Healthcare Networks of America
RESTORING PHYSICIAN PROSPERITY

Facility Enrollment Form

Business Name: _____

Address: ____
City: __ State: Zip Code: ___

Phone: _____ Fax: _

Federal Tax ID #: _____ NPI #: _____

Contact Person: ____ Title: _

Contact Phone: _____ Ext: _____

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):

- ☐ Ambulatory Surgical Center
- ☐ Audiology Center
- ☐ Diagnostic Imaging Center
- ☐ Durable Medical Equipment
- ☐ Home Health
- ☐ Medical Supply Company
- ☐ Pathology/Lab
- ☐ Skilled Nursing Facility
- ☐ Sleep Center
- ☐ 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).

Adverse Legal Action	**Date**	**Taken By**	**Resolution**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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: _____