Humana

LBPC Delegation & Vendor Compliance

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: ____** If no, please include contact name under each function below.	Date contact can be made:
Email Address:	Phone Number:
Entity Compliance Officer Contact Name:	Title:
Email Address:	Phone 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: __All __HMO __ PPO __ Humana One __ POS __ EPO **__Commercial Group Products: __All** __HMO __ PPO __ POS __ EPO **Federal Network Only?** ____ Yes _____ No
__Medicare Individual Products: __All __HMO __ PPO __ POS __ FFS **__Medicare Group Products: __All** __HMO __ PPO __ POS __ FFS
__ Medicaid: __All __Medical __ LTSS __ 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-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-delegation**: __Yes __ No __ Part A __ Part B

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:

__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 Home- PCMH** Is the Provider accredited by NCQA? __Yes __ No
__Network Management Services (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 RFD is for Credentialing Delegation only 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?	**Type in yes or no**
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.

Delegation & Vendor Compliance

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