Facility & Organization - Assessment Form

To complete the credentialing process, please enter your contact information below and provide Humana with current copies of all requested items. They are required for the facility to participate with Humana.

Facility information
Name to appear in the directory (DBA):
Products: ❑ Health maintenance organization (HMO) ❑ Preferred provider organization (PPO) ❑ Medicare ❑ Medicaid
Facility Tax Identification Number (TIN):
Facility National Provider Identifier (NPI) number:
Medicaid ID number:
Medicare ID number:
Credentialing contact name:
Contact email address:
Contact phone number:

Please provide the following:

- Organizational provider assessment form (completed, signed and dated)
- State license (if applicable to state requirements)
- Accreditation, certification or Centers for Medicare & Medicaid Services (CMS) letter
- Accreditation, certification or CMS site survey
- Drug Enforcement Administration (DEA) registration certificate (if applicable)
- Malpractice insurance policy face sheet showing effective and expiration date and limits of liability
- Clinical Laboratory Improvement Amendments (CLIA) (if applicable)
- Attestation and release of information form
- Disclosure of Ownership form
- W-9 form

Humana.

Organizational Provider Assessment Form

Organization information	
Legal name of organization:	
D/B/A name of organization (If applicable):	
Historic name(s) of organization (If under same ownership):	
Hospital or health system affiliation (If applicable):	
Organization Medicare number:	Organization Medicaid number:
Organization Tax Identification Number (TIN):	Organization National Provider Identifier (NPI):
Ownership type: (Select one) ☐ Sole proprietorship ☐ City/county/state owned ☐ Corporation/LLC/partnership ☐ Federally owned	Select one: ☐ For profit ☐ Non-profit
Products: (Select all that apply) ☐ HMO ☐ Medicare ☐ PPO ☐ Medicaid	

Organization type	
☐ Hospital	☐ Home health agency
☐ Skilled nursing facility/nursing home	☐ Free-standing surgery center
☐ Hospice	☐ Clinical laboratories
☐ Durable medical equipment (DME)	☐ Urgent care center
☐ Comprehensive outpatient rehabilitation	☐ End stage renal disease services/dialysis services
☐ Outpatient physical therapy	☐ Speech pathology
☐ Outpatient diabetes self-management training facility	☐ Portable X-ray suppliers
☐ Rural health clinic	☐ Federally qualified health center (FQHC)
☐ Birthing center	☐ Diagnostic/radiology/imaging center
☐ Substance abuse disorder	☐ Opioid treatment program
☐ Behavioral health facility:	
☐ Other facility type:	

Physical location information					
Site-specific Medicare number:			Site-specific Medicaid number:		
Site-specific TIN:			Site-specific NPI:		
Street address:					
City:			State:		
ZIP:			County:		
Phone:			Fax:		
Credentialing contact information					
Credentialing contact name:			Credentialing contact email:		
Credentialing contact phone:			Credentialing contact fax:		
Street address:					
City:			State:		ZIP:
☐ Check here if all correspondence can be directed to the physical location above. If not, complete the section(s) below.					
Mailing address					
Street address:					
Address line 2:					
City:			State:		ZIP:
Phone:			Fax:		
Contact name:			Email:		
Billing address (If different than mailing)					
Street address:					
Address line 2:					
City:			State:		ZIP:
Phone:			Fax:		
Contact name:			Email:		
Hours of operation					
Day	Open	Close	Day	Open	Close
Monday:			Friday:		
Tuesday:			Saturday:		
Wednesday:			Sunday:		
Thursday:			☐ Telehealth services are available		
Accessibilities					
☐ Americans with Disabilities Act (ADA) compliant			ADA access for: ☐ Building ☐ Parking ☐ Restroom		
☐ Telecommunication device for the deaf (TDD) capability			☐ Interpreters available		
☐ Answering service			☐ 24/7 phone coverage		
☐ Is this location on a public transportation route?			☐ No ☐ Yes (explain)_____		
Languages spoken by office personal: ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Russian ☐ Arabic ☐ Other _____					
License and credentials					
☐ Check here if this location is not required to be licensed, certified or registered by a state agency. (Attached 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:
General 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:	
☐ The Joint Commission (TJC)	☐ Accreditation Association for Ambulatory Health Care (AAAHC)
☐ Commission on Accreditation of Rehabilitation Facilities (CARF)	☐ Continuing Care Accreditation Co (CCAC)
☐ Community Health Accreditation for Healthcare (ACHC)	☐ Healthcare Facilities Accreditation Program (AOA HFAP)
☐ American Association for Accreditation for Ambulatory Surgery Facilities (AAAASF)	☐ American College of Radiology (ACR)
☐ National Integrated Accreditation for Healthcare Organizations (DNV-NIAHO)	☐ Council on Accreditation (COA)
☐ Clinical Laboratory Accreditation (COLA, Inc.)	☐ American Association of Diabetes Educators (AADE)
☐ Indian Health Service (IHS)	☐ Commission on Accreditation for Home Care New Jersey (NJCAHC)
☐ Commission for the Accreditation of Birth Centers (CABC)	☐ Intersocietal Accreditation Commission (IAC)
☐ Substance Abuse and Mental Health Services Administration (SAMHSA)	☐ Other:
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	

Additional Location Addendum

Organization information			**Service Location_____of _____** (If applicable) Copy pages for each additional location
Demographics			
Location name:			
Location DBA name:		Location type:	
Site address:			
City, State ZIP			
Site NPI:	Site Medicare number:	Site Medicaid 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: _____ _____ _____

Hours of operation					
Day	**Open**	**Close**	**Day**	**Open**	**Close**
Monday:			Friday:		
Tuesday:			Saturday:		
Wednesday:			Sunday:		
Thursday:					
☐ Telehealth services are available					

Accessibilities				
☐ Americans with Disabilities Act (ADA) compliant	ADA access for	☐ Building	☐ Parking	☐ Restroom
☐ TDD capability	☐ Interpreters available			
☐ Answering service	☐ 24/7 phone coverage			
☐ Is this location on a public transportation route?	☐ No	☐ Yes (explain)_____		
Languages spoken by office personal: ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Russian ☐ Arabic ☐ Other _____				

Organizational service provider screening

1) 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) 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) Indicate the method used to verify the identity of individuals rendering services for your organization:
   - ☐ Verification of a state driver's license or other government identification
   - ☐ Background check agency, contracted organization or vendor
   - ☐ Other process (please describe):_____
   - ☐ No process (please explain): _____

4) 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 a controlled substance) are rendering 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 no contest 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 at any time 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) 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) 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) 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 ever 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:

DISCLOSURE OF OWNERSHIP, BUSINESS TRANSACTIONS & EXCLUSIONS STATEMENT FOR PROVIDERS)

The federal regulations set forth in 42 CFR 455.104, 455.105 and 455.106 require providers who are entering into or renewing a provider agreement to disclose to managed care organizations that contract with the Medicaid agency: 1) the identity of all owners with a control interest of 5% or greater, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity. **This statement must be completed whether or not you have any information to report.**

OWNERSHIP & CONTROL INTERESTS (42 CFR 455.104)

A. Please provide the following information for each Person with an Ownership or Control Interest in you as a Provider, or in any Subcontractor in which you, as a Provider, have direct or indirect ownership of 5% or more. If no such ownership exists, please indicate this with an "N/A."

	Full Legal Name	Address	% of Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

B. If any Person with an Ownership or Control Interest listed in subsection IV (A) is related to another Person with an Ownership or Control Interest listed in section A as a spouse, parent, child or sibling, please complete the following section. If no such relationship exists, please indicate this with an "N/A."

	Full Legal Name	Address	% of Owner	Interest	SSN or FEIN	Relationship
1						
2						
3						

C. For each Person with an Ownership or Control Interest listed in subsection IV (A) who also has an ownership or control interest in an organization other than those indicated in section A, please provide the following information. If no such relationship exists, please indicate this with an "N/A."

	Full Name of Business or Organization	Name of Other	Address	SSN or FEIN	% of Ownership Interest
1					
2					
3					

SIGNIFICANT BUSINESS TRANSACTIONS (42 CFR 455.405)

A. Please report your ownership of any Subcontractor with whom you as a Provider have had business transactions totaling more than twenty five thousand dollars ($25,000.00) during the previous twelve (12) month period ending on the date of this request. If no such ownership exists please indicate this with an "N/A."

	Full Legal Name	Address	SSN or FEIN	Reason
1				
2				
3				

B. Please report any Significant Business Transactions between you as a Provider and any Wholly Owned, Supplier, or between you as a Provider and any Subcontractor, during the previous five (5) year period ending on the date of this request. If no such business transactions exist, please indicate this with an "N/A."

	Name of Wholly Owned Supplier	Address	SSN or FEIN	Nature of Business Transactions
1				
2				
3				

EXCLUDED INDIVIDUALS OR ENTITIES (42 CFR 455.106)

A. Are there any Persons with an Ownership or Control Interest in you as a Provider, or any type of your managing Employees, Agents or Subcontractors who have ever:

Been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 and 1128A of the Social Security Act?

☐ Yes ☐ No

Been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

B. Do you as a Provider have any agreements for the provisions of items or services related to the health plan's obligations under its contract with the Department of Human Services or the Centers for Medicare and Medicaid Services with an individual or entity who has been excluded from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act?

☐ Yes ☐ No

If you answered "Yes" to any of the above questions, list the name and social security number or Tax ID of the individual or entity and reason for answering "Yes" (i.e., conviction of a criminal offense related to involvement in or exclusion from participation in Medicare, Medicaid, or other federally funded government health care programs in accordance with Sections 1128 or 1128A of the Social Security Act).

	Full Legal Name	Address	SSN or FEIN	Reason
1				
2				
3				

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 Organization's 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: _____