CenCal HEALTH®
Local. Quality. Healthcare.

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

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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

Answer every question YES or NO.
Provide a detailed explanation, including dates below for all for any question(s) answered YES.
Use a separate sheet if necessary.
Be sure to Sign and date Attestation.

☐ Yes ☐ No	1. Has this facility ever had or currently have pending any legal actions against it?
☐ Yes ☐ No	2. Has this facility ever been convicted of a crime, excluding misdemeanors?
☐ Yes ☐ No	3. Has any government agency ever investigated, suspended, revoked, or taken other action against this facility/organization's license to conduct business?
☐ Yes ☐ No	4. At any time has any license or certification been revoked, denied, or suspended by others or voluntarily given up by the facility, or are any actions which may lead to such conclusions now underway?
☐ Yes ☐ No	5. At any time, has this facility/organization been assessed a penalty or fined by a government agency or is the facility currently under investigation by the Medicaid or Medicare programs or any other government agency?
☐ Yes ☐ No	6. At any time, has any third party payor ever revoked, reduced, denied, or suspended this facility's network participation due to inappropriate utilization management, quality of care issue, or for any other reason?
☐ Yes ☐ No	7. Has any managing employee or person with an ownership or controlling interest in this facility/organization been excluded from participation in any government health care program?
☐ Yes ☐ No	8. Has this facility, under any current former name or business identity, ever had its accreditation revoked or suspended?

Explanation for question(s) answered YES:

I, the undersigned authorized agent, hereby attest and certify that all statements on this entire Application are true, accurate, and complete to the best of my knowledge. I fully understand that any falsification of information or omissions from this Application may be grounds for denial of this Application as a Health Plan participating provider or cause for summary dismissal from the Health Plan.

I further understand, as an authorized agent of the applicant, that I and the organization have the burden of producing adequate information for the proper evaluation of the organization's competence, character, and ethics in resolving doubts about such qualifications.

I warrant that I have the authority to sign this application on behalf of the entity for which I am signing in a representative capacity.

_____ _____
Printed Name of Authorized Representative | Authorized Representative's Title

_____ _____/_____/_____
Signature of Authorized Representative | Date Signed

New Provider Training
Attestation Form

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, via the New Provider Orientation training videos located online at www.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) (including sensitivity, diversity, communication skills, cultural competency, health needs for various populations, Social Drivers of Health and disparity impacts on Member's health care) – *Coming Soon!*
- ✓ 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

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

D. Data Collection and Reporting Requirements

E. 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

_____ _____
Signature Date

_____ _____
Print First & Last Name Group Billing NPI#

_____
Title

☐ Our practice, including Practitioners and Medical Staff, acknowledges and confirm(s) to have received Cultural Competency, Health Literacy & Linguistics training and Seniors and Persons with Disabilities (SPD) Sensitivity training resources located online at cencalhealth.org/providers/cultural-linguistic-resources/cultural-competency-and-health-literacy/

Please list all Rendering Practitioners within your organization that received these training resources below. This applies to newly joining physicians to your organization, and/or being re-credentialed with CenCal Health.

_____ _____
Signature Date

_____ _____
Print First & Last Name Practitioner NPI#

_____ _____
Signature Date

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Print First & Last Name Practitioner NPI#

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