.

I acknowledge that a decision about participation for the organization on this application will be delayed until all required information is received and/or verified. I acknowledge that acceptance of this application does not constitute approval or acceptance or participating status with the Managed Care Organization and does not grant this facility any rights or privileges of participation until such time as a contract is consummated and written notice of participating status is issued to this facility by the Managed Care Organization. All services rendered to its Members must be individually authorized until a written notice of participation and conditions of participation is issued by the Managed Care Organization.

This facility 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 certify that the appropriate state license or certification source is checked for all new employees or contracted service providers prior to the first provision of service. I certify that the appropriate state license or certification source is checked at least annually for existing and contracted service providers to ensure that every licensed individual providing services as a representative of the applicant holds a current license or certification to provide services. I certify that criminal background checks are conducted for all new employees or contracted service providers prior to the first provision of service. I certify that the applicant does not employ or contract with any individual convicted of a felony for a healthcare-related crime, including, but not limited to, healthcare fraud, patient abuse and the unlawful manufacture, distribution, prescription or dispensing of a controlled substance.

I certify that the on-line exclusion lists for the Department of Health and Human Services Office of Inspector General (**http://oig.hhs.gov/exclusions/exclusions_list.asp**) and System for Award Management (**https://sam.gov/content/exclusions**) are checked for all new employees or care providers prior to the first provision of service and for existing employees or contracted service providers on a monthly basis to ensure that no state or federally excluded individuals perform any function related to any state or federal healthcare program. I certify that I will remove any employee or contracted service provider found on one of the above referenced federal exclusion lists from any functions related to a state or federal healthcare program.

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.

Authorized Signer: _____ Date: _____

Printed Name of Signer: _____

Authorized Signer Title: _____Signer's Email Address: _____

Printed Facility Name: _____