

EST. 1993



Healthcare Networks of America

Facility Credentialing Form

Business _____ Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Federal Tax ID #: _____ NPI #: _____

Ext: _____

Contact Person: _____ Title: _____

Contact Phone: _____

Email: _____

Website: _____

License #: _____ Exp. Date: _____

DEA Certificate # _____ Expiration Date: _____

Name of Malpractice Company: _____ Exp. Date: _____
(Submit copy of Malpractice, License, and DEA Certificate)

Medicare ID #: _____

Type of Facility (Check all that apply):

- | | |
|---|---|
| <input type="checkbox"/> Ambulatory Surgical Center | <input type="checkbox"/> Medical Supply Company |
| <input type="checkbox"/> Audiology Center | <input type="checkbox"/> Pathology/Lab |
| <input type="checkbox"/> Diagnostic Imaging Center | <input type="checkbox"/> Skilled Nursing Facility |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Sleep Center |
| <input type="checkbox"/> Home Health | <input type="checkbox"/> Urgent Care Center |

Accreditation Information

Note: Copy and complete this section if more than one accreditation needs to be reported

Check one of the following and furnish additional information as requested:

- The enrolling supplier is not accredited.
- The enrolling supplier, including the business location, is accredited.

Name of Accrediting Organization: _____

Date of Last Accreditation: _____ Expiration of Accreditation: _____

- The enrolling supplier, including the business location is in the process of obtaining accreditation.

Name of Accrediting Organization: _____

Date Supplier Applied for Accreditation: _____

Adverse Legal History

1. Have you or your organization, under any current or former name or business identity, ever had an adverse legal action imposed against you/it?

Yes – Continue Below

2. If yes, report each adverse legal action, when it occurred, the Federal or State agency or the court/administrative body that imposed the action, and the resolution, if any.

Attach a copy of the adverse legal action documentation(s) and resolutions(s).

<u>Adverse Legal Action</u>	<u>Date</u>	<u>Taken By</u>	<u>Resolution</u>
_____	_____	_____	_____
_____	_____	_____	_____

Annual Network Participation

\$275 Annual Network Participation to be paid by:

Check #: _____ MasterCard/Visa American Express Card

Number: _____

Exp. _____ Date: _____

_____ 3 or 4 digit security code: _____

I authorize the above card to be charged for my membership fee.

Signature: _____ Date: _____

You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide or have provided to us. This may include text messages, automatic telephone dialing systems, prerecorded voice and/or fax. We do not sell or distribute our lists. This information is used for internal purposes only.

Signature: _____ Date: _____

PO BOX 71717, PHOENIX, ARIZONA 85050 VOICE 877.311.3338 FAX 602.485.3100

WWW.HNA-NET.COM

HEALTHCARE NETWORKS OF AMERICA, LLC FACILITY AGREEMENT

PARTIES: "Network": HEALTHCARE NETWORKS OF AMERICA

Business Name:

RECITALS

1. Network has established a national marketing network through which it negotiates and obtains patient contracts and conduct general marketing activities.
2. Facility is a licensed facility that desires access to Network and additional benefits as are offered from time to time by Network, subject to and in accordance with the terms of this Facility Agreement (the "Agreement").

AGREEMENTS

1. Facility
 - 1.1 Membership fee. Facility shall pay to Network an initial annual network participation equal to \$275.
 - 1.2 Term. The term of the Facility agreement shall begin on the Effective Date, and shall automatically renew on an annual basis upon receipt of Facility's annual network participation then in effect, if any, as communicated by Network to Facility from time to time, unless sooner terminated as provided herein.
2. Rights, Duties and Obligations of Facility. During the term hereof, Facility shall have the following rights, duties and obligations with respect to the membership.
 - 2.1 Participation in Marketing/Contracting. Facility shall have the opportunity to participate in such marketing, and contracting programs as are developed or negotiated from time to time by Network. Such participation shall be on terms and conditions and subject to such costs and fee schedules agreed to from time to time by Network and Facility. Network intends to seek patient contracts on behalf of the Facilities with national and local employers and third-party payers. Facility shall be under no obligation to participate in any such marketing, advertising or patient programs

3. Rights, Duties, and Obligations of Network. During the term hereof, Network shall have the following rights, duties, and obligations with respect to the Facility. Obligation to notify payer contracts of new facilities upon credentialing completion on a monthly basis.
4. Termination. This Agreement, and the Membership issued to Facility hereby, may be terminated as follows:
 - 4.1 Termination by Facility. Facility may terminate this Agreement, for any or no reason, on thirty (30) days' prior written notice to Network.
 - 4.2 Termination by Network. Network may terminate this Agreement, on thirty (30) days' prior written notice to Facility.
5. Indemnification. HNA and the facility(s) shall mutually indemnify and hold harmless each other from any and all claims and losses which each may suffer or incur as a result of any action by the other pursuant to the terms of this agreement, but only if such claims or losses are not due to willful malfeasance, bad faith, negligence or reckless disregard of its obligations and duties under the terms of this agreement.
6. Choice of Law. This Agreement shall be governed by and construed in accordance with the internal law of the State of Arizona, but not the conflicts or choice of law provisions thereof.

You consent to us contacting you using all channels of communication and for all purposes. We will use the contact information you provide or have provided to us. This may include text messages, automatic telephone dialing systems, prerecorded voice and/or fax. We do not sell or distribute our lists. This information is used for internal purposes only.

IN WITNESS WHEREOF, the parties have caused this Agreement to be duly executed and delivered as of the date first set forth herein.

"NETWORK"

"Business Name"

HEALTHCARE NETWORKS OF AMERICA, LLC By: _____

By: _____

Print _____

Print _____

Address:

Address:

PO Box 71717
Phoenix, Arizona 85050
Fax: 602-485-3100

Phone: _____

Fax: _____