ReliaCare Alliance IPA Provider Application

Please complete all information and submit copies of the following items: W-9 Form, Certificate of Insurance, Certificate of Operation, Listing of services provided, and Listing of Providers affiliated with your organization, listing of additional sites, listing of all certifications

1. Provider Information

Name of Organization: _____

State/ city License # _____ Medicaid #:_____

NPI#: _____ Medicare #: _____

Accreditation: (if applicable) Accredit By_____ EXP___/___/___

Corporate Office Information

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact Name: _____ Contact Phone: _____

Contact Fax _____ Email: _____

Billing Information (If different from above)

Payee Name: _____ Federal Tax ID (TIN): _____

Address: _____

City: _____ State: _____ Zip: _____

Contact: _____ Title: _____

Contact Phone: _____ Contact Fax: _____

2. Provider Locations

Attach additional copies of this section as needed

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Contact: _____ Title: _____

Email: _____ Handicap Accessible: Yes □ No □

Counties Serviced: _____

Please list any zip codes that are excluded: _____

States Serviced: _____ National Provider: Yes □ No □

Languages Spoken: _____ Mail Order: Yes □ No □

Office Hours:

Mon	Tue	Wed	Thu	Fri	Sat	Sun

Services: DME □ Soft Supplies □ Orthotics □ Prosthetics □ Pedorthics □

3. Provider Accessibility Checklist

Please complete the information below, so that your provider file could be updated to ensure that you have provided us with your Company's ADA accessibility.

Provider Name:			
Address Line 1:			
Address Line 2:			
City:	State:	Zip:	County:
Phone:	Fax:	Primary Contact:	
Does this office meet ADA accessibility requirements? ☐ Yes ☐ No			
Check all that apply:			
Handicap Accessible:	☐ Building	☐ Parking	☐ Restroom
Services for Disabled:	☐ Text Telephone	☐ American Sign Language	☐ Mental/Physical Impairment
Accessible by Public Transportation:	☐ Bus	☐ Subway	☐ Regional Train

4. Background Check Attestation Form

RELIACARE ALLIANCE IPA adheres to Federal and State regulatory requirements, as it relates to the enrollment of their DME and O&P providers.

Our participating providers must confirm to us and attest that the Company conducts a background check on their employees.

The following must be completed:

Name(s) of Employees:	Criminal Background	
	Yes	No
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐
_____	☐	☐

(Please attach sample poof of your employee's check report)

(If additional employees need to be listed, please attach a separate sheet)

5. Orthotic and Prosthetic Service

Please attach additional copies of this section for each facility

What age limits do you accept? Lowest Age: _____ Highest Age: _____

Facility Name: _____

Facility Address: _____

Facility Hours: _____

Please indicate all services that Applicant provides in this service location:

SERVICE	ADULT	PEDIATRIC
Upper Extremity Prosthetics		
Lower Extremity Prosthetics		
Myoelectric Prosthetics		
Upper Extremity Orthotics		
Lower Extremity Orthotics		
Spinal Orthotics		
Halos		
Pedorthotics		
Cranial Orthotics (Pediatric Only)		
Reciprocating Gait Orthosis (Pediatric Only)		
Post Mastectomy (Adult Only)		
Compression Stockings (Adult Only)		
Other:		

6. Durable Medical Equipment Services

Please attach additional copies of this section for each facility

What age limits do you accept? Lowest Age: _____ Highest Age: _____

Please check off the following services/products that your company provides

Commodes/Urinals/Bed Pans		Patient Lifts	
Continuous Passive Motion (DPM) Devices		Walkers	
Blood Glucose Monitors & Supplies (Mail Order)		Blood Glucose Monitors & Supplies (Non-Mail Order)	
Seat Lift Mechanisms		Off the Shelf Orthotics	
Tracheostomy Supplies		Urological Supplies	
Heat and Cold Application		Nebulizer Equipment & Supplies	
Hospital Beds – Electric		Oxygen Equipment & Supplies	
Hospital Beds – Manual		Respiratory Therapy	
Enteral Equipment & Supplies		Respiratory Suction Pumps	
CPAP/BIPAP Devices		Surgical Dressing	
Pressure Reducing Beds/Mattresses/Pads		Diabetic Shoe Inserts (off the shelf)	
Traction Equipment		Related Accessories	
TENS		Wheelchairs (Standard Power)	
Canes and Crutches		Wheelchairs (Standard Manual)	
Power Operated Vehicles (Scooters)		Wheelchair Seating Cushions	

Any additional specialties not listed: _____

_____

_____

7. Attestations and Signature

THE UNDERSIGNED ATTESTS, REPRESENTS AND WARRANTS THAT THEY HAVE REVIEWED ALL THE INFORMATION AND MATERIAL INCLUDED AND PROVIDED BY THE UNDERSIGNED IN ALL THE SECTIONS OF THIS APPLICATION, AND THAT ALL SUCH MATERIAL AND INFORMATION IS COMPLETE AND ACCURATE.

THE UNDERSIGNED AUTHORIZES ANY INDIVIDUAL OR ENTITY IN THE POSSESSION OF ANY INFORMATION BEARING ON ME OR MY FACILITIES' QUALIFICATIONS TO RELEASE SUCH INFORMATION TO ***RELIACARE ALLIANCE, IPA*** ("RELIACARE") UPON RELIACARE'S REQUEST.

THE UNDERSIGNED FURTHER AGREES TO NOTIFY ***RELIACARE ALLIANCE, IPA*** IN A TIMELY MANNER NOT TO EXCEED THIRTY (30) DAYS OF ANY CHANGE IN THE STATUS OF THE INFORMATION OR MATERIAL INCLUDED IN THE APPLICATION. THE UNDERSIGNED UNDERSTANDS THAT THE MERE SUBMISSION OF THE APPLICATION DOES NOT ENTITLE THEM OR THEIR FACILITIES TO BE AN INDEPENDENT CONTRACTOR PROVIDING SERVICES ON BEHALF OF RELIACARE, OR TO BILL OR COLLECT PAYMENT FROM RELIACARE FOR SERVICES THEY OR THEIR FACILITIES PROVIDE, OR TO BILL OR COLLECT PAYMENT FROM INSURANCE COMPANIES WITH WHICH RELIACARE HAS ENTERED INTO AGREEMENTS FOR SERVICES THEY OR THEIR FACILITIES PROVIDE.

THE INDIVIDUAL UNDERSIGNED REPRESENTS AND WARRANTS THAT (S)HE IS AUTHORIZED TO OBLIGATE THE APPLICANT AS CONTEMPLATED BY THIS APPLICATION, AND THAT NO CORPORATE OR OTHER ENTITY ACTION IS NECESSARY TO OBLIGATE THE APPLICANT.

Signature: _____ Date: _____

Name: _____

Title: _____

Company: _____

Address: _____

City, State, Zip: _____

8. Application Checklist

- ☐ Completed Application
- ☐ /2YLJfŜűŜŘ 5hh óŘλăŏf2ădzNŜ 2ŦhøyŜNăKʌLJú
- ☐ Completed attached W9
- ☐ StatekCity License
- ☐ Medicare and Medicaid Acceptance Letter or recent remittances
- ☐ Copies of any relevant certifications or accreditation documentation
- ☐ Proof of your employee's Background check report
- ☐ Certificate(s) of current Malpractice, Commercial, and General Liability coverage (***Coverage must be for $1,000,000 - $3,000,000***)