INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

Applications must be typed or completed in black ink, or they will not be accepted.
Applications will be scanned - please do NOT staple.

Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.

1. Enter the complete name of the individual or facility.

2a. Check the appropriate boxes for the action(s) you request.

2b. If this is a revalidation, please complete the entire application. If you have additional service locations for revalidation, please complete Page 13.

2c. If you are reactivating a provider number, indicate the PROMISe™ **13 digit** provider number you wish to have reactivated and complete the application as an initial enrollment.

2d. If you are adding a provider to an existing group, enter the PROMISe™ 13 digit group provider number. The 4-digit service location code must correspond with a valid active street address. **We will not assign fees to a service location listed as a P.O. Box.**
•Fee assignments may only be made between "like provider types". Call the Enrollment Hotline for verification at 1-800-537-8862.

3. **Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes. Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the healthcare provider applying for enrollment. Refer to:**

http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/nationalprovideridentifiernpiinformation

4. Enter the requested effective date for your action request.

5. Enter your provider type number and description (e.g., provider type 31, Physician).

6. Enter your **primary** specialty name and code number. **See the requirements for your provider type**.

7. Enter your specialty name(s) and code number(s), if applicable. **See the requirements for your provider type**.

8. Enter your sub-specialty name(s) and code number(s), if applicable. **See the requirements for your provider type.**

9. Enter your Social Security Number**. A copy of your Social Security card, W-2, or document generated by the Federal IRS containing your Social Security Number must accompany your application. If completing #9, do not complete #10. Refer to the checklist for additional requirements.**

10. Enter your Tax Identification Number (TIN). **A copy of the TIN label or document generated by the Federal IRS containing the name and IRS number of the entity applying for enrollment must accompany this application. A W-9 form will not be accepted. If completing #10, do not complete #9.**

11. Enter your legal name as it is filed with the IRS and as it appears on IRS generated documents.

12a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).

12b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.

13a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.

13b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/stamped fictitious business name statement/permit.**

14. Enter your date of birth.

15. Enter your gender.

16. Enter the title/degree you currently hold.

17a. Enter your IRS address. This address is where your 1099 tax documents will be sent.

17b-f. Enter the contact information for the IRS address.

18. Check the appropriate box for the business type of the individual or facility applying for enrollment. Check 1 box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.

19a-d. Enter your license number (if applicable), issuing state, issue date, and expiration date.
*__A copy of your license must be included with the application.__

20. Enter your Drug Enforcement Agency (DEA) Number (if applicable).
__* A copy of your DEA certificate must be included with the application.__

21. If you have a CLIA certificate and a Dept. of Health Laboratory Permit associated with this service location.
*__A copy of both documents must be included with the application.__

22. Enter your CMS number.
__*A copy of your CMS certification must be included with the application.__

23a. Enter a valid service location address. **The address must be a physical location, not a post office box. The zip code must contain 9 digits and the phone number must be for the service location. Refer to block #27 of the application to list an additional address (es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 23a.**

NOTE* you can sign up for the Electronic Funds Transfer Direct Deposit Option by following the link below:
http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm

23b. Answer question, if yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins or RA's please call the phone number listed.

23c. If you wish Medicare claims to crossover to this service location check this box. **Note: This crossover can be added to only one service location.**

23d-g. Enter contact information.

23h. Indicate whether you or your staff is able to communicate with patients in any language other than English.

23i. If applicable, list the additional languages in which you or your staff can communicate.

23j. Answer questions 1 through 4 pertaining to the Americans with Disabilities Act (ADA).

23k. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **Refer to the PEP Descriptions and the requirements for your provider type.**

24. Indicate whether you retain any managing employees or agents.
*IF "yes" complete Attachment I found here:
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf

25a-e. The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions, A through E.

If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application. (Refer to the Confidential Information sheet).

25f. Include responses to 25F, 1 to 14, if you answered YES to any of the questions in 25A-E.

26. Sign the application and print your name, title, and date **(The signature should be that of the individual applying for enrollment or someone able to represent the facility applying for enrollment). Use black ink.**

27. This page, beginning with block #27, may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in 23a. **This sheet cannot be used to add a service location.**

27a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.

27b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.

27c. Enter the e-mail address of the contact person for this address.

27d-g. Enter the contact information for this address.

- Use page 13 to add additional service locations upon **the INITIAL ENROLLMENT OF AN INDIVIDUAL.**
- **Facilities must complete a new base application to add additional service locations to their file.**
- **The individual applying for enrollment or a representative of the facility applying for enrollment must complete the Provider Agreement included with the application.**

When completed, review the "Did You Remember…" Checklist included with the application.

Return your application and other documentation to the address listed on the requirements for your specific provider type.

If no address is listed on the requirements for your specific provider type/specialty, please mail to:

DPW Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program (PEP) code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to consumers of that program. Providers should use the following PEP codes when enrolling in PROMISe™ and should use the descriptions in this document to determine which PEP code to use when enrolling in PROMISe™.

Adult Autism Waiver—Contact Number: (866) 539-7689
Email: ra-odpautismwaiver@pa.gov
Website: http://www.dpw.state.pa.us/foradults/autismservices/adultautismwaiver/index.htm

The AAW is designed to help adults with an autism spectrum disorder participate in their communities in the way that they want to, based on their individual needs. It is a statewide home and community-based waiver. To become an AAW provider, contact the Bureau of Autism Services and an enrollment representative will reply by phone or by sending an electronic "Provider Packet." The packet includes necessary links, information and instructions on how to become an enrolled provider.

Aging Waiver – Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/agingwaiver/index.htm

Aging Waiver provides home and community-based services to eligible persons age 60 or older who are clinically eligible for nursing facility care. Eligibility criteria includes: U.S. citizen or permanent resident, Individuals age 60 or older, Asset limit of $8,000, and Income limit of 300% of the federal benefit rate. Individuals must require a nursing facility level of care. Information and listing of services provided by this PEP can be found by following the link above:

For service descriptions and qualifications required of providers follow the "View the Current Aging Waiver" link under the "Learn more" section of the webpage.

AIDS Waiver - Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/agingwaiver/index.htm

AIDS Waiver provides home and community-based services to eligible persons age 21 or older who have symptomatic HIV Disease or AIDS. Eligibility criteria includes: U.S. citizen or permanent resident, PA resident age 21 or older with symptomatic HIV or AIDS, Asset limit of $8,000, and Income limit of 300% of federal benefit rate. Individuals must meet level of care for nursing facility (cannot be receiving Medical Assistance hospice services). Information and listing of services provided by this PEP can be found by following the link above:

For service descriptions and qualifications required of providers follow the "View the Current Aging Waiver" link under the "Learn more" section of the webpage.

Providers in a non-mandatory Managed Care Counties must be approved by the Bureau of Quality and Provide management in the Office of Long term Living. Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

Attendant Care Waiver/ Act 150 Program - Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/attendantcare/attendantcareact150/index.htm

Attendant Care Waiver/Act 150 Program enables individuals with physical disabilities aged 18-59 to live in their own homes and communities. Eligibility criteria for both programs includes: U.S. citizen or permanent resident, PA resident aged 18-59 with provisions to transition at age 60 to comparable programs seamlessly, Physical impairment expected to last for at least a continuous 12 months or that may result in death, Mentally alert and able to manage/direct own care but assistance required to complete functions of daily living, self-care and mobility. For the Attendant Care Waiver, nursing facility level of care is required, with an asset limit of $8,000 and income limit of 300% of the federal benefit rate. For the Act 150 Program, nursing facility level of care is not required and the individual may have income or resources too high for MA eligibility.

For service descriptions and provider qualification requirements follow the "View the Current Attendant Care Waiver" link under the "Learn more" section of the webpage.

BHHC – Contact Number: (800) 433-4459
Email: HC-Services@pa.gov

Assignment of BH HC reflects an enrollment in PROMISe to serve in-plan supplemental HealthChoices clients. This PEP is not considered an entitlement for funding from any MHMR Program, nor a guarantee of a definitive number of referrals.

COMMCARE Waiver - Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/temp/commcarewaiver/index.htm

COMMCARE Waiver provides home and community-based services for individuals with a medically determined diagnosis of traumatic brain injury (TBI). COMMCARE prevents the institutionalization of individuals with TBI and helps them to remain as independent as possible. Eligibility criteria includes: U.S. citizen or permanent resident, PA resident age 21 and older with a diagnosis of TBI who require a nursing facility level of care, Asset limit of $8,000, and Income limit of 300% of the federal benefit rate. Information and listing of services provided by this PEP can be found by following the link above:

For service descriptions and provider qualification requirements follow the "View the Current Attendant Care Waiver" link under the "Learn more" section of the webpage.

Consolidated Waiver – (888) 565-9435
Email: ra-odpproviderenroll@pa.gov

Home and Community-Based program developed for Pennsylvania residents age 3 and older with a medically determined diagnosis of mental retardation. The Consolidated Waiver is designed to provide services to eligible persons with mental retardation so that they can remain in the community

Fee-for-Service (FFS) - Contact Number: (800) 537-8862 – Select Option 1; then Option 4; then Option 2
Email: ra-PRovApp@pa.gov

A comprehensive set of Medical Assistance services which include reimbursement for direct inpatient and outpatient, physical health, and behavioral health services to consumers through components of the Medical Assistance Program. If you are trying to provide services under the Managed Care and/or FFS programs, you should select the FFS PEP.

If you are requesting enrollment to be a provider of a HealthChoices Supplemental Service(s) for Behavioral Health, contact the BH-MCO with which you will be doing business as this application is not applicable.

Healthy Beginnings Plus (HBP) - Contact Number: (800) 537-8861 – Select Option 1, then Option 4, then Option 4. You can leave a voice mail after the prompt.
Email: RAFFS_HBP@pa.gov

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance, to have a positive prenatal care experience. HBP expands the scope of maternity services that can be reimbursed by the Medical Assistance Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the HBP program. Services covered by HBP include childbirth and parenting classes, nutritional and psychosocial counseling, smoking cessation counseling, home health services and other individualized client services. Please note: A separate HBP enrollment application must be completed to add this program to your eligibility.

Independence Waiver - Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/temp/independencewaiver/index.htm

Independence Waiver provides home and community-based services for persons with physical disabilities to allow them to live in the community and remain as independent as possible. Also provides services to people dependent on medical technology (required to sustain life or replace vital bodily function and avert immediate threat to life). Eligibility criteria includes: U.S. citizen or permanent resident, Age 18-60 with a physical disability, Asset limit of $8,000, and Income limit of 300% of the federal benefit rate. Additional criteria includes: Disability likely to continue indefinitely and results in functional limitations in 3 or more major life activities: mobility, communication, self-care, self-direction, independent living, and learning; cannot have an intellectual disability or a major mental disorder as a primary diagnosis; requires a nursing facility level of care. Information and listing of services provided by this PEP can be found by following the link above:

For service descriptions and provider qualification requirements follow the "View the Current Independence Waiver" link under the "Learn more" section of the webpage.

Living Independently for Elders (LIFE) – Contact Number: (717) 772-2570 or (800) 932-0939
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/lifelivingindependencefortheelderly/index.htm

Providers should enroll as a provider under the Long Living Independently for Elders (LIFE) if they plan to provide long-term care services to Nursing Facility Clinically Eligible (NFCE) individuals age 55 or over. All providers in this PEP must be approved by the Bureau of Quality and Provider Management and have an existing agreement with the Department to provide services under the national Program of All-inclusive Care for the Elderly (PACE) model under either federal PACE provider Status or under Prepaid Health Plan Authority. The goal is to maintain individuals in the community, but services are also provided in institutional settings when appropriate. Providers manage and provide an all-inclusive package of services to enrolled recipients and are reimbursed a monthly capitation payment for services provided. Information regarding the LIFE program can be found by following the link above:

Mental Retardation Base Program (MR Base Program) - Contact Number: (888) 565-9435
Email: ra-odpproviderenroll@pa.gov

The MR Base Program is a program that is designed for Pennsylvania residents of any age who have a medically determined diagnosis of mental retardation.

OBRA Waiver - Contact Number: **(717) 772-2570 or (800) 932-0939**
Email: ra-hcbsenprov@pa.gov
Website: http://www.dpw.state.pa.us/fordisabilityservices/alternativestonursinghomes/temp/obrawaiver/index.htm

OBRA Waiver provides home and community-based services to people with developmental physical disabilities to allow them to live in the community and remain as independent as possible. Eligibility criteria includes: U.S. citizen or permanent resident, PA resident age 18-59 that requires an intermediate care facility/other related conditions (ICF/ORC) level of care, Asset limit of $8,000, and Income limit of 300% of the federal benefit rate. In addition, the disability must be likely to continue indefinitely and have occurred before age 22; the disability results in 3 or more substantial functional limitations in major life activities: mobility, communication, self-care, self-direction, independent living, and learning. The individual cannot have intellectual disability or a major mental disorder as a primary diagnosis. Information and listing of services provided by this PEP can be found by following the link above:

For service descriptions and provider qualification requirements follow the "View the Current OBRA Waiver" link under the "Learn more" section of the webpage.

Person/family Directed Support Waiver (Per/Family Services) – Contact Number: (888) -565-9435
Email: ra-odpproviderenroll@pa.gov

The Person/Family Directed Support Waiver is a Home and Community-Based waiver program that is designed for Pennsylvania residents age 3 and older with a medically determined diagnosis of Mental Retardation. This waiver is designed to prevent the institutionalization of individuals with mental retardation who do not require Office of Developmental Programs licensed community residential services and allows these individuals to remain in the community.

ATTENTION ODP PROVIDERS:

Fax completed application to ODP @ 717-783-5141 or mail to:

Office of Developmental Programs - ID
Room 413 Health and Welfare Building
Harrisburg, PA 17101
Attn: Provider Enrollment

ATTENTION OLTL PROVIDERS:

Mail completed applications to:

Office of Long Term Living
Bureau of Provider Services – Enrollment Section
555 Walnut Street
P.O. Box 8025
Harrisburg, PA 17105-8025

PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of:
   Facility:

_____

or

Last Name: _____First: _____MI: _____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment: ☐ Individual ☐ Facility

b. ☐ Revalidation: ☐ Individual ☐ Facility

c. ☐ Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **(13 digits)**
(Complete the application as an initial enrollment.)

d. ☐ Fee Assignment — Add this provider to existing provider group. Specify group provider number:

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (**Must be a 13 digit number to be processed**).

3. National Provider Identifier Number: _ _ _ _ _ _ _ _ _ _ (10 digits)

Taxonomy(s): _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits)

Taxonomy(s): _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits)

4. Requested Effective Date:
yyyy / mm / dd – (2004/07/31)

_ _ _ _/_ _/_ _

5. Provider Type Number and Description:

Number: ___ ___ **(2 digits)**

Description: _____

6. Primary Specialty and Code

Primary Specialty: _____

Code Number: ___ ___ ___ **(3 digits)**

7. Specialty(s) and Code(s)

Specialty(s): _____

Code Number(s): ___ ___ ___ / ___ ___ ___ **(3 digits)**

8. Sub-specialty(s) and Codes(s) Sub-Specialty(s): _____ Code Number(s):_____

9. Social Security Number:

___ ___ ___ - ___ ___ - ___ ___ ___ ___

10. Federal Tax ID Number:
(If #9 is completed, DO NOT complete this item)

___ ___ ___ ___ ___ ___ ___ ___ ___ **(9 digits)**

***A copy of your social security card OR a document generated by the IRS with your name and SSN must accompany this application.**
***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application.**

11. Legal Name Shown on Attached Document:

_____

12a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

☐ Yes ☐ No

12b. If so, list the MCO(s):

_____

_____

13a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?

☐ Yes ☐ No

13b. If yes, list the Statement/Permit number and the name:

Number: _____

Name: _____

***A legible copy of the recorded/stamped fictitious business name statement/permit is required for your application to be processed.**

14. Date of Birth: yyyy / mm / dd (2004/07/31)

__ __ __ __ /__ __ /__ __

15. Gender: Male ☐ Female ☐

16. Title/Degree as it appears on license:

17a. IRS Address: **Note**: **This is the address where your 1099 tax document will be sent.**

Street: _____ Room/Suite:_____

City: _____ State:_____ Zip:_ _ _ _ _-_ _ _ _ **(9 digits)**

17b. Contact Name/Title:

Name: _____

Title: _____

17c. Contact E-Mail Address:

17d. Contact Phone:

( )

17e. Contact Toll-Free Phone:

( )

17f. Contact Fax Number:

( )

18. Business Type: (Check **1** Box Only)

☐ Business Corporation, For Profit ☐ Not For Profit ☐ Sole Proprietorship
☐ Estate/Trust ☐ Partnership
☐ Government Owned ☐ Public Service Corporation

19. a. License Number: _____ b. Issuing State:_____

c. Issue Date: _____ d. Expiration Date: _____

***A copy of your license is required for your application to be processed.**

20. Drug Enforcement Agency (DEA) Number: _____

***If you have a DEA number, a copy of your DEA certificate is required for your application to be processed.**

21. Is a CLIA certificate and a Dept of Health Lab Permit associated with this Service Location? ☐ Yes ☐ No

***if YES please provide a copy of both with this application**

22. CMS Certification number: _____

***A copy of your CMS certification is required for your application to be processed.**

Note: NEW individual providers only- To add additional service locations upon INITIAL enrollment only, refer to page 12. Copy as needed and fill out for each service location you wish to add.

23a. Service Location Address: **(A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)**

Street: _____ Room/Suite:_____

City: _____ State: _____ Zip:_ _ _ _ _-_ _ _ _ **(9 digits)** County: _____

Business Phone: ( ) _____ - _____ Fax Number: ( ) _____ - _____

Is this address an active Rural Health Clinic or FQHC? ☐ **Yes** ☐ **No**

Check all applicable boxes. This service location is also a: ☐ **Pay-to** ☐ **Mail-to** ☐ **Home Office**
If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #27.

IF you wish to utilize the Electronic Funds Transfer Direct Deposit Option please follow link for further information:
http://www.dpw.state.pa.us/provider/doingbusinesswithdpw/electronicfundstransferdirectdepositinformation/index.htm

23b. Would you like to receive E-Mail notification of new bulletins? Yes ☐ *No ☐
E-Mail address is **required if answered YES** to receive notification of MA bulletins: _____
*By answering **NO** you are agreeing to be responsible to check for new MABs on your own by visiting the following website: http://www.dpw.state.pa.us/publications/bulletinsearch/index.htm OR by signing up to receive notification of new MABs through the Listserv option on the DPW website: http://www.dpw.state.pa.us/provider/index.htm (select 'eBulletins' Listserv option to join).
IF you wish to continue receiving paper bulletins call 1.800.537.8862 option 1 to see if you meet the requirements.
Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

23c. Check this block only if you wish your Medicare claims to crossover to this service location. ☐

23d. Contact Name: _____ Contact Phone: _____

Title: _____

23e. Contact Toll-Free Phone:	23f. Contact Fax Number:	23g. Contact E-Mail address:
( )	( )	

23h. In addition to English do you or your staff communicate with patients in another language?	23i. If "Yes", list language(s):
Yes ☐ No ☐	_____ _____

23j. (1) Does the office have exterior or interior steps leading to the main entrance doorway?
Yes ☐ No ☐ Exterior ☐ Interior ☐
(2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?
Yes ☐ No ☐ Permanent ☐ Portable ☐
(3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes ☐ No ☐
No exterior steps ☐ No interior steps ☐
Permanent ramp ☐ Portable ramp ☐
(4) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities ACT (ADA)? If yes, attach a copy of the exemption to your application.
Yes ☐ No ☐

23k. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

24. Does the provider retain any managing employees or agents? ☐ **Yes *** ☐ **No**
IF "YES" please complete Attachment I (Managing Employee or Agent Disclosure Form) found here:
http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf

25. **CONFIDENTIAL INFORMATION**

Have you, any agent, or managing employee ever:

25a. Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

☐ Yes ☐ No

25b. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

☐ Yes ☐ No

25c. Had a controlled drug license withdrawn?

☐ Yes ☐ No

25d. Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

☐ Yes ☐ No

25e. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

☐ Yes ☐ No

25f. **If you answered "Yes" to any of the questions listed above, you <u>MUST</u> provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:**

1. Name and title of individual
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disposition/State
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) convicted of
13. Sentence(s)
14. Categorization of offense (e.g. felony, misdemeanor)

26. This form requires the original signature of the individual applying for enrollment.

_____ _____

Title Printed Name

_____ _____

Original Signature Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 23a

NOTE: Do not use this sheet to add service locations.

27 a. **Address:** Street Suite/Box City State Zip **(9-digits)** County

b. This address is a: ☐ Mail-to ☐ Pay-to ☐ Home Office	c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number: ( )

a. **Address:** Street Suite/Box City State Zip (**9-digits)** County

b. This address is a: ☐ Mail-to ☐ Pay-to ☐ Home Office	c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number: ( )

a. **Address:** Street Suite/Box City State Zip **(9-digits)** County

b. This address is a: ☐ Mail-to ☐ Pay-to ☐ Home Office	c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone: ( )	f. Toll-Free Phone ( )	g. Fax Number: ( )

Note: NEW individual providers only- To add additional service locations upon INITIAL enrollment copy this page as needed and fill out for each service location you wish to add.

1. Service Location Address: **(A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)**

Street: _____ Room/Suite:_____

City: _____ State: _____ Zip:_ _ _ _ _ -_ _ _ _ **(9 digits)** County: _____

Business Phone: ( ) _____ - _____

Fax Number: ( ) _____ - _____

Is this address an active Rural Health Clinic or FQHC? ☐ **Yes** ☐ **No**

Check all applicable boxes. This service location is also a: ☐ **Pay-to** ☐ **Mail-to** ☐ **Home Office**
If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #27.

2. Add rendering provider to : □ Existing provider group number : ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (13 digits)
Add rendering provider to: □ new provider group applicant group name: _____

3. Specialty(s) and Code(s), if applicable:

Specialty: _____

Code Number: ___ ___ ___ **(3 digits)**

4. Sub-Specialty(s) and Code(s), if applicable:

Sub-Specialty(s): _____

Code Number(s): ___ ___ ___ / ___ ___ ___ (**3 digits)**

5. If the taxonomy(s) for this service location differ(s) from the service location on page 1, block 3 please provide the taxonomy(s) for this particular service location:
Taxonomy(s): _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _(10 digits)

6. Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

7. Check this block only if you wish your Medicare claims to crossover to this service location. ☐

8. Contact Name: _____ Contact Phone: _____

Title: _____

9. Contact Toll-Free Phone:
( )

10. Contact Fax Number:
( )

11. Contact E-Mail address:

12. (1) Does the office have exterior or interior steps leading to the main entrance doorway?
Yes ☐ No ☐ Exterior ☐ Interior ☐
(2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?
Yes ☐ No ☐ Permanent ☐ Portable ☐
(3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes ☐ No ☐
No exterior steps ☐ No interior steps ☐
Permanent ramp ☐ Portable ramp ☐
(4) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities ACT (ADA)? If yes, attach a copy of the exemption to your application.
Yes ☐ No ☐

13. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

PROVIDER AGREEMENT FOR OUTPATIENT PROVIDERS

1. This is to certify that _____
(PROVIDER NAME)
Agrees to participate in the Pennsylvania Medical Assistance Program on the following terms:

2. The provider shall comply with all applicable State and Federal laws regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.

3. Specifically, and without limitations, the provider shall:

   A. Keep any records necessary to disclose the extent of services the provider furnishes to recipients;

   B. Upon request, furnish to the Department of Public Welfare, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit, any other authorized governmental agencies and the designee of any of the foregoing, any information maintained under paragraph (A) above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program; and

   C. Comply with the disclosure requirements specified in 42 CFR, Part 455, Subpart B (relating to Disclosure of Information by Providers and Fiscal Agents), or any amendments thereto.

4. This agreement shall continue in effect unless and until it is terminated by either the provider or the Department. Either the provider or the Department may terminate this agreement, without cause, upon thirty days prior written notice to the other. The provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulations.

PROVIDER

By: _____ _____
(Original Signature) **(Date)**

_____
(Name – Please Type or Print)

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and **submit it with your application**. Incomplete applications will be returned.

Please remember applications will be scanned - do not staple.

Did you remember to….

- ❑ **USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.**
- ❑ **Complete all spaces** as required on the application with either your correct information or N/A.
- ❑ **Complete the Provider Disclosure/Ownership or Control interest form; found here:** http://www.dpw.state.pa.us/cs/groups/webcontent/documents/form/p_011861.pdf
- ❑ Ensure that you have entered the **correct number of digits** where specified.
- ❑ If you have more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- ❑ Indicate ***one*** **primary** provider type, provider specialty and sub-specialty(s), as applicable.
- ❑ Include a copy of your **Social Security card, W-2 or any document generated by the Federal IRS** showing your name and SS number. If the Social Security card states "Valid for work only with INS authorization", please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- ❑ Include **documentation generated by the Federal IRS** showing the name associated with the FEIN. Remember, a **W-9 is not permissible**.
- ❑ Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- ❑ If applicable, **include a copy** of your:
  - ❑ Professional license
  - ❑ CLIA certificate and Dept. of Health Lab Permit if applicable.
  - ❑ Mammography certificate, including the list of mammography certified members and their PROMISe™ 13 digit provider numbers.
  - ❑ Permit from the Department of Health.
  - ❑ Any other certification, license, or permit that applies.
- ❑ Include a legible copy of your **DEA certificate**, if applicable.
- ❑ Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the entity applying for enrollment.
- ❑ Enter **at least 1** Provider Eligibility Program (PEP).
- ❑ Show proof of home state Medicaid participation (out of state providers only).
- ❑ Only the **person applying for enrollment or a representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement. Signature stamp not accepted.**

When completed, review the "Did You Remember…" Checklist included with the application.
Then return your application and other documentation TO THE ADDRESS LISTED ON THE REQUIREMENTS FOR YOUR SPECIFIC PROVIDER TYPE. If no address is listed on the requirements for your specific provider type/specialty, please mail to:

DPW Enrollment Unit, PO Box 8045 Harrisburg, PA 17105-8045