



Heartland Therapy Provider Network

Provider Credentialing Application

Please send completed application to: **HTPN**
 Attn: Provider Relations Department
 524 Kingsley Avenue
 Orange Park, FL 32073

Fax: 866-240-7630

You can expect to receive notification of your participation status with HTPN in approximately 6-8 weeks. When accepted into the network, you will be sent a signed, executed copy of the Provider Agreement. Please retain a copy of the credentialing application for your records.

INSTRUCTIONS

Before submitting the Application, make sure you have completed the following:

Business Information: Pages 1 and 2 should be completed once, on behalf of the entire group. Complete all fields requested. If the question is not applicable, indicate "N/A". Page 2 should be signed by an authorized party.

Clinic Information: Page 3 and 4 should be completed for each clinic location. Please create additional copies, as needed. Page 5 can be completed by the company as a whole, or by clinic.

Credentialing Documents:

1. **W-9:** Complete one if all billing is directed to a centralized facility. Multiple copies may be made if billing is directed to each location.
2. **Certificate of Insurance:** Face sheet of professional liability indicated by name, clinicians and locations covered, coverage amounts, effective date and expiration date, and policy number.
3. **Accreditation Certificates:** As applicable, provide documentation of CARF, CORF, Medicare, or Medicaid accreditation.
4. **Therapist / Clinician State License:** Copies of current state licenses.
5. **Therapists Resume and CV**

FCE Provider Application: The FCE Provider Application should be completed only if your organization is interested in performing FCEs. FCE Provider Participation is subject to an approval process, terms and conditions, and rate negotiations. Application should include additional credentialing documents:

1. **FCE Sample**
2. **Certificate of FCE course Completion**

Note: HTPN provides course instruction and certification to physical and occupational therapists interested in performing FCEs. HTPN has created a custom FCE to meet the needs of its clients. For additional information, please contact HTPN.

Yes, please call me to discuss FCE training! Name of Contact: _____
Phone: _____



Business Information

Business Name (Group): _____
 DBA: _____ Tax ID #: _____
 Name of Owner(s) / CEO(s): _____ NPI#: _____
 Email: _____ URL: www. _____
 Phone: _____ Fax: _____
 Contracting Contact: _____ Phone: _____

Billing Practices

Billing Contact: _____ Phone: _____
 Email Address: _____ Fax: _____
 How often do you submit claims? Weekly Bi-Monthly Monthly Other: _____
 Who handles your billing? Outsource Service Centralized Billing Individual Facility
 Do you utilize a software billing system? NO YES If Yes, which one? _____
 Average Number of Visits / Patient: _____ Average Billed Number of Modalities / Visit: _____
 Standard Treatment Time Billed / Patient: _____

Provider Attestation

Please complete the following questions on behalf of your company and all employees. Positive responses (Yes) require a written explanation attached to this document.

Questions:

Check (√) YES NO

Questions:	Check (√)	YES	NO
1. Has someone's license, registration, or certification to practice in their profession ever been voluntarily or involuntarily relinquished, denied, suspended, revoked, restricted, or has been subject to a fine, reprimand, consent order, or probation?			
2. Have you voluntarily or involuntarily surrendered, limited your privileges or not reapplied for privileges while under investigation?			
3. Have you ever been terminated for cause or not reviewed for cause from participation, or been subject to any disciplinary action, by any managed care organizations (including HMOs, PPOs, or provider organizations such as IPAs, PHOs)?			
4. Have your Federal DEA and/or State Controlled Dangerous Substances (CDS) certificate(s) or authorization(s) ever been challenged, denied, revoked, restricted, denied renewal, or voluntarily or involuntarily relinquished?			
5. Have you ever been disciplined, excluded from, debarred, suspended, reprimanded, sanctioned, censured, disqualified or otherwise restricted in regard to participation in the Medicare or Medicaid program, or in regard to other federal or state governmental Healthcare programs?			
6. Have you ever been suspended, fined, disciplined, sanctioned, or otherwise restricted or excluded from participating in any private health insurance program?			
7. Are you currently the subject of an investigation by any hospital, licensing authority, DEA or CDS authorizing entities, education or training program, Medicare or Medicaid program?			
8. To your knowledge, has information pertaining to you ever been reported to the National Practitioner Data Bank to Healthcare Integrity and Protection Data Bank?			
9. Have you ever received sanctions from or are you currently the subject of investigation by any regulatory agencies (e.g. CLIA, OSHA, etc.)?			
10. Has your professional liability coverage ever been cancelled, restricted, declined or not renewed by the carrier based on your liability history?			
11. Have you ever been assessed a surcharge, or rated in a high-risk class for your specialty, by your professional liability insurance carrier, based on your liability history?			

12. Have you ever had any professional liability actions (pending, settled, arbitrated, mediated, or litigated) within the past 10 years? If yes, provide information on each case.		
13. Have you ever been denied liability insurance coverage?		
14. Are there any professional liability (i.e. malpractice) claims, suits, judgments, settlements, or arbitration proceedings, involving you currently pending?		
15. Have you or any employee currently employed ever been accused of sexual harassment or other illegal misconduct?		
16. Have you or any employee currently employed ever been convicted of, pled guilty to, or pled no contest to any felony?		
17. Do you or any employee currently employed use any chemical substances that would in any way impair or limit your ability to practice and perform the functions of your job with reasonable skill and safety?		

Treatment and Documentation Standards

Please complete the following questions on behalf of your company and all employees Check (√) YES NO

1. Does all documentation (every page) contain the patient's name and signed by hand, stamped, or electronically written?		
2. Is documentation legible? (illegible documentation is subject to claim denial)		
3. Do therapy evaluations contain review of conditions or contraindications that may adversely affect care (e.g. pregnancy, use of blood thinners, cancer)?		
4. Do therapy evaluations contain review of employment history including occupation at the time of injury, employer, current work status, and current duty status?		
5. Does the treatment plan correlate with the patient's history, examination findings, and the accepted practicing standards and/or specialized certifications/trainings?		
6. Will the practitioners only perform services that he or she are qualified to provide and retains the responsibility for treating the patients in a safe environment?		
7. Will the treatment frequency and duration follow the physician's prescription and not exceed HTPN authorization?		
8. Will daily notes follow professional association and State guidelines?		
9. Will daily notes contain objective measures to satisfactorily track quantifiable patient progress?		
10. Will you fax HTPN daily notes on a weekly basis to allow HTPN the opportunity to monitor the patient's attendance and report progress to all parties involved?		
11. Will you return HTPN's Weekly Activity Report with daily notes to report past and future scheduled appointments?		

Credentialing Documents

Copies of the following documents must be attached to contract. Documents are to be current and valid.

- W-9** – Complete billing address, signed, and dated
- Certificate of Insurance** – Professional Liability for each facility, reflecting coverage for each clinician.
- Accreditation Certificates** – as applicable (CARF, CORF, Medicare, Medicaid)

Authorization and Release of Records

On behalf of this/these facility(s), I, the undersigned, hereby release and discharge Heartland Therapy Provider Network (“HTPN”) and any individuals or organizations providing information about this facility and any and all persons, employees, representatives or agents of any of the above from all liability or claims of any nature in connection with the information furnished hereunder. HTPN shall notify Provider of the intent to provide credentialing material to an HTPN Client in any method other than basic information about location, staff and services offered, or an audit conducted on site at HTPN. A copy of this Authorization and release may be provided to, including, but not limited to, each individual, facility, or organization where information about this facility’s credentials is sought and shall remain in effect unless specifically revoked in writing by this facility.

On behalf of this/these facility(s), I, the undersigned, hereby acknowledge that the information submitted on this form is true to the best of my knowledge and belief. I fully understand that any significant misstatements in or omissions from this form are grounds for exclusion and that Heartland Therapy Provider Network and its representatives will not be held liable for any and all acts of exclusion from participation in HTPN.

Provider / Applicant Name / Title

Provider / Applicant Signature

Date



Complete for each clinic location

II. Clinic Information

Clinic Address: _____ **Phone:** _____
City/ST/ZIP: _____ **Fax:** _____

Clinic Standards

The following standards address various components of the facility. Please answer each question:

Question	Check (√)	YES	NO
Is the clinic neat and clean and a minimum of 500 square feet?			
Does the facility meet ADA Accessibility requirements?			
Is this site accessible by public transportation?			
Is the clinic equipped with rehabilitation equipment with sufficient space to accommodate a varied patient mix?			
Are all modalities and pneumatic equipment calibrated and checked for safety every two years?			
Are operating hours to treat patients a minimum of thirty-five hours per week and open at least three (3) days per week?			
Are all health care providers employed at the clinic in accordance with their Practice Act of their respective state and profession?			

Hours of Operation: (Open to Close)

Monday	Tuesday	Wednesday	Thursday	Friday	Sat

Languages Spoken by Staff: _____

Therapies Provided: Physical Occupational Physical Reconditioning
 Certified Hand Therapy Aquatic Massage Therapy (LMT)

Specialized Services: Indicate which specialties your facility participates:

- | | | |
|-------------------------------------|--|--------------------------------------|
| ___ ASTYM | ___ Sports Injuries | ___ Adolescent/Adult Obesity Program |
| ___ Ergonomic Evaluation (worksite) | ___ Isokinetic Testing / Strengthening | ___ Orthotic Training UE / LE |
| ___ Post-Offer Employment Screens | ___ Balance/Dizziness Correction | ___ Cardiovascular Equipment |
| ___ Functional Capacity Evaluation | ___ Vestibular Rehabilitation | ___ Personal Training |
| FCE Type: _____ | ___ Manual / Soft Tissue Therapy | |
| ___ Splinting | ___ Wound Care / Sterile Whirlpool | |
| ___ Health Club / Fitness Ctr. | ___ Wound Care / Debridement | |

Other specialized services: _____

Patient Scheduling and Authorization

HTPN strongly believes in a team approach and open communication to successful patient outcomes. Please answer the following:

Question	Check (√)	YES	NO
Will you perform best efforts to schedule therapy evaluations within two days from the time of the request?			
At the time of the evaluation, can the additional visits (within the authorization parameters and clinic scheduling practices) get scheduled and sent to HTPN?			
Will you treat the patient only within the authorization parameters provided by HTPN?			
In the event that an outside party contacts the provider with authorization, will the facility contact HTPN immediately? Does the facility understand that HTPN is authorizing party and all HTPN authorizations will be submitted to the provider in written form?			
Will the facility sent HTPN requests for additional authorization with attached progress update and/or physician's prescription? (HTPN will make best efforts to obtain authorization within 48 hours. If not obtained, HTPN will update the provider on a daily basis.)			



This form should be completed if you would like to receive FCE referrals and have a clinician that is certified to perform Functional Capacity Evaluations. All FCE formats are subject to review to ensure that they contain HTPN's minimum criteria.

FCE Type and Standards

Name / Type of FCE your facility performs: _____
How many hours are required to perform your FCE? _____ Hour(s) Required for Report: _____
Average Number of FCEs Performed per Month: _____
Scheduling time frame requirement: _____
Preferred days and times for scheduling: _____

Preferred method of sending referral and FCE information: [] Fax [] Email

- 1. Are you willing to complete the one-page HTPN Summary Report, which must be submitted at the same time as the FCE? [] YES [] NO
2. Are you willing to address additional questions and/or forms provided by HTPN and its clients within your report format? [] YES [] NO
3. Once the FCE has been completed, are you able to provide to HTPN the report within 48 hours? [] YES [] NO
4. Do you require a physician prescription or clearance to perform the FCE? [] YES [] NO
5. Are you willing to submit an addendum to the FCE, should the original report require change or if information requested prior to the FCE was not addressed in the report? [] YES [] NO

Please indicate if your FCE report format contains the following:

- The formal FCE report is type written [] YES [] NO
Required assignment Physical Demand Category (PDC) [] YES [] NO
Validity criteria and level of effort determination [] YES [] NO
Identification of factors that may contribute to performance [] YES [] NO
Time record of patient arrival and departure [] YES [] NO
Attire, Mode of Transportation, and Translation Service [] YES [] NO
Treatment and Medical History [] YES [] NO
Musculoskeletal Assessment to include AROM, MMT, Gait Assessment, Sensation, Posture, and Balance [] YES [] NO
Cardiovascular assessment [] YES [] NO
Material Handling / Lifting Capacity Assessment [] YES [] NO
JAMAR grip strength testing [] YES [] NO
Ability to test upper extremity function such as gross and fine motor skill [] YES [] NO
Functional Task Assessment and Tolerance Assignment [] YES [] NO
Work-specific functional task assessment [] YES [] NO
Ability to perform battery of tests for all referral types (i.e. disability assessment, own occupation, or any occupation) [] YES [] NO
Baseline of vitals (heart rate, blood pressure) [] YES [] NO

Therapist Name(s)	Credentials (OTR, PT, etc)	License Number	Clinic Location(s)	Email Address*

*Email address is solely for the purpose of sending referral information such as medical records and job descriptions. If you do not wish to have information sent via email, please enter a fax number in the table.

Please indicate if any of the clinicians referenced above speak another language: _____

I understand the information in this form is true and accurate to the best of my knowledge. I further agree to provide HTPN updated information as requested by HTPN or as necessary for re-credentialing purposes. I understand that, at times, HTPN may request additional forms to be completed on behalf of HTPN or its customers. I agree to complete these forms willingly and within a reasonable time frame.

Supplemental Documents to Attach:

- State Therapist Licensure** – Please provide a copy of state license for all clinicians above
- Resume and CV**
- Sample FCE** – Please provide a sample FCE, omitting all personal information.
- FCE Course Completion Certificates** – Please provide a copy of certificate of FCE course completion.

 Provider / Applicant Name / Title (Print)

 Provider / Applicant Signature

 Date