DME Provider Application 6.25

This provider application is for all *i*Care lines of business including Medicare DSNP, Medicaid, Family Care Partnership and Family Care, operating under the brand name Inclusa. If you were not aware, in June 2023, Inclusa entered into an Asset Purchase Agreement with Independent Care Health Plan ("*i*Care"), a Humana Inc. subsidiary, pursuant to which *i*Care acquired substantially all Inclusa's Family Care assets. *i*Care is working towards system integration; however, currently *i*Care and Family Care branded Inclusa are operationally independent.

If the application is approved and moved forward, all Providers will receive education and resources to successfully serve all *i*Care lines of business.

INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED UNTIL ALL INFORMATION REQUIRED HAS BEEN RECEIVED

Required Documents	Applicable/Attached		
	Yes	No	N/A
Completed Application			
Completed W-9 Form			
Face Sheet of Current Business Liability Insurance			
Additional Required Document(s), if applicable	**Yes**	**No**	**N/A**
Copy of practitioner roster, please include name, NPI, and license type			
Copy(s) of all Federal, State, and/or local professional licenses, certifications, and/or registrations specifically required to operate			
Copy(s) of all Federal, State, and/or local business licenses, certifications, and/or registrations specifically required to operate			
Copy(s) of all Accreditation Certificates and the most recent survey results			
Copy(s) of the most recent CMS survey, including a corrective action plan if deficiencies were cited and evidence from CMS that all deficiencies are remedied			
Copy(s) of the most recent DQA survey, including a corrective action plan if deficiencies were cited and evidence from DQA that all deficiencies are remedied			

- **Submit application form and other documents requested by one of the following methods:**

  Email: providerupdates@icarehealthplan.org

  Fax: 1-414-272-5618

Instructions: All fields **must** be completed, unless identified as "if applicable"

SECTION I – COMPANY / AGENCY INFORMATION

Legal Business Name (as it appears on your W-9 Form):	
Doing Business as Name (DBA), if applicable:	
Address (as it appears on W-9 Form):	
City, State, Zip:	**Website,** if applicable:
General Phone Number:	**General Fax Number:**
Tax Identification Number (TIN), EIN/SSN:	**National Provider Identifier (NPI),** if applicable:
Medicaid ID#, if applicable**:**	**Medicare ID#,** if applicable:

SECTION II – CONTACT INFORMATION

Contract Contact Information		
Name:	Title:	
Address:	City, State, Zip:	
Phone:	Email:	Fax:
Billing Contact Information		
Name:	Title:	
Address:	City, State, Zip:	
Phone:	Email:	Fax:
Credentialing Contact Information		
Name:	Title:	
Address:	City, State, Zip:	
Phone:	Email:	Fax:
Payment/Remittance Information		
Name:	Title:	
Address:	City, State, Zip:	
Phone:	Email:	Fax:

SECTION III: MUST be completed for EACH LOCATION. Additional pages found on the website.

Location Name (and dba, if applicable)	Address, City, State, Zip:	
Location Contact/Title:	Location Email Address:	Location Phone Number:
Location Fax Number:	Location TIN:	NPI (if applicable):

Accepting New Patients: ☐ Yes ☐ No

Same Day Appointments: ☐ Yes ☐ No

Electronic Health Records (EHR): ☐ Yes ☐ No

Telehealth Services:
- ☐ Telehealth **Only**-check if no in-person services are available
- ☐ Video Telehealth
- ☐ Telephonic Telehealth

Populations Served:
- ☐ Children: Starting Age: _____
- ☐ Adolescents
- ☐ Adults
- ☐ Seniors

Accessibilities:
- ☐ Americans with Disabilities Act compliant
- ☐ ADA Access for Building
- ☐ ADA Access for Parking
- ☐ ADA Access for Restroom
- ☐ 24/7 Phone Coverage
- ☐ Answering Service
- ☐ Is this location on a public transportation route?
- ☐ Text Telephony (TTY)
- ☐ Mental/Physical Impairment Services
- ☐ American Sign Language
- ☐ Interpreter Services Available

Languages Spoken (other than English):
- ☐ Spanish
- ☐ Hmong
- ☐ Chinese
- ☐ Somali
- ☐ Lao
- ☐ Russian
- ☐ Burmese
- ☐ Other(s):

_____

*i*Care encourages all Minority-Owned (MBE), Service-Disabled Veteran-Owned (DVB) and Woman-Owned (WBE) businesses to register with WISDP Supplier Diversity Program.

Indicate if you are registered with the WISDP Supplier Diversity Program:
- ☐ Minority Owned Business
- ☐ Service-Disabled Veteran-Owned
- ☐ Woman-Owned Business

Location Hours:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Licensure, Certifications or Accreditation, if applicable:	**Number**	**Effective Date**	**Expiration Date**
Medicaid Provider			
Wisconsin DQA Certified/Licensed			
Accrediting Organization			
Other Memberships/Certifications			
WI Coalition for Collaborative Excellence in Assisted Living (WCCEAL)			
WI Supplier Diversity Program			
Has this location or facility ever been revoked or denied any of the above?		☐ Yes ☐ No	

SECTION IV: LOCATION SERVICES, CHECK ALL THAT APPLY

☐ Bath and Toilet	☐ Mobility Equipment
☐ Aids Breast Pumps	☐ Oxygen and Respiratory Equipment and Supplies
☐ CPAP/Bi PAP	☐ Patient Lifts
☐ Custom Wheelchairs and Seating	☐ Power Operated Vehicle and Accessories
☐ Diabetic Shoes	☐ Prosthetics and Orthotics
☐ Diabetic Supplies	☐ Range of Motion Equipment Vision
☐ Equipment Repair and Rental	☐ Prosthetics
☐ Hearing Aid Equipment	☐ Walker Wheelchair
☐ Hospital Beds and Accessories	☐ Wound Care Supplies
☐ Incontinence and Ostomy Supplies	☐ Other:
☐ Infusion and Injection Supplies	
☐ Mastectomy and Lymphedema Supplies	

Single Specialty Practice, please list:

Multi-Specialty Practice, please list:

Other, please list:

Counties Served (required only for providers who travel, ship, or deliver):

☐ Serves all Counties in Wisconsin

☐ List counties

SECTION V: EXCLUSION CERTIFICATION

I hereby certify the online exclusion list for Health and Human Services, Office of Inspector General (OIG) is checked for all new hires and at least quarterly for existing employees to ensure that no excluded employees work in any capacity related to any state or federal health care program. I understand that Managed Care Organizations are precluded from contracting with providers who have been excluded from participation in any state or federal health care program. I also hereby certify that I will remove any employee found on one of the above referenced list from any work related to any state or federal health care program.

Signature of Authorized Representative	Printed Name of Authorized Representative
Authorized Representative's Title	Date Signed

SECTION VI: ATTESTATION QUESTIONS

Please answer the following questions "Yes" or "No." If your answer to any of the following questions is "Yes," please provide details and reasons, as specific to each question, on a separate sheet or letterhead. Please sign and date each additional sheet submitted. Provider attests that as it relates to the facilities and services selected:

Has this provider, under any current or former business identity, **ever** had any felony or misdemeanor convictions, under Federal or State law, related to (a) the delivery of an item or service under Medicare or State health care program, or (b) the abuse or neglect of a patient in connection with delivery of a health care item or service?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, **ever** had any felony or misdemeanor convictions, under Federal or State law, related to fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of a health care item or service?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, **ever** had any felony or misdemeanor convictions under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance?	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, **ever** had licensure to provide health care by any state licensing authority revoked or suspended? This includes the surrender of such a license while a formal disciplinary proceeding was pending before a State licensing authority.	☐ Yes ☐ No
Has this provider, under any current or former name or business identity, **ever** had accreditation revoked or suspended?	☐ Yes ☐ No

cont'd SECTION VII: ATTESTATION QUESTIONS

Has this provider, under any current or former name or business identity, **ever** been suspended or excluded from participation in, or any sanction imposed by, a Federal or State health care program, or any debarment from participation in participation in any Federal Executive procurement or non-procurement program?	☐ Yes ☐ No
Is this provider, under any current or former name or business identity, currently suspended from Medicare payment under any Medicare billing number?	☐ Yes ☐ No

Agency attests that as it relates to the facilities and services selected:

Has verified qualifications of each staff member, including academic preparation and relevant experience.	☐ Yes ☐ No
Maintains a training plan for each staff member and has a mechanism for ensuring that all necessary training has been completed *prior* to performing work.	☐ Yes ☐ No
Completes Caregiver Background Checks on all employees *prior* to the employee providing direct services to Member, and every four (4) years thereafter or any time that entity has a reason to believe that a new check should be obtained.	☐ Yes ☐ No
Has a mechanism to track the completion of Caregiver Background Checks to ensure compliance with the requirements in the *i*Care contract.	☐ Yes ☐ No
Maintains the Caregiver Background Check results on its premises for at least the duration of the Long-Term Care contract with *i*Care.	☐ Yes ☐ No
Change in Program: Prior approval by the certifying and licensing agencies is required for all program changes.	☐ Yes ☐ No
Prior approval by the licensing agency is required for all program changes. In addition, *i*Care requires proposed changes for approval 30 days prior to implementing the proposed program change.	☐ Yes ☐ No
Organization has trained or will train its employees and downstream related entities on cultural competency each calendar year. The content used is *i*Care's Cultural Competency Training or is materially similar.	☐ Yes ☐ No

The individual identified below acknowledges that they have reviewed the statements above and attests that the information herein be true and accurate:

_____ _____

Signature of Authorized Representative Printed Name of Authorized Representative

_____ _____

Authorized Representative's Title Date Signed

AUTHORIZATION FOR RELEASE OF INFORMATION AND ATTESTATION

The organization identified below (hereinafter "the Organization") has applied to be a participating provider with Independent Care Health Plan (*i*Care). In order for *i*Care to evaluate the Organization's qualifications, Organization authorizes *i*Care and its authorized representatives and agents to consult with any third party who may have information (including information that otherwise may be privileged or confidential) relating to the qualifications, competence and conduct of said Organization. Organization also authorizes any such third party (including the credentials verification organization) to release such information, related reports and documents to *i*Care and its authorized representatives and agents upon request and receipt of a copy of this Authorization for Release of Information.

The undersigned certifies that all information in the Organization's application is warranted to be true, accurate and complete. Organization also agrees to immediately update *i*Care on any changes in the information submitted in the application and agrees to provide such additional information and execute such additional forms as may be requested by *i*Care in order to evaluate the Organization's qualifications, competence and conduct.

As an applicant for credentialing or recredentialing with *i*Care, Organization has the right to review the information submitted in support of the credentialing application. Organization acknowledges that *i*Care will notify the Organization of any information obtained during the credentialing process that varies substantially from the information provided by Organization to *i*Care and that it will have the right to correct any and all erroneous information in the application.

By submitting an application for credentialing or recredentialing with *i*Care, Organization agrees to be bound by the terms of the credentialing program, as it may be amended by *i*Care from time to time. Organization understands that *i*Care will use this information solely in conjunction with the application for and status as a participating provider and that the information is not subject to re-disclosure except as permitted by Federal and State Law.

Organization hereby releases from liability *i*Care and its directors, officers, employees and authorized representatives, including the credentialing agent, its directors, employees, representatives, agents and third parties for any acts performed in good faith in providing or receiving information, reports or other documents relating to or in evaluating Organization's professional qualifications, competence or conduct. This release from liability shall include, but not be limited to, actions related to the following:

- Organization's application to be a participating provider with *i*Care.
- Periodic appraisals undertaken for recredentialing, utilization review or otherwise for quality management; and
- Proceedings for termination, suspension or restriction of the Organization's status as a participating provider with *i*Care or any other disciplinary action.

This authorization is valid for 365 days and if the Organization becomes an *i*Care participating provider, for the time period that the Organization remains an *i*Care provider.

_____ _____

Signature of Authorized Representative | Printed Name of Authorized Representative

_____ _____

Authorized Representative's Title | Date Signed

_____

Print Name of Organization