



REQUEST FOR DELEGATION (RFD)

INSTRUCTIONS:

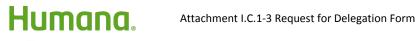
- RFD must be completed by Humana associates.
- Electronic RFD can be found in the following location:
 http://teams.humana.com/sites/DelegationVendor/about/SitePages/RequestDel.aspx
- Prior to submitting this RFD, please visit go/delegationcompliance for instructions on the delegation process, and to
 ensure you have the proper Delegation Council and Contract Approval Committee (CAC) approvals.

Please select one of the following:

- New delegate
- Change to a current delegation____
- Repapering only_

Entity Information Provide the correct and full legal entity name and DBA as this information is used to verify that the potential delegate is eligible to participate in the Medicare and/or Medicaid product:					
Full Legal Entity Name* (as it appears on Base Agreement):	DBA:				
Mailing					
Address:	City: State: Zip:				
Tax ID:					
Entity Contact Name:					
Check here if the contact name is the same for all functions:	Date contact				
If no, please include contact name under each function below.	can be made:				
Email	Phone				
Address:	Number:				
Entity Compliance Officer					
Contact Name:	Title:				
Email	Phone				
Address:	Number:				

Delegation Requested for the Following Markets: (Please list "National" for national contracts.)				
Delegation Requested for the Following Lines of Business: NOTE: If delegating multiple functions and lines of business vary by function, please indicate the appropriate line of business for each function.				
Commercial Individual Products:AllHMOPPOHumana OnePOSEPOCommercial Group Products:AllHMOPPOPOSEPO Federal Network Only?YesNo				
Medicare Individual Products:AllHMO PPOPOS FFSMedicare Group Products:AllHMO PPOPOS FFS				
Medicaid:AllMedicalLTSS Dual List applicable State(s):				
Dental Exchange:				





Requested Delegated Functions:					
CREDENTIALING If delegating Credentialing for Florida Medicaid, you must also select delegation of Network Management Services below. Are providers within the organization: Provider Delegation Facility Delegation Employed Providers Contracted Providers Both					
Sub-delegation:Yes No Sub-Delegate/MSO Name:					
Sub-delegation:res Nosub-delegate/MsO Name. Sub-delegate Contact Name: Telephone: Email:					
Including Behavioral Health					
Behavioral Health Sub-delegation:Yes No Sub-Delegate/MSO Name:					
Sub-delegate Contact Name: Telephone: Email:					
Will delegate require access to Protected Health Information (PHI)?Yes No					
CLAIMS					
Contract Approval Committee (CAC) Date Approved:					
Part A/inpatient Part B/outpatient					
Sub-Delegate/ MSO Name:					
Sub-delegate Contact Name: Telephone: Email:					
What types of claims will be processed?Participating Provider Non-Participating Provider					
Including Behavioral Health					
Behavioral Health Sub-delegation:Yes No Sub-Delegate/MSO Name:					
Sub-delegate Contact Name: Telephone: Email:					
What types of claims will be processed?Participating Provider Non-Participating Provider					
Please obtain the financial guarantee and send a copy to delegationcompliance@humana.com					
CLINICAL HEALTH SERVICES					
Contract Approval Committee (CAC) Date Approved:					
Utilization Management:Part A/inpatient Part B/outpatient					
Sub-delegation :Yes No Part A Part B Sub-Delegate/ MSO Name:					
Sub-delegate Contact Name: Telephone: Email:					
Including Behavioral Health					
Behavioral Health Sub-delegation:Yes No Sub-Delegate/MSO Name:					
Sub-delegate Contact Name: Telephone: Email:					

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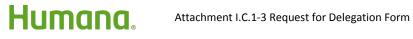


Disease Management				
List programs Entity will provide:				
Sub-delegation:Yes No	Sub-Delegate/ MSO Name:			
Sub-delegate Contact Name:	Telephone:	Email:		
Complex Case Management				
Sub-delegation:Yes No	Sub-Delegate/ MSO Name:			
Sub-delegate Contact Name:	Telephone:	Email:		
Patient Centered Medical Hon	ne- PCMH			
Is the Provider accredited by NCQA?	Yes No			
Network Management Service	es (Florida Medicaid Only)			
Sub-delegation:Yes No	Sub-Delegate/ MSO Name:			
Sub-delegate Contact Name:	Telephone:	Email:		
Special Needs Plan-Model of Care:				
Dual Eligible Chronic	Institution			
Sub-delegation:Yes No	Sub-Delegate/ MSO Name:			
Sub-delegate Contact Name:	Telephone:	Email:		
Other (Additional delegated functions not listed above. Please provide description below.)				
Delegated Function:				
Sub-delegation:Yes No	Sub-Delegate/ MSO Name:			
Sub-delegate Contact Name:	Telephone:	Email:		
Offshore Contracting: If PED is for	or Cradentialing Dalogation	anly you may skin this saction		

Offshore Contracting: If RFD is for <u>Credentialing Delegation only</u> you may skip this section. Will the Delegate utilize or subcontract with an off shore vendor (vendor located outside of the United States or United States territory) to meet contractual obligations to Humana? If yes, what is the name of the offshore vendor?

If the answer to above is "Yes", the delegate is to complete the required First Tier, Downstream and Related Entities (FDR) Offshore Contracting Information and Attestation Form. Use the following link to download the form http://go/offshore. The form includes instructions for the delegate. If the answer above is "No," then no further action is required.

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Humana Information:		
Humana Relationship Manager:		Submission Date:
Humana Relationship Manager Email Address:		
Market:		•
	Delegation Target	
Please specify each market that will be involved!	Effective Date:	
Humana Relationship Manager Delegate Name:		

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