Durable Medical Equipment Provider Onboarding Packet

Thank you for your interest in joining the CenCal Health provider network. We greatly value your partnership in better serving our community. CenCal Health credentials all DMEs who provide products and services to our members. Enclosed is a credentialing application and additional documents required to begin the onboarding process. Please complete the packet in its entirety.

The following must accompany your application:

- □ Copy of Home Medical Device Retailer License/Home Medical Retailer Exempt License
- □ Copy of Business License
- □ Copy of Fictitious Business Name Statement
- □ Copy of California Medicaid (Medi-Cal) participation approval
- □ Proof of facility Commercial General Liability coverage
- □ Proof of facility Professional Liability coverage (if applicable)
- □ New Provider Training Orientation Attestation

Medi-Cal Enrollment is Separate and Required
Beginning January 1, 2018, federal law requires that all non-exempt providers of services to Medi-Cal recipients must be screened and enrolled as Medi-Cal providers by the Department of Health Care Services (DHCS). This is a requirement in addition to CenCal Health's onboarding and credentialing process. Please find more information about the Medi-Cal enrollment process on our website here.

All provider credentialing applications are reviewed by the CenCal Health Credentials and Peer Review Committee or a Medical Director. To ensure timely processing of your application, please complete and return all documents listed above as soon as possible. Forms may be submitted in the following ways:

Mail: CenCal Health, Attn: Provider Services Department
4050 Calle Real, Santa Barbara, CA 93110
Email: provideronboarding@cencalhealth.org
Fax: (805) 681-3033

We appreciate your cooperation during the onboarding process. If you have any questions, please contact us at the above email.

Thank You,

CenCal Health – Provider Services Department

CenCal HEALTH®
Local. Quality. Healthcare.

Durable Medical Equipment Provider 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. Please do not use abbreviations when completing the application. **Current copies of the following documents must be submitted with this application:**

*State Medical License(s)	*Business License (if applicable)	*W-9 Form
*Seller's Permit (if applicable)	*Liability Insurance Face Sheet	*NPI Verification (CMS/NPPES Conformation)
*Home Medical Device Retailer License (if applicable)	*Home Medical DEI/ICE Retailer Exempted License (if applicable)	*Fictious Business Name Statement

PRACTICE INFORMATION

Please check all that apply:

☐ Sole Proprietor ☐ Partnership (attach legible copy of agreement) ☐ Government entity

☐ Corporation ☐ Limited Liability Company (LLC) ☐ Nonprofit Corporation

Corporate Number: _____ LLC Number: _____ Type of nonprofit:_____

State Incorporated: _____ State Registered/Filed: _____ ☐ Other: _____

Legal Name of applicant or provider (as listed with the IRS):				
Doing Business As (DBA), if different:		Business Telephone Number: ( )		
Is this a fictitious business name? ☐ Yes ☐ No	If yes, list the Fictitious Business Name Statement Number.		Effective Date:	
Business Address:	City:	County:	State:	Zip Code:
Pay-To Address:	City:	County:	State:	Zip Code:
Contract Address:	City:	County:	State:	Zip Code:
E-Mail Address:				
National Provider Identification (NPI):		Medi-Cal Number:		
Primary Taxonomy Code:	Taxonomy Code:		Taxonomy Code:	
Taxpayer Identification Number (TIN):		Social Security Number: If sole proprietor is not using a TIN.		
Any local business license number/ permits:	Medicare/Other NPI/Medicare Billing Number:		Seller's Permit Number:	
Office Contact Name:	Phone Number:		Fax Number:	

If you have a Second Practice/Office, please list all information:				
Legal Name of applicant or provider (as listed with the IRS):				
Doing Business As (DBA), if different:		Business Telephone Number: ( )		
Is this a fictitious business name? □ Yes □ No	If yes, list the Fictitious Business Name Statement Number.		Effective Date:	
Business Address:	City:	County:	State:	Zip Code:
Pay-To Address:	City:	County:	State:	Zip Code:
Contract Address:	City:	County:	State:	Zip Code:
E-Mail Address:				
National Provider Identification (NPI):				
Primary Taxonomy Code:	Taxonomy Code:	Taxonomy Code:		
Taxpayer Identification Number (TIN):				
Office Contact Name:	Phone Number:	Fax Number:		

Wheelchair Accessible: □ Yes □ No Other special access arrangements?
_____

Number of blocks to the Nearest Public Transportation Stop: _____

Please List any foreign languages fluently spoken by you or your staff.	
Languages Spoken by Staff (specify staff position)	Languages Spoken by Provider

A. Do you have a retail business open and available to the general public which meets all local laws and ordinance regarding business licensing and operations and is readily identifiable as a place in which you sell, rent, or lease durable medical equipment, incontinence medical supplies, and/or medical supply items? ☐ Yes ☐ No

If no, please explain:

_____

B. Do you have adequate inventory and staff to meet both your current and your anticipated sales and service requirement? ☐ Yes ☐ No

If no, please explain:

C. Does your business have regular and permanently posted business hours? ☐ Yes ☐ No

Business days and hours of operation: Days:_____ Hours: _____

D. Does your business have permanently attached signage that identifies the name of the business as stated on this application? ☐ Yes ☐ No

E. Do you have the necessary equipment, office supplies, and facilities available to carry out your business, including storing and retrieving such records as are necessary to fully disclose the type and extent of services provided to Medi-Cal beneficiaries? ☐ Yes ☐ No

F. Does your business involve the trade, sale, rental, or transfer of upholstered-furniture (including wheelchair) or beddings? ☐ Yes ☐ No

If yes, provide your Home Medical Device Retailer License number _____, or your retail furniture and bedding dealer's license or retail furniture dealer's license number _____.

G. Does your business involve the trade, sale, rental, or transfer of medical devices or durable medical equipment/devices for use in the home to treat acute or chronic illness or injuries? ☐ Yes ☐ No

If yes, provide your Home Medical Device Retailer license number _____.

H. Does your business involve the trade, sale, rental, or transfer of dangerous or legend drugs and/or dangerous or legend medical equipment? ☐ Yes ☐ No

If yes, provide your Home Medical Device Retailer Exemptee license number _____.

I. Does the applicant provide custom rehabilitation equipment and custom rehabilitation technology services to Medi-Cal beneficiaries? ☐ Yes ☐ No

If yes, does the applicant have on staff, either as an employee or independent contractor, or does the applicant have a contractual relationship with, a qualified rehabilitation professional who was directly involved in determining the specific custom rehabilitation equipment needs of the patient and was directly involved with, or closely supervised, the final fitting and delivery of the custom rehabilitation equipment? ☐ Yes ☐ No

J. Applicant or provider business activities include the sale, rental, and/or lease of the type of items checked below. Give the percentage of each business activity in which the applicant or provider engages. Total the percentages at the end of this question. Percentages must total 100 percent.

☐ Beds _____ %

☐ Wheelchairs _____ %

☐ Ostomy supplies (describe):
_____ _____ %

☐ Oxygen therapy equipment and supplies (describe):
_____ _____ %

☐ Urinary catheters, bags, etc. (describe):
_____ _____ %

☐ Incontinence medical supplies (describe):
_____ _____ %

☐ Infusion equipment and supplies (describe):
_____ _____ %

☐ Other (describe):
_____ _____ %

Total: _____ %

Proof of Liability Insurance				
Name of Insurance Company:				
Insurance Policy Number:	Date Policy Issued: (mm/dd/yyyy)		Expiration date of policy: (mm/dd/yyyy)	
Address:		City:	State:	Zip Code:
Insurance Policy Amounts: Occurrence: $			Aggregate: $	

Information about Individual Signing this Application		
Print name:		☐ Male ☐ Female
Driver's license or state-issued identification number:	Date of Birth:	Social Security Number:

I declare under penalty of perjury under the laws of the State of California that the foregoing information in this document, in the attachments, are true, accurate, and complete to the best of my knowledge and belief. I declare that I have the authority to legally bind the applicant or provider pursuant to Title 22, CCR section 51000.30(a)(2)(B).

Signature of provider:_____ Title: _____

Date: _____

ATTESTATION QUESTIONS
Please answer the following questions "yes" or "no." ***If your answer to questions A through I is "yes," or if your answer to J is "no," please provide full details on separate sheet.***
A. Have you, as applicant provider, ever been charged, suspended, fined, disciplined, or otherwise sanctioned, subjected to probationary conditions, restricted or excluded, or have you, the applicant/provider, voluntarily or involuntarily relinquished eligibility to provide services or accepted conditions on your eligibility to provide services, for reasons relating to possible incompetence or improper professional conduct, or breach of contract or program conditions, by Medicare, Medicaid, or any public program, or is any such action pending? ☐ Yes ☐ No
B. As the applicant/provider, have your clinical privileges, membership, contractual participation or employment by any medical organization (e.g. hospital medical staff, medical group, independent practice association (IPA), health plan, health maintenance organization (HMO), preferred provider organization (PPO), private payer (including those that contract with public program, medical society, professional association, medical school faculty position or other health delivery entity or systems), ever been denied, suspended, restricted, reduced, subject to probationary conditions, revoked or not renewed for possible incompetence, improper professional conduct or breach of contract, or is any such action pending? ☐ Yes ☐ No
C. Has the individual license, certificate, or other approval to provide health care of the applicant/provider **ever** been suspended or revoked? ☐ Yes ☐ No
D. Have you, as applicant/provider, ever been convicted of any crime (other than a minor traffic violation)? ☐ Yes ☐ No
E. Do you, as applicant/provider, presently use any drugs illegally? ☐ Yes ☐ No
F. Do you, as applicant/provider, have any history of chemical dependency/substance abuse? ☐ Yes ☐ No
G. Have any judgments been entered against you, as applicant/provider,, or settlements been agreed to by you, as applicant/provider, with the last seven (7) years, in professional liability cases, or are there any filed and served professional liability lawsuits/arbitrations against you, as applicant/provider, pending? ☐ Yes ☐ No
H. As applicant/provider, has your professional liability insurance ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged), or have you as applicant provider ever been denied professional liability insurance, or has any professional liability carrier provided you with written notice of any intent to deny, cancel, not renew, or limit your liability insurance or its coverage of any procedures? ☐ Yes ☐ No
I. Do you, the applicant/provider, currently participate or have you ever participated as a provider in the Medi-cal program or in another state's Medicaid program? ☐ Yes ☐ No
J. Are you able to perform all the services required by your agreement with, or the professional staff bylaws of, the Healthcare Organization to which you are applying, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients? ☐ Yes ☐ No

I hereby affirm that the information submitted in this document, and any attachments hereto, are true, accurate, and complete to the best of my knowledge and belief. I agree to provide Central California Alliance for Health with any updated information regarding all questions on this application form as such information becomes available and such additional information as may be requested by the Alliance or its authorized representatives or required by the credentialing criteria of the Alliance.

Print Name: _____

Signature: _____ **Date:** _____

Information Release/Acknowledgements

I hereby consent to the disclosure, inspection and copying of information and documents relating to my credentials, qualifications and performance ("credentialing information") by and between "this Healthcare Organization" and other Healthcare Organizations (e.g., hospital medical staffs, medical groups, independent practice associations {IPAs}, health plans, health maintenance organizations {HMOs}, preferred provider organizations {PPOs}, other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies {with respect to certification of coverage and claims history}, licensing authorities, and businesses and individuals acting as their agents (collectively, "Healthcare Organizations"), for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect credentialing information f

I am informed and acknowledge that federal and state[3] laws provide immunity protections to certain individuals and entities for their acts and/or communications in connection with evaluating the qualifications of healthcare providers. I hereby release all persons and entities, including this Healthcare Organization, engaged in quality assessment, peer review and credentialing on behalf of this Healthcare Organization, and all persons and entities providing credentialing information to such representatives of this Healthcare Organization, from any liability they might incur for their acts and/or communications in connection with evaluation of my qualifications for participation in this Healthcare Organization, to the extent that those acts and/or communications are protected by state or federal law.

I understand that I shall be afforded such fair procedures with respect to my participation in this Healthcare Organization as may be required by state and federal law and regulation, including but not limited to, California Business and Professions Code Section 809 et seq, if applicable.

I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualifications and for resolving any doubt about such qualifications.

During such time as this application is being processed, I agree to update the application should there be any change in the information provided.

In addition to any notice required by any contract with a Healthcare Organization, I agree to notify this Healthcare Organization immediately in writing of the occurrence of any of the following: (I) the unstayed suspension, revocation or nonrenewal of my license to practice medicine in California; (ii) any suspension, revocation or nonrenewal of my DEA or other controlled substances registration; or (iii) any cancellation or nonrenewal of my professional liability insurance coverage.

I further agree to notify this Healthcare Organization in writing, promptly and no later than fourteen (14) calendar days from the occurrence of any of the following: (i) receipt of written notice of any adverse action against me by the Medical Board of California taken or pending, including but not limited to, any accusation filed, temporary restraining order, or imposition of any interim suspension, probation or limitations affecting my license to practice medicine; or (ii) any adverse action against me by any Healthcare Organization which has resulted in the filing of a Section 805 report with the Medical Board of California, or a report with the National Practitioner Data Bank; or (iii) the denial, revocation, suspension, reduction, limitation, nonrenewal or voluntary relinquishment by resignation of my medical staff membership or clinical privileges at any Healthcare Organization; or (iv) any material reduction in my professional liability insurance coverage; or (v) my receipt of written notice of any legal action against me, including, without limitation, any filed and served malpractice suit or arbitration action; or (vi) my conviction of any crime (excluding mi

I hereby affirm that the information submitted in this application and any addenda thereto (including my curriculum vitae if attached) is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my participation agreement. A photocopy of this document shall be as effective as the original, however, original signatures and current dates are required on all pages.

Print Name Here: _____

Signature _____ **Date:** _____

3. The intent of this release is to apply at a minimum, protections comparable to those available in California to any action, regardless of where such action is brought.

New Provider Training Attestation Form

Organizational Practice Name: _____

By signing below, I am acknowledging having received the below information as part of CenCal Health's new provider orientation. I understand that this information is always available to me within the **CenCal Health Provider Manual Operations Guide**, online at **cencalhealth.org/providers/welcome-to-the-network**, and through the Provider Relations Department.

A. Overview of CenCal Health

- Summary of Managed Care
- CenCal Health Programs
- Acronyms
- Provider Communication

B. Standard Training Material

- Member Eligibility
- Covered Services and Carved Out Services
- Member Access (including appointment waiting time standards and ensuring telephone translation and language access)
- Required Preventive Services [including Early, Periodic Screening, Diagnosis and Testing (EPSDT)] services for Members less than 21 years of age
- Coordination of Care and Referrals (including non-covered services)
- Radiology Benefit Manager (RBM)
- Medical Record Documentation and Coding Requirements
- Prior Authorization and Utilization Management (including policies and procedures for clinical protocols governing Referral Authorization Forms (RAFs) & Treatment Authorization Requests (TARs)
- Mental Health & Behavioral Health Therapy Benefit [includes Specialty Mental Health Services (SMHS) and Non-Specialty Mental Health Services (NSMHS), Substance Use Disorder (SUD) and Intellectual and Developmental Disabilities (IDD)], and children with special health care needs
- California Children's Services (CCS) and Whole Child Model (WCM)
- Regional Centers (including Tri-Counties Regional Center)
- Child Health and Disability Prevention Program (CHDP)
- Seniors and Persons with Disabilities (SPD)
- Members with chronic conditions
- Cultural Linguistics, Interpreter Services, Alternative Format Selection and Language Requirements
- Pharmacy
- Grievance and Appeals Policies and Procedures
- Member Rights and Responsibilities
- Diversity, Equity, and Inclusion (DEI) Training
- Quality Improvement and Health Equity Transformation Program
- Population Health Management Program
- Health Education Resources
- Provider and Member Incentive Programs, as applicable

C. Information/Data Sharing, Data Collection, and Reporting Requirements

- Secure Data Sharing Methods
- Member and Member Care Team Contact Information

D. Website Demonstration

- Online Provider Directory
- Contracted Provider List (PDF)
- Provider Manual
- Transaction Services
- Provider Portal

In addition to the above topics, CenCal Health provides additional information to Primary Care Providers (PCPs), including:

- Facility Site Review
- Incentive Programs
- Reports available for Primary Care Providers

Training Acknowledgment & Attestation

Signature _____ Date _____

Print First & Last Name _____ Group Billing NPI# _____

Title _____ Practitioner NPI# (if applicable) _____

○ Our practice, including Practitioners and Medical Staff, acknowledges and confirm(s) to have received all CenCal Health Provider Regulatory Training resources.

Please provide a list all Rendering Practitioners within your organization who have completed these training resources. This applies to newly joining physicians to your organization, and/or being re-credentialed with CenCal Health. If you are using a Roster, please leave this section blank.

Print First & Last Name _____ Date _____

Practitioner NPI# _____

(continue to next page)

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

Print First & Last Name

Date

Practitioner NPI#

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