# HOMELINK

## Chiropractic, Acupuncture, and/or Massage Therapy CREDENTIALING APPLICATION

***Control Number:** ☐

***A Control Number must be included in the box above in order for HOMELINK to process your credentialing application. The Control Number is located in the faxed cover letter or email you received with instructions for downloading this credentialing application. If you are a new HOMELINK provider completing a credentialing application for the first time, please enter X12345 in the Control Number box above. Contact the HOMELINK Credentialing Department by phone at 866-575-8482 or email at HomelinkCredentialing@vgm.com if you have any questions.***

***This credentialing application is for facilities only. HOMELINK sub-delegates to Applicant credentialing of acupuncturists and other clinicians.***

***To become a HOMELINK Chiropractic, Acupuncture, and/or Massage Therapy Network Provider, please contact Don Knock with HOMELINK Provider Relations at 855-874-6940 or don.knock@vgm.com.***

**COMPANY TYPE** ***(check all that apply)*:**

☐ Chiropractic
☐ Acupuncture
☐ Massage Therapy
☐ Other_____ *(please specify)*

| Legal and Main Contact Information | | |
|---|---|---|
| Legal Company Name: | | |
| Practice/DBA: | | |
| Address: | | |
| City: | State: | Zip Code (9 digit): |
| Main Phone #: | Alt Phone #: | |
| Fax #: | | |
| Federal Tax ID #: ***(attach a copy of W-9)*** | | |
| Credentialing Contact Name: | Credentialing Contact Phone #: | |
| Credentialing Contact Email Address: | | |
| Do you have access to the internet: ☐ Yes ☐ No | | |
| Website Address: | | |
| Is your company a Minority Business Enterprise (MBE)? ☐ Yes ☐ No | | |
| Is your company a Women Business Enterprise (WBE)? ☐ Yes ☐ No | | |
| Is your company a Veteran-Owned Business? ☐ Yes ☐ No | | |

## Primary and Additional Facility Locations

Please complete below for Primary Company facility location and copy this page and complete for each additional facility location. All changes must be communicated within 15 business days of change to HomelinkCredentialing@vgm.com

| | | |
|---|---|---|
| Facility Name: | | |
| Address: | | |
| City: | State: | Zip Code (9 digit): |
| County: | | |
| Phone #: | Fax #: | |
| Contact Name & Title: | Contact Phone #: | |
| Contact Email Address: | | |
| Referral Email Address: | | |
| Medicare #: | (***attach a copy of Medicare Enrollment Letter)*** | |
| Medicaid #: | | |
| Business License #: | State License #: | |
| Federal Tax ID #: | ***(attach a copy of W-9)*** | |
| NPI # *(If applicable):* | | |
| State Sales Tax #: | (***attach a copy of Sales Tax Certificate)***: | |

| | | |
|---|---|---|
| Office Hours (M-F): | Saturday Hours:<br>Sunday Hours:<br>Holiday Hours: | 24 Hour On-Call/After-Hours Coverage: ☐ Yes ☐ No |

| | | | |
|---|---|---|---|
| Walk-In's Accepted<br>☐ Yes ☐ No | Handicap Access<br>☐ Yes ☐ No | Appointment Only<br>☐ Yes ☐ No | Open During Lunch<br>☐ Yes ☐ No |

**Please Check ✓ the Services that are Provided at the Above Location**

| | | |
|---|---|---|
| **Chiropractic:**<br>☐ Chiropractic Manipulation<br>☐ Activator<br>☐ Modalities<br>☐ Exercise<br>☐ Physical Therapy (by licensed therapist)<br>☐ Occupational Therapy (by licensed therapist)<br>☐ Functional Capacity Evaluation<br>☐ Work Hardening/Conditioning<br>☐ DOT Exams<br>☐ Drug & Alcohol Testing<br>☐ Sport Physicals<br>☐ X-Rays<br>☐ Diagnostic Imaging | **Acupuncture:**<br>☐Acupuncture<br>☐ Herbal Medicine/Supplements<br>Electro-Acupuncture<br>☐ Modalities<br>☐ Exercise | **Massage Therapy:**<br>☐Massage Therapy<br>☐ Modalities<br>☐ Exercise |

☐ Please attest by checking this box that all appropriate training is provided to staff for all services marked above.

| Billing/Remit Addresses | | |
|---|---|---|
| Address: | | |
| City: | State: | Zip Code (9 digit): |
| County: | | |
| Main Phone #: | Alt Phone #: | |
| Fax #: | | |
| Billing Contact Name: | Billing Contact Phone #: | |
| Billing Contact Email Address: | | |

☐ **Check the box if the billing/remit address applies to all facility locations**

| General Information | |
|---|---|
| Is Applicant's organization required to have a state license to provide services?<br>***If yes, attach copies of each current license with expiration dates.***<br><br>***It is not necessary to send copies of individual clinician licenses.*** | ☐ Yes ☐ No |
| Is Applicant's organization required to have a business license to provide services?<br>***If yes, attach copies of each current license with expiration dates.***<br><br>***It is not necessary to send copies of individual clinician licenses.*** | ☐ Yes ☐ No |
| Does Applicant currently own any Foreign Assets, Companies, and/or Offices?<br>***If yes, attach a copy of your W-8.***<br><br>***HOMELINK's policy is not to engage in any services or financial activity with any individual or entity that has or has been suspected to have direct or indirect ties with terrorism.*** | ☐ Yes ☐ No |
| Is Applicant's organization currently certified by the Drug Enforcement Agency (DEA)?<br><br>***If yes, attach a copy of your current Drug Enforcement Agency (DEA) Certification.*** | ☐ Yes ☐ No |
| Does Applicant's organization currently subcontract any services?<br><br>***If yes, who credentials these subcontractors?_____***<br><br>***If yes, provide a list of individuals and/or entities that you subcontract with along with a list of services these individuals and/or entities are subcontracted for.*** | ☐ Yes ☐ No |

| Insurance Information | |
|---|---|
| Commercial General Liability Coverage (CGL)? | ☐ Yes ☐ No |
| Professional Liability Coverage? | ☐ Yes ☐ No |

Applicant agrees to keep in full force and effect and maintain at its sole cost and expense the following policies of insurance:

*a.* Commercial General Liability Coverage (CGL) - $1 million per occurrence / $3 million aggregate

*b.* CGL policy must name HOMELINK as additional insured and include product liability/complete operations coverage

*c.* Professional Liability/E&O – $1 million per occurrence / $3 million aggregate

Applicant shall, at its own cost and expense, procure and maintain policies of CGL and professional liability insurance as required in the state where the Applicant offers Covered Services, in minimum coverage amounts in accordance to above, minimum coverage amounts, or if greater, in minimum coverage amounts required in the state where Applicant offers covered services, to insure Applicant and its employees against claims for damages arising by reason of personal injury, loss or death resulting directly or indirectly from or in connection with the performance of any covered services by Applicant, its employees and agents.

Attach a copy of Applicant's CGL and Professional Liability Certificate of Insurance including amount of coverage. Applicant must list HOMELINK as an Additional Insured on all CGL and Professional Liability policies.

Applicant is responsible for any insurer fees for adding HOMELINK as an additional insured on Applicant's applicable insurance policies**.**

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|---|---|
| **Applicant attests that the above policies of insurance are currently in force at or above the established coverage limits.**<br>***Failure to meet the above minimum insurance coverage requirements will result in denial of this application.*** | ☐ Yes ☐ No |

Applicant shall, except where a new policy is secured and no lapse in coverage occurs, provide HOMELINK with written notification of any cancellation, termination, expiration or alteration of any such policies within twenty-four (24) hours after provider receives notice of such change in policies.

**Applicant must send HOMELINK updated copies of your Certificates of Insurance when renewed each year.**

| | |
|---|---|
| Has Applicant's CGL coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years?<br>***If yes, attach a copy of any CGL adverse actions for the past five (5) years.*** | ☐ Yes ☐ No |
| Has Applicant's Professional Liability coverage been denied, suspended, cancelled, lapsed, or not renewed within the last five (5) years?<br>***If yes, attach a copy of any Professional Liability adverse actions for the past five (5) years.*** | ☐ Yes ☐ No |
| Has Applicant ever had any professional liability actions settled, arbitrated, mediated or litigated? | ☐ Yes ☐ No |

| **Disclosures**<br>***If you respond Yes to any of the following questions below, please attach a summary of any legal actions, adverse sanctions, disciplinary actions, etc., signed by owner.*** | |
|---|---|
| Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor ever been convicted of a felony or misdemeanor other than minor traffic violations? | ☐ Yes<br>☐ No |
| Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor ever 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<br>☐ No |
| Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor ever incurred any civil monetary penalties or assessments imposed under section 1128(a) of the Social Security Act? | ☐ Yes<br>☐ No |
| Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor ever been excluded from participation in Medicare or any of the state health care programs, such as Medicaid? | ☐ Yes<br>☐ No |
| Does Applicant or any owner, officer, director, employee, agent, and/or subcontractor have a direct or indirect ownership interest (or any combination thereof) of 5% or more in the organization? | ☐ Yes<br>☐ No |
| Has Applicant or any owner, officer, director, employee, agent, and/or subcontractor (including your organization) ever been on the OIG's LEIE, SAM, and/or State Medicaid exclusion lists? ***(This information will be verified.)*** | ☐ Yes<br>☐ No |
| Does Applicant's organization perform monthly OIG LEIE, SAM, and/or Medicaid exclusion verification checks on your owners, officers, directors, employees, agents, and/or subcontractors? ***(You may be asked to provide verification of this at any time.)*** | ☐ Yes<br>☐ No |
| Has Applicant's organization ever been refused participation from, not renewed or terminated for cause, or been subject to disciplinary action, by any managed care or provider organizations (including HMO's, PPO's, IPA's or PHO's)? | ☐ Yes<br>☐ No |
| Has Applicant's organization 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<br>☐ No |
| Has any person with a $\geq$ 5% indirect or direct ownership or control interest in Applicant's 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<br>☐ No |
| Has Applicant's state and/or business license(s) ever been voluntarily or involuntarily relinquished, denied, suspended, revoked or restricted? | ☐ Yes<br>☐ No |
| Does Applicant use offshore subcontractor services such as billing, customer service, etc.?<br><br>***HOMELINK must approve the use of any offshore subcontractor.*** | ☐ Yes<br>☐ No |

| **Attestations**<br>***All applicable documents in this section must be provided to HOMELINK, upon request, within two (2) business days or sooner if required by a payer or accreditation organization.*** | |
|---|---|
| Applicant attests to compliance with the Section 1557 of the Affordable Care Act of 2010, in regards to ensuring that individuals with disabilities and/or limited English proficiency have access to its applicable materials and services. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to compliance with the standards of Title 45, Section 156.705 (Maintenance of Records for Federally-Facilitated Exchanges) and Section 156.715 (Compliance Reviews of QHP Issuers in Federally-Facilitated Exchanges) in the Code of Federal Regulations. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having an established Business Continuity and Disaster Recovery Plan (BCDR) and/or Emergency Preparedness Plan, as required by CMS, and it is reviewed, tested, and updated annually. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to performing multi-jurisdictional criminal background checks, fingerprints, and/or drug screens on owners, officers, directors, employees, agent, and/or subcontractors in accordance with federal, state, and local law, and having an established written policy outlining the screening procedures. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having procedures in place to verify the education (i.e., graduate of chiropractic medicine from an institution that is accredited by the Council on Chiropractic Education), state licensure (i.e., valid, current license in good standing), certification Boards, work history for last five (5) years, and National Practitioner Data Bank (NPDB), of employees and subcontractors that are chiropractors as required by state law?<br><br>***If Yes, you agree to provide proof of the above as required by state law, upon request, within two (2) business days or sooner if required by a payer or accreditation organization.*** | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having procedures in place to verify the education (i.e., advanced degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM)), state licensure (i.e., valid, current license in good standing), certification Boards (i.e., National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)), work history for last five (5) years, and National Practitioner Data Bank (NPDB), of employees and subcontractors that are acupuncturists as required by state law?<br><br>***If Yes, you agree to provide proof of the above as required by state law, upon request, within two (2) business days or sooner if required by a payer or accreditation organization.*** | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having procedures in place to verify the education, state licensure (i.e., valid, current license in good standing), certification Boards (i.e., Federation of State Massage Therapy Boards, Massage & Body Work Licensing Examination), work history for last five (5) years, and National Practitioner Data Bank (NPDB), of employees and subcontractors that are massage therapists as required by state law?<br>***If Yes, you agree to provide proof of the above as required by state law, upon request, within two (2) business days or sooner if required by a payer or accreditation organization*** | ☐ Yes<br>☐ No<br>☐ NA |

| | |
|---|---|
| Applicant attests to holding all applicable organizational licensure, endorsements, permits, registrations, and/or accreditations that are current, active, and in good standing, in accordance with state and/or local law. | ☐ Yes<br>☐ No<br>☐ NA |
| Provider attests to having adopted and is currently adhering to a drug-free and alcohol-free workplace written policy and program.<br>***If No, provide an explanation:_____*** | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having a Sales Tax Certificate. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having Human Resources policies and procedures. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having a current Patient Satisfaction Survey with results. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having a current Quality Assurance and Performance Improvement (QAPI) Program. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having HIPAA Privacy and Security policies and procedures and to conducting employee and subcontractor training as required by state and federal law. | ☐ Yes<br>☐ No<br>☐ NA |
| The Health Insurance Portability and Accountability Act (HIPAA) Security Rule as amended by the HITECH Act of 2009 establishes a national set of minimum security standards, including Administrative, Physical, and Technical Safeguards, to secure Protected Health Information (PHI) that an Applicant may create, receive, maintain, or transmit during a healthcare transaction. Applicant attests to having implemented the applicable Administrative, Physical, and Technical Safeguards of the HIPAA Security Rule, including notification procedures for breaches of unsecured PHI, in compliance with 45 CFR Part 164 Subparts C and D. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicants attests to completing state-required workers' compensation certification training. | ☐ Yes<br>☐ No<br>☐ NA |
| Applicant attests to having an established Advanced Directive written policy. | ☐ Yes<br>☐ No<br>☐ NA |

| | |
|---|---|
| Applicant attests to assume full responsibility for, and to indemnify and hold HOMELINK harmless from and against any and all claims, demands, causes of action, fines, fees, penalties, costs, expenses, losses, damages or liabilities of any type or nature whatsoever, including but not limited to reasonable attorneys' fees and expenses, arising from or in connection with any loss, personal injury or death resulting or arising from, directly or indirectly, the performance of covered services by Applicant, its employees and agents. Applicant shall not be responsible for any liability imposed by law upon HOMELINK, and HOMELINK shall not be responsible for any liability imposed by law upon Applicant. HOMELINK and Applicant each agrees to be responsible for its own liabilities to whatever degree determined. | ☐ Yes<br>☐ No |
| Applicant attests to meeting all applicable requirements of the Occupational Safety and Health Administration's (OSHA) COVID-19 ETS (Emergency Temporary Standard) regarding occupational exposure. | ☐ Yes<br>☐ No<br>☐ NA |

## Applicant Confidentiality/Non-Disclosure Statement

As a credentialed entity for HOMELINK®, Applicant understands that their employees and/or subcontractors will routinely handle and be in receipt of sensitive Protected Health Information (PHI) and/or financial data. Applicant 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 PHI. Applicant understands that any medical records, medical information, PHI, and financial data is their responsibility and that the information contained within is the property of the patient and cannot be disclosed or otherwise used without patient consent, unless permitted by state and/or federal law.

By signing below, Applicant agrees to conform to the release of information policies and the confidentiality of the information about the patients with whom both parties are engaged in coordinating and/or providing services. Applicant 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.

Applicant accepts complete responsibility for the actions of their owners, officers, directors, employees, agents, and/or subcontractors and understands that violation of HOMELINK privacy and security policies may warrant immediate termination of the HOMELINK Chiropractic, Acupuncture, and/or Massage Therapy Provider Agreement between HOMELINK and Applicant and/or legal action.

## Signature

**By signing below, 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.**

**I agree to notify HOMELINK in a timely manner, not to exceed sixty (60) days, of any changes in the information contained in this application.**

**Name of Company:_____(Print)**

**By:_____(Print)**

**Signature:_____ Date:_____**

**Title:_____ Phone:_____**

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

## Applicant Documentation Requirements

*Please provide the following documentation as required by the terms of your HOMELINK Chiropractic, Acupuncture, and/or Massage Therapy Provider Agreement.*

To facilitate prompt processing of your credentialing application, please return only the forms and documents requested below. It is not necessary to provide us with booklets or binders as extraneous material may delay processing. If you need assistance completing this application, please contact the HOMELINK Credentialing Department at HomelinkCredentialing@vgm.com or call 866-575-8482.

Your completed application can be emailed to HomelinkCredentialing@vgm.com or faxed to 855-863-7189 or mailed to:

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

☐ Completed HOMELINK Chiropractic, Acupuncture, and/or Massage Therapy Credentialing Application
☐ A list of locations, hours of operation (including after-hours coverage), and NPI for each location
☐ Servicing Counties: 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.)
☐ Copy of signed W-9
☐ Copy of signed W-8 (if applicable)
☐ Copy of Medicare Certification Letter (if applicable)
☐ Copy of Sales Tax Certificate
☐ Copies of state and/or business licenses (if applicable)
☐ Copies of Certificates of Insurance showing adequate coverages and limits as outlined in the Insurance Information section listing HOMELINK as an additional insured
☐ Copies of any Commercial General Liability and Professional Liability insurance adverse actions for the past five (5) years, as applicable
☐ Copy of state-required workers' compensation certification training (if applicable)
☐ Copy of accreditation certificate including expiration date (if applicable)
☐ An overview of any felony or applicable misdemeanor convictions (if applicable)
☐ If Medicare certified and not accredited, a copy of most recent CMS or State Agency survey/site visit results, including deficiencies and corrective actions

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