MANAGED CARE APPLICATION

INSTRUCTIONS

This form should be typed or legibly printed in black or blue ink. If more space is needed than provided on original, attach additional sheets and reference the question being answered.

Current copies of the following documents MUST be submitted with this application, failure to supply the items listed will delay your information from being loaded into the claims systems of MCP's insurance providers.

	A photo copy of current State License
	Copy of National Board for Certification Certificate or Letter (if applicable)
	Copy of Audioprosthology Certification by ACA (if applicable)
	Copy of Audiology Certification by ASHA (if applicable)
	Copy of any other professional license/certification/registration which applies
	Copy of the Department. of the Treasury, IRS confirmation letter, showing your EIN/Company Name combination (or the confirmation email of the same)
	W-9 Form (latest version available from www.IRS.com)
	Current City/County Business License (if your city/county does not issue or require a Business License, please provide verification from your city/county)
	If using a Fictitious Name; a copy of the Fictitious Business Name Statement or Permit from issuing authority
	Copy of Insurance Policy showing policy number, policy dates, name of Insurer, declaration page demonstrating the amount of coverage which complies with the insurance requirements listed on page 3 of this application
	List **ALL** current equipment used by provider
	Copy of current calibration certificate(s) showing facility name and address, date of calibration and identifying equipment information
	List of current services provider offers
	Copy of Company Patient Office Questionnaire
	Applicants current resume, CV or at least a five year work history
	Copy of confirmation email or letter showing applicants name and National Provider Identifying Number. Please include both Individual and Organization NPI information
	Copy of Quality Management Policy or statement of how you ensure that your services meet or exceed the community standards and ensure referring physician and patient satisfaction
	Copy of the Department of Health Services (MediCal)acceptance letter (EDS) certifying that facility is a Medi-cal Certified Provider (if applicable)
	Sample copy of providers billing claim form with providers fields filled out - CMS1500 with items 25, 31, 32 a&b, and 33 a &b completed, or unique provider billing form (no patient information please)
	Completed and signed Attestation Questionnaire (page 4)
	Completed application with supporting documentation and signature (page 4)
	Completed and signed Authorization and Release form (page 5)
	Signed 'Letter of Resolution' on your company letterhead (see page 6 for example)
	Signed File Maintenance Contract (page 7)
	Filing fee of $1000.00 paid to the order of HHP/CA Managed Care Program

MANAGED CARE APPLICATION

PROVIDER DEMOGRAPHIC INFORMATION:
**If provider would like to list multiple facilities, please fill out a separate application for each location.

Legal Business Name:			
DBA Name (if applicable):		Corporate Status (LLC, Corporation, Partnership, etc.)	
Applicants Name:		Credentials:	Federal Tax ID Number:
National Provider Identifier (NPI): Individual-		NPI Organization-	
Address:		Suite #:	
City:	County:	State:	Zip + 4 digit postal code
Telephone Number:		Fax Number:	
Applicants Email:		URL/Web address:	

OFFICE CONTACT: Please list the person you would like us to contact when needing updated information for your managed care file, if different than above.

Office Contact (if different than applicant):	Office Contact Phone Number:
Office Contact Fax Number	Office Contact E-mail Address:

MAILING ADDRESS (If different than above):

Mailing Address (If different than above):		Suite #:	
City:	County:	State:	Zip:

HOURS OF OPERATION

Mon-Thur. _____	Fri. _____	Sat. _____	Sun. _____

BILLING INFORMATION (if applicable):

Billing Co. Name:		Billing Co. Address:	
City:	County:	State:	Zip:
Billing Co. Phone:		Billing Co. Fax:	
Billing Co. Contact:		Billing Co. E-mail	

BUSINESS STRUCTURE/OWERNERSHIP:

Is the provider a unit of a larger entity/agency/corporation/network?			
If yes, name of larger entity/agency/corporation/network:			
Address:		Suite #:	
City:	County:	State:	Zip:
Telephone Number:		Fax Number:	
NPI Number (if applicable)			

ADA COMPLIANCE

I attest that this facility complies with State, Federal and local requirements for handicap access as well as the standards required by the 1992 Federal American Disability Act.

Applicants Signature:_____ Date: _____

LICENSURE: Please provide copies of current licenses with completed application.

State License Number:	Issue Date:	Expiration Date:
Medi-Cal:	Issue Date:	Expiration Date:
Other:	Issue Date:	Expiration Date:

INSURANCE COVERAGE: Please provide a copy of current insurance information with completed application.

Please provide evidence of professional liability and comprehensive general liability insurance or funded self insurance information. HHP/CA's Managed Care Program requires that all contracted facilities carry adequate professional and general liability coverage. The following minimums MUST be adhered to by all facilities:

General Liability:	Professional (Malpractice):
$1,000,000 per occurrence	$1,000,000 per occurrence
$3,000,000 in aggregate	$3,000,000 in aggregate

GENERAL LIABILITY COVERAGE:

Liability Carrier:	Policy Dates:
$_____ per occurrence	$_____ in aggregate

PROFESSIONAL (MALPRACTICE) COVERAGE:

Professional Carrier	Policy Dates:
$_____ per occurrence	$_____ in aggregate

SUGGESTED HEALTH PLANS AND IPA's FOR FUTURE CONTRACTS:

Please list any Health Plans and IPA's from your area that you would like to be included in the Managed Care Program. If you have contact information for any of the suggested providers, please include that information with this application. For future suggestions, please email them to samantha@hhpca.org.

1	Name of Health Plan or IPA:	Contact information if known:
2	Name of Health Plan or IPA:	Contact information if known:

Please add any additional information, comment or suggestion concerning the Health Plans or IPA's you have listed above here. Attach a separate page if you have more suggestions.

HIPPA COMPLIANCE

I attest that this facility complies with State, Federal and local requirements in regards to The Health Insurance Portability and Accountability Act (HIPAA). records retention and overall patient confidentiality.

Applicants Signature:_____ Date: _____

ATTESTATION QUESTIONS:

Please answer the following questions, 'yes' or 'no'. If you answer 'yes' please provide full details on a separate piece of paper. These attestation questions pertain to the HHP/CA member who is applying for the Managed Care Program.

I am a: ☐ Dispensing Audiologist ☐ Hearing Aid Dispenser

A.	Has your professional/malpractice insurance ever been denied, canceled, not renewed or surcharged without your consent or by your request? (If yes please complete and attach Addendum B to this application)	☐ YES ☐ NO
B.	Is there currently any professional/malpractice action against you?	☐ YES ☐ NO
C.	Are you currently under investigation by any government agency?	☐ YES ☐ NO
D.	Have you ever been expelled, fined by or suspended from receiving payment under MediCare, Medicaid or MediCal?	☐ YES ☐ NO
E.	Has your accreditation status ever been reduced, terminated, suspended or revoked?	☐ YES ☐ NO
F.	Is your malpractice insurance provided through a self-insurance trust or program? If yes please contact the HHP/CA Managed Care office for further instructions and requirements. 916-447-1975	☐ YES ☐ NO
G.	Has any action ever been taken against your license in any state, including but not limited to revocation, suspension limitation, probation or voluntarily relinquishment?	☐ YES ☐ NO
H.	Is there licensure action pending in any state at this time?	☐ YES ☐ NO
I.	Have you ever been subject to discipline by your medical or specialty society?	☐ YES ☐ NO
J.	Have you ever been convicted of a felony?	☐ YES ☐ NO
K.	Do you now, or have you ever, experienced any physical, emotional or mental condition, which affected your clinical practice?	☐ YES ☐ NO
L.	Are you currently being treated for alcoholism or substance abuse?	☐ YES ☐ NO
M.	Are you in a medical diversion program?	☐ YES ☐ NO
N.	Have you ever been disenrolled from participation in a PPO, HMO or similar managed care plan?	☐ YES ☐ NO

Attest:_____

Name: _____

Title: _____

Note: The HHP/CA's Managed Care Program, reserves the right to request documentation from the applicant to confirm the information maintained in this attestation.

I hereby affirm that the information submitted in this application is true to the best of my knowledge and belief and is furnished in good faith. I understand that significant omissions or misrepresentations may result in denial of application or termination of the participating provider program.

A photocopy of this document shall be as effective as the original.

_____ _____

Printed Name **Title**

_____ _____

Signature **Date**

(A Stamped Signature Is Not Acceptable)

AUTHORIZATION AND RELEASE OF INFORMATION

For purposes of making this application for participation or continued participation in the HHP/CA Managed Care Program (MCP). I certify that all information provided to MCP on behalf of this facility is true and correct to the best of my knowledge and belief. I agree to notify MCP within 14 days of any material changes provided to MCP previously. I understand and agree that if MCP determines, in it's sole discretion, that this application contains any intentional or significant misstatements, misrepresentations or omissions, MCP's acceptance of this application for participation and any subsequent participation provider agreement which MCP enters into with the facility will be void.

On behalf of the facility, I hereby authorize the release to MCP any information held by any person, entity or governmental agency which in his/her/it's official capacity has information relevant to the evaluation of any initial and/or recredentialing information. On behalf of the facility, I agree to hold any such person, entity or government agency providing MCP with such information harmless from any liability to the facility for providing such information.

On behalf of the facility, I hereby authorize MCP to release any and all information, related in any way to the facility to any person, entity or governmental agency which (a) providers MCP with an authorization signed by me; or (b) has a legal right to know under any state of federal law. The facility agrees to hold MCP harmless from any liability for providing any such information as specified herein.

I understand and agree that the certification, authorizations and other provisions contained herein shall remain in force for so long as this application is pending and, if accepted for participation or continued participation, for so long as the facility's participation provider agreement with MCP remains in force.

I also understand and agree that: (a) the facility has the burden of producing all information required or requested by MCP in connection with this application; (b) MCP is under no obligation to complete the processing of this application until such information is provided by the facility; and (c) MCP has the sole discretion to determine whether or not the facility will be a participating provider.

Upon acceptance into the managed care program, I agree to report all disciplinary actions and changes in malpractice coverage, institutional privileges or professional licensure on a timely basis.

PROVIDERS RIGHTS

1	The provider has the right to review information submitted to MCP in support of their application. The provider may request to review such information at any time by contacting MCP office at (916) 447-1975 or by sending a written request via the USPS to Hearing HealthCare Providers CA - Managed Care Program, Documentation Request, 1121 L Street, Suite 409 Sacramento CA 95814. An MCP representative will notify the provider of a date and time when such information will be available for review at the MCP's office located in Sacramento, CA.
2	The provider has the right, upon request, to be informed of the status of their application.
3	The provider will be notified in the event that information obtained from other sources varies substantially from that provided by the provider and they will be given the opportunity to clarify and/or correct this information prior to the finalization of the credentials/recredentials process.

_____ _____

Printed Name **Title**

_____ _____

Signature **Date**

(A Stamped Signature Is Not Acceptable)

LE LETTER OF RESOLUTION

Please type the following information onto your company letterhead, sign and date and return with your application.

(Your company information or logo must appear on the letter)

Type the date the letter was created

Your Name
Company Name
Company Address

Re: Letter of Resolution

I (Please insert applicants' name here) whose signature appears below authorize the HHP/CA Managed Care Program Director and its representatives to act on my behalf in matters related to the Managed Care Program. I further understand that information contained in this application in whole or part can and will be used to obtain new insurance provider contracts.

I further understand that Hearing HealthCare Providers of California is not responsible for any injury or claims arising out of acts by individuals enrolled in this program. Enrollees shall assume all risks and liabilities both personal and financial in connection with enrollment and subsequent participation in said managed care contracts. The Hearing HealthCare Providers of California represents no warranties, either expressed or implied as to guaranteeing signed contracts.

_____	_____
Signature	**Title**
_____	_____
Printed Name	**NPI Number**
_____	_____
Date	**License Number**

AINTENANCE AGREEMENT: Please read the following carefully before signing.

MCP files are available and subject to random audits by our insurance providers and therefore must be kept current with viable information. Upon acceptance into the MCP you will be responsible for keeping your HHP/CA membership current and in good standing and your managed care file up to date with current documentation. Failure to do so may cause a delay in payments from the insurance providers, suspension from the program or possible expulsion.

By signing this document you understand it is your responsibility to maintain your managed care file and keep it current to the best of your ability. Upon renewal of any of the items listed below, participant agrees to send to MCP a legible copy of the document either by mail, email or fax within 30 days of the documents renewal date.

In the event that an item can not be obtained in a timely manner or that there might be a problem renewing an item, the participant will notify the MCP office immediately to discuss the issue and keep the MCP up to date as to the situation.

Files that are not kept up to date are subject to termination from the Managed Care Program and a refilling fee may be assessed to bring the file current.

MCP staff will send reminders on expiring documents either by mail, email or fax, although it is ultimately the participants sole responsibility to ensure MCP has the current documentation on file at all times.

The following list contains items that will need to be copied and either mailed, faxed or emailed to MCP on an annual basis. This is the basic information needed to keep your managed care file current with our insurance providers. This list is subject to change at any time.

	A photo copy of current State License
	Business License issued by your City/County (please check renewal dates, some cities/counties have a quarterly renewal periods)
	Certificate of Insurance from your Liability/Professional Insurance provider(s) or a copy of the Declaration Page showing the types of coverage and the amounts of coverage and the coverage dates
	Copy of current calibration certificate(s) showing facility name and address, date of calibration and identifying equipment information

The following items need to be maintained and if changes occur (i.e. business moves, incorporates, etc.) the provider must contact the MCP office and necessary documents will then need to be completed. This information is what the insurance companies use to contact you so current information is necessary at all times. This list is subject to change at any time.

	HHP/CA annual membership dues
	List all current equipment used by provider (please report promptly the loss or replacement of any equipment)
	Address and contact information (contact person, phone, fax and email, etc.)
	Company status, (Inc., LLC, Sole Proprietor, etc.) is current and tax identification information is up to date

These are not complete lists, each provider may have items that only pertain to his/her city/county/ business type or structure

I have read and understand the File Maintenance agreement and by signing this document understand that I am responsible for keeping my file current and in good standing.

_____ _____

Signature **Title**

_____ _____

Printed Name **Date**

_____ _____

MCP Signature **Date**

_____

MCP Printed Name

Return application and all attachments to:

Samantha Marcantonio, Assistant Director
HHP/CA Managed Care Program
1121 L Street, Suite 409
Sacramento, CA 95814

Questions? Call 916-447-1975 - fax to 916-442-4394
or email to samantha@hhpca.org