INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ INDIVIDUAL PRACTITIONER ENROLLMENT APPLICATION

Table of Contents

Applications must be typed or completed in black ink, or they will not be accepted.
All sections must be completed in full; if left blank, application will be rejected.
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 your complete name.

2. Check the appropriate box(es) for the action(s) you request.

2a. If this is an initial enrollment, check this box. Please complete the entire application.

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

2c. If you are reactivating a provider number, indicate the PROMISe™ **9 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 ending 4-digit service location code must correspond with a valid active street address**.**

- **Fee assignments may only be made between "like provider types". For example, a physician can only be assigned to a provider type 31, physician group.**

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.**

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

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

6. Enter your primary specialty name and code number.

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**.**
   If you are a U.S. citizen, but were not born in the U.S. you must provide a copy of your U.S. resident card or your U.S. issued passport. If you are not a U.S. citizen you must provide a copy of your I-797B, Notice of Action issued by the Department of Homeland Security, U.S. Citizenship and Immigration Services.

10. Enter your date of birth.

11. Enter your gender

12. Dental Providers only – If you have an anesthesia permit please answer yes, and attach a copy.

13. If you have a CLIA certificate and a Dept. of Health Laboratory Permit associated with this service location please attach a copy of both documents with this application.

14. Enter your license number, issuing state, issue date, and expiration date.
    A copy of your license must be included with the application.

15. Enter your Drug Enforcement Agency (DEA) Number, Issue Date and Expiration Date (if applicable).
    A copy of your DEA certificate must be included with the application.

16a. Enter your IRS address. **This address is where your 1099 tax documents will be sent. The zip code must contain 9 digits.**

16b-e. Enter the contact information for the IRS address.

17a. 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 Attachment 1 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 17a.**
Please indicate if the physical address is handicap accessible
Please indicate if the physical address is an FQHC or RHC location
Please indicate if the physical address has been screened by one of the listed entities
****IF YOU ARE ENROLLING AS AN ORGERING, REFERRING AND PRESCRIBING PROVIDER, PLEASE INDICATE YOUR PRIMARY SERVICE LOCATION HERE**
***NOTE* you can sign up for the Electronic Funds Transfer Direct Deposit Option by following the link below:**
http://www.dhs.pa.gov/provider/electronicfundstransferdirectdepositinformation/index.htm

17b. 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.**

17c. Indicate whether or not you would like to receive email notification of new bulletins. If yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins please call the phone number listed.

17d. If you require paper RA's please call the phone number listed.

17e-h. Enter service location contact information. This is the contact name, phone number and e-mail address we will use if we have any questions about this application.

17i. Indicate whether you or your staff is able to communicate with patients in any language other than English.

17j. If applicable, list the additional languages in which you or your staff can communicate.

18. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). Refer to the PEP Descriptions (page 4) and the requirements for your provider type. **Ordering, Referring, Prescribing only providers may use ENP PEP**

19a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).

19b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.

20a-c. Enter Board Certification Information **(If applicable). A copy of the corresponding Board Certification is required.**

21a-e. Enter Liability Insurance Information.

22a-f. 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.**

23a-i. 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**

- **Sign and Date the Authorization and Attestation. A valid e-mail address is also required. (Page 19)**

- **The individual applying for enrollment must sign and date the Provider Agreement (Page 20-21) included with the application.**

- **Attachment 1 –** This page may be used to add a mail-to, pay-to, and or home office address to the previously defined service location address listed in 17a. **This sheet cannot be used to add a service location.**
  Page 22
- Enter the corresponding mail-to, pay-to, and/or home office address.
- Indicate whether you are adding a mail-to, pay-to, and/or home office address.
- Enter the e-mail address of the contact person for this address.
- Enter the contact information for this address.
- **Attachment 2 -** This page may be used to add additional service locations**.**
  Page 23 **Please note – Medicare crossover can only be selected on one of your service locations.**

- **Attachment 3 – This attachment is a REQUIRED document. Please complete fully; attach additional pages if necessary.**
  Page 24-26

When completed, review the checklist on page 27 for a list of the most common reasons enrollment applications are not accepted.

Provider Eligibility Program (PEP) Descriptions

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

ACT 150 Program
Office of Long Term Living - (800) 932-0939

This program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible. The ACT 150 Program is operated only with State funds.

Eligibility:
Recipients either do not meet the level of care for a federally supported waiver or do not meet the financial limitations for the Attendant Care Waiver.

Services:
- Personal Assistance Services
- Personal Emergency Response System
- Service Coordination

Adult Autism Waiver (AAW)
Bureau of Autism Services - (866) 539-7689

The AAW is designed to provide long-term services and supports for community living, tailored to the specific needs of adults age 21 or older with Autism Spectrum Disorder (ASD). The program is designed to help adults with ASD participate in their communities in the way they want to, based upon their identified needs.

Eligibility:
Recipients must be 21 or older and have a diagnosis of ASD and meet certain diagnostic, functional and financial eligibility criteria.

Services:
- Assistive Technology
- Behavioral Specialist
- Community Inclusion and Community Transition
- Counseling
- Day Habilitation
- Environmental Modifications
- Family Counseling and Family Training
- Job Assessment and Job Finding
- Nutritional Consultation
- Occupational Therapy
- Residential Habilitation
- Respite
- Speech Therapy
- Supported Employment
- Supports Coordination
- Temporary Crisis Services
- Transitional Work Services

Aging Waiver (formerly PDA Waiver/Bridge Program)
Office of Long Term Living - (800) 932-0939

This program provides services to eligible persons over the age of 60 in order to prevent institutionalization and allows them to remain as independent as possible.

Eligibility:
Recipients must be 60 years of age or older, meet the level of care needs for a Skilled Nursing Facility, and meet the financial requirements as determined by the County Assistance Office (CAO).

Services:

- Accessibility Adaptation
- Adult Daily Living
- Community Transition Services
- Home Delivered Meals
- Home Health
- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Telecare Services
- Therapeutic and Counseling Services
- Transition Service Coordination

AIDS Waiver
Office of Long Term Living - (800) 932-0939

This is a federally approved special program which allows the Commonwealth of Pennsylvania to provide certain home and community-based services not provided under the regular fee-for-service program to persons with symptomatic HIV disease or AIDS.

Eligibility:
Categorically and medically needy recipients may be eligible if they are diagnosed as having AIDS or symptomatic HIV disease, are certified by a physician and recipient as needing an intermediate or higher level of care and the cost of services under the waiver does not exceed alternative care under the regular MA Program.

MA recipients who are enrolled in a managed care organization (MCO) or an MA Hospice Program are not eligible to participate in this home and community-based waiver program. Contact the MCO for comparable services.

Services:

- Homemaker services
- Nutritional consultations by registered dietitians
- Supplemental skilled nursing visits
- Supplemental home health aide visits
- Supplies not covered by the State Plan

Attendant Care Waiver
Office of Long Term Living - (800) 932-0939

This program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

Eligibility:
Recipients must be between the ages 18–59, physically disabled, mentally alert, and eligible for nursing facility services.

Services:
- Community Transition Services
- Personal Assistance Services
- Personal Emergency Response System
- Service Coordination
- Transition Service Coordination

Behavioral Health HealthChoices (Beh Hlth HC)
Office of Mental Health and Substance Abuse Services - (800) 433-4459

This PEP is used to identify providers who are approved to serve recipients enrolled exclusively in HealthChoices.

Eligibility:
- Recipients are HealthChoices only eligible;
- Provider must contract with the contracted County or Contracted Behavioral Health Managed Care Organization (BH-MCO)
- Licensed/certified/approved service description and credentialed by the contracted County or BH-MCO;
- Requires written pre-requisite documentation from the contracted County or BH-MCO;
- Used exclusively by OMHSAS

Services:
- Alternative treatment services which are discretionary, cost-effective alternatives to acute levels of care
- Contact contracted County or BH-MCO for definition of services

Community Care Waiver (COMMCARE)
Office of Long Term Living - (800) 932-0939

This program was designed to prevent institutionalization of individuals with traumatic brain injury (TBI) and to allow them to remain as independent as possible.

Eligibility:
Pennsylvania residents age 21 and older who experience a medically determinable diagnosis of traumatic brain injury and require a Special Rehabilitative Facility (SRF) level of care. Traumatic brain injury is defined as a sudden insult to the brain or its coverings, not of a degenerative, congenital or post-operative nature, which is expected to last indefinitely.

Services:
- Accessibility Adaptations
- Adult Daily Living
- Community Integration
- Community Transition Services
- Home Health

- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day
- Supported Employment
- Therapeutic and Counseling Services
- Transition Service Coordination

Consolidated Community Reporting Initiative Performance Outcome Management System (EPOMS)
Office of Mental Health and Substance Abuse Services - (800) 433-4459

This PEP is used to identify providers who are approved to serve county based-funded mental health recipients.

Eligibility:
- Recipients are non-Medicaid - county funded only;
- Providers do not receive payment through the MMIS (encounter data reporting only);
- The PEP can be added to an independent service location; in conjunction with a Beh Hlth HC or FFS PEP;
- Provider must contract with the County Mental Health Office;
- Licensed/certified/service description and approved by the County Mental Health Office;
- Requires written pre-requisite documentation from the County Mental Health Office;
- Used exclusively by OMHSAS

Services:
- All county funded providers must enroll at the appropriate service location for the county rendered service;
- Contact contracted County Mental Health Office for definition of services

Consolidated Waiver
Office of Developmental Programs – ra-odpproviderenroll@pa.gov

The Consolidated Waiver is a Home and Community-Based program that is designed for Pennsylvania residents ages 3 and older with a diagnosis of an intellectual disability.

The Pennsylvania Consolidated Waiver is designed to help individuals with an intellectual disability to live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based service models.

Services:
- Assistive technology
- Behavioral support
- Companion
- Education support
- Home accessibility adaptations
- Home and community habilitation (unlicensed)
- Homemaker/chore

- Licensed day habilitation
- Nursing
- Prevocational
- (Licensed) residential habilitation
- (Unlicensed) residential habilitation
- Respite
- Specialized supplies
- Supported employment
- Supports broker
- Supports coordination
- Therapy (physical, occupational, visual/mobility, behavioral and speech and language)
- Transitional work
- Transportation
- Vehicle accessibility adaptations

Early Intervention (WAV15)
Office of Child Development and Early Learning - (717) 772-2376

Eligibility:
Infants and toddlers age birth to age 3 who have a 25% delay in one or more areas of development when compared to other children of the same age, or a physical disability such as hearing or vision loss, or informed clinical opinion that the child has a delay or the child has known physical or mental conditions which have high probability for development delays. Infants and toddlers also meet the Medical Assistance requirements.

Services:
Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

EI Base Funds (WAV16)
Office of Child Development and Early Learning - (717) 772-2376

Eligibility:
Infants and toddlers age birth to age 3 who have a 25% delay in one or more areas of development when compared to other children of the same age, or a physical disability such as hearing or vision loss, or informed clinical opinion that the child has a delay or the child has known physical or mental conditions which have high probability for development delays.

Services:
Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

Fee-for-Service
Office of Medical Assistance Programs - (800) 537-8862

The traditional delivery system of the Medical Assistance (MA) program which provides payment on a per-service basis for health care providers who render services to eligible MA recipients.

Eligibility:
All MA Recipients.

Services:
- Behavioral health services
- Inpatient services
- Outpatient services
- Physical health services

Healthy Beginnings Plus
Office of Medical Assistance Programs - (800) 537-8862

Healthy Beginnings Plus is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance (MA). Healthy Beginnings Plus expands the scope of maternity services that can be reimbursed by the MA Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the Healthy Beginnings Plus program.

Eligibility:
Pregnant women who elect to participate in Healthy Beginnings Plus.

Services:
- Childbirth and parenting classes
- Home health services
- Nutritional and psychosocial counseling
- Other individualized client services
- Smoking cessation counseling

Independence Waiver
Office of Long Term Living - (800) 932-0939

This program provides services to eligible persons with physical disabilities in order to prevent institutionalization and allows them to remain as independent as possible.

Eligibility:
Recipients must be 18 years of age and older, suffer from severe physical disability which is likely to continue indefinitely and results in substantial functional limitations in three or more major life activities. Recipients must be eligible for nursing facility services, the primary diagnosis cannot be a mental health diagnosis or mental retardation, and the recipients cannot be ventilator dependent.

Services:
- Accessibility Adaptation
- Adult Daily Living
- Community Integration
- Community Transition Services
- Home Health

- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Supported Employment
- Therapeutic and Counseling Services
- Transition Service Coordination

Infants, Toddlers and Families Waiver (WAV11)
Office of Child Development and Early Learning - (717) 772-2376

Eligibility:
Infants and toddlers, birth to age 3 who have a 50% delay in one area of development or two 25% delays in two areas of development when compared to other children of the same age and meets the Medical Assistance requirements.

Services:
Early Intervention supports and services are designed to meet the developmental needs of children with a disability as well as the needs of the family related to enhancing the child's development in one or more of the following areas:

- Physical development, including vision and hearing
- Cognitive development
- Communication development
- Social or emotional development
- Adaptive development

Intellectual Disability Base Program (formerly MR Base Program)
Office of Developmental Programs - ra-odpproviderenroll@pa.gov

The ID Base Program is program that is designed for Pennsylvania residents of any age who have a diagnosis of an intellectual disability. These services are offered through the Office of Developmental Programs.

Services available under the Medicaid waivers may also be provided and funded as base services. Base services are generally funded 90% state and 10% county, except for residential services that are 100% state funded.

Services:

- Base Service not Otherwise Specified
- Family aide
- Family education training
- Family Support Services/Individual Payment
- Home Rehabilitation
- Licensed residential services in homes where 9 or more individuals reside
- Recreation/leisure time activities
- Service coordination
- Special Diet Preparation
- Support (Medical Environment)

Omnibus Budget Reconciliation Act Waiver (OBRA Waiver)
Office of Long Term Living - (800) 932-0939

Also known as the Community Services Program for Persons with Disabilities, provides services to persons with developmental disabilities so that they can live in the community and remain as independent as possible (this includes relocating or diverting individuals from a nursing home to a community setting).

Eligibility:
Recipients must be developmentally disabled, the disability manifests itself before age 22, and the disability is likely to continue indefinitely which results in substantial functional limitations in three or more major life activities. The recipient can be a nursing facility resident determined to be inappropriately placed. The primary diagnosis cannot be a mental health diagnosis or mental retardation and community residents who meet ICF/ORC level of care (high need for habilitation services) may be eligible.

Services:

- Accessibility Adaptation
- Adult Daily Living
- Community Integration
- Community Transition Services
- Home Health
- Non-Medical Transportation
- Personal Assistance Services
- Personal Emergency Response System
- Prevocational Services
- Residential Habilitation
- Respite
- Service Coordination
- Specialized Medical Equipment and Supplies
- Structured Day
- Supported Employment
- Therapeutic and Counseling Services
- Transition Service Coordination

Person/Family Directed Support Waiver (P/FDS)
Office of Developmental Programs - ra-odpproviderenroll@pa.gov

The Person/Family Directed Support Waiver is a Home and Community-Based program that is designed for Pennsylvania residents age 3 and older with a diagnosis of an intellectual disability.

The Pennsylvania P/FDS Waiver is designed to help individuals with an intellectual disability to live more independently in their homes and communities and to provide a variety of services that promote community living, including self-directed service models and traditional, agency-based service models.

Services:

- Assistive technology
- Behavioral support
- Companion
- Education support
- Home accessibility adaptations
- Home and community habilitation (unlicensed)
- Homemaker/chore

- Licensed day habilitation
- Nursing
- Prevocational
- Respite
- Specialized supplies
- Supported employment
- Supports broker
- Supports coordination
- Therapy (physical, occupational, visual/mobility, behavioral and speech and language)
- Transitional work
- Transportation
- Vehicle accessibility adaptations

PROMISe™ INDIVIDUAL PRACTITIONER ENROLLMENT APPLICATION

1. Enter Individual Name of Enrollee:

Last Name:_____First:_____MI: _____

2. Action Request: Check Boxes that Apply:

2a. ☐ Initial Enrollment
2b. ☐ Revalidation
2c. ☐ Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known):_____ _____ (Complete as an initial enrollment.)
Please note: See page 19 if re-enrolling (for requirements for providers seeking to re-enroll).

2d. ☐ 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 – Example: (2004/07/31)

_____/_____/_____

5. Provider Type Number and Description:

Number: ____ **(2 digits)**
Description:

6. Primary Specialty and Code (See requirements page):
Specialty:

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

7. Specialty(s) and Code(s), if applicable:
Specialty(s): _____

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

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

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

9. Social Security Number:_____–_____– _____
If you are a U.S. citizen, but were not born in the U.S. you must provide a copy of your U.S. resident card or your U.S. issued passport. If you are not a U.S. citizen you must provide a copy of your I-797B, Notice of Action issued by the Department of Homeland Security, U.S. Citizenship and Immigration Services.

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

_____/_____/ _ ___

11. Gender
Male ☐ Female ☐

12. Dental Providers – Do you have a permit for the administration of anesthesia issued by the PA Department of State? ☐ Yes ☐ No If you answered yes, please attach a copy of your Permit.

13. 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.

14a. License Number:_____ b. Issuing State:_____

c. Initial issue Date:_____ d. Expiration Date: _____

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

15a. Drug Enforcement Agency (DEA) Number:_____

b. Initial issue Date:_____ Expiration date_____

c. Check this box if you do not have a DEA certificate number ☐

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

16a. **Please enter the address where your 1099 tax document will be sent.**

Street:_____ Room/Suite:_____

City:_____State:_____Zip:_ _ _ _ _–_ _ _ _ **(9 digits)**

16b. Contact Name/Title: Name: _____ Title: _____	16c. Contact persons' E-Mail Address - *Required:
16d. Contact Phone: ( )	16e. Contact Fax Number: ( )

17a. 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: ( )_____-_____

- Does the office have exterior or interior steps leading to the main entrance doorway?
  Yes ☐ No ☐ Exterior ☐ Interior ☐
- If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?
  Yes ☐ No ☐ Permanent ☐ Portable ☐
- 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 ☐

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

Has the provider named in question 1 been screened for this location within the last 60 months by:

Medicare?	Yes	No
Children's Health Insurance Program (CHIP)?	Yes (Complete below)	No
Another state's Medicaid program?	Yes (Complete below)	No

_____ _____ _____

Screening State | Screening Contact Phone Number | Screening contact email address

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 Attachment 1.

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

17b. Check this block only if you wish your Medicare claims to crossover to this service location. ☐

17c. 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.dhs.pa.gov/publications/bulletinsearch **OR** by signing up to receive notifications of new MABs through the MA Electronic Bulletins Listserv

IF you wish to continue receiving paper bulletins call 1.800.537.8862 option 1 to see if you meet the requirements.

17d. 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.

***This is the contact name and phone number we will use if we have any questions about this application**.

17e. Service Location Contact Name:_____ Title:_____

17f. Contact Phone:	17g. Contact Fax Number:	17h.Contact E-Mail address -*Required
( )	( )	

17i. In addition to English do you or your staff communicate with patients in another language? Yes ☐ No ☐	17j. If "Yes", list language(s): _____

18. Provider Eligibility Program (PEP). See pages 4-12 for PEP descriptions.

a. _____ b._____ c. _____

19a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)? ☐ Yes ☐ No	19b. If so, list the MCO(s): _____ _____

-This Space Intentionally Left Blank -

Credentialing Information

Please Provide the Information requested in questions 20-23.

20. Board certification: Are you Board Certified? ☐ **Yes*** ☐ **No**

***If YES you MUST attach a copy of your board certification**

a. **Primary specialty**_____

Name of certifying board _____

b. Secondary specialty_____

Name of certifying board _____

c. Please mark this box if you have additional board certifications to include in an attachment ☐

21. Professional Liability Insurance

a. Carrier Name: _____

b. Amount of Insurance_____

c. Effective Date (yyyy/mm/dd) _____

d. Expiration Date (yyyy/mm/dd) _____

e. **For providers whose primary practice is in Pennsylvania, do you participate with the Medical Care Availability and Reduction of Error Act (MCare)?** Yes ☐ No ☐

- This Space Intentionally Left Blank -

22. Have you ever:

A. Had clinical privileges or hospital privileges denied, suspended, restricted, revoked, or not renewed; either voluntarily or involuntarily for an agreed to definite or indefinite period of time?

If ☐ Yes, please attach details ☐ No

B. Had any judgments entered against you or settlements been agreed to in any professional liability cases?

If ☐ Yes, please attach details ☐ No

C. Are there any professional liability lawsuits pending against you at the present time?

If ☐ Yes, please attach details ☐ No

D. Do you have physical or mental health condition(s) which in any way impairs your ability to practice your profession, with or without accommodations?

If ☐ Yes, please attach details ☐ No

E. Do you have any physical or mental health condition(s) which in any way poses a risk of harm to your patients?

If ☐ Yes, please attach details ☐ No

F. Are you currently using, or have you used in the past five years, drugs or any other chemical substance that has or may impair your ability to practice your profession?

If ☐ Yes, please attach details ☐ No

If you answered "Yes" to any of the questions above, you MUST provide a detailed statement of the circumstances relating to the "YES" response as well as an explanation as to why you think this response should not result in a denial of your enrollment to participate in MA Program. You may also submit statements from professional associates or peer review bodies. Include in your statement the following information as it applies to each situation:

- Name and title of the individual applicant
- Date of professional malpractice action
- Description of professional malpractice action
- Explanation of any physical or mental health condition(s) that impairs your ability to practice your profession
- Explanation of any physical or mental health condition(s) that poses a risk of harm to your patients
- Explanation of drug or chemical substance use

23. Have you or anyone in your employ ever:

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

If ☐ Yes, please attach details ☐ No

B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had your 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)?

If ☐ Yes, please attach details ☐ No

C. Had a controlled drug license withdrawn?

If ☐ Yes, please attach details ☐ No

D. Been convicted of a criminal offense related to Medicare or Medicaid, or a state health care program?

If ☐ Yes, please attach details ☐ No

E. Been convicted of a criminal offense relating to the unlawful manufacture, distribution, prescription or dispensing of a controlled substance?

If ☐ Yes, please attach details ☐ No

F. Been convicted of interference with or obstruction of any investigation?

If ☐ Yes, please attach details ☐ No

G. In connection with the delivery of a health care item or service, or with respect to any act or omission in a heath care program, been convicted of any criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

If ☐ Yes, please attach details ☐ No

H. Been in default on repayments of scholarship obligations or loans in connection with your education as a health professional?

If ☐ Yes, please attach details ☐ No

I. Been subject to a civil penalty or assessment for any act or omission related to Medicare, Medicaid, or a state health care program?

If ☐ Yes, please attach details ☐ No

**** In addition to answering the above questions you are REQUIRED to complete Attachment 3 – PROVIDER DISCLOSURE STATEMENT.**

If you answered "YES" to any of the questions above, you MUST provide a detailed statement of the circumstances relating to the "YES" response as well as an explanation as to why you think this response should not result in a denial of your enrollment to participate in the MA Program. Include in your statement the following information as it applies to each situation:

- Name of individual
- Name of licensing, certifying or other agency taking action
- Date of action or criminal conviction
- Type of action
- Length of suspension/preclusion or other action
- Disposition (current status or outcome)
  - sentence
  - civil penalties
  - restitution
- Offense(s) convicted of
  - date
- Categorization of offense (e.g. felony, misdemeanor)
- Date license was surrendered or withdrawn (if applicable)

***** In addition to the above you MUST also submit three (3) statements from professional associates or peer review bodies testifying to your capabilities and professionalism.***

Notice to Providers Seeking to Re-enroll:

Providers whose enrollment and participation in the MA Program had been terminated by the Department and who are seeking to re-enroll, must include three (3) statements from peer review bodies, probation officers where appropriate, or professional associates, giving factual evidence of why they believe the violations leading to the termination will not be repeated. Providers must include a statement setting forth the reasons why he or she should be re-enrolled in the MA Program.

AUTHORIZATION AND ATTESTATION

I hereby authorize the Department of Human Services to contact individuals or entities, including querying the National Practitioner Data Bank or the Healthcare and Integrity Protection Data Bank, for the purpose of verifying my credentials or information contained in this application.

I affirm that the information submitted in or with this application is true, accurate and complete. I understand that any false statements made therein are subject to the penalties contained in 18 PA. C.S. § 4904, relating to any unsworn falsifications to authorities.

_____ _____

Original Signature **Date**

_____

(Name – Please Type or Print)

_____

E-Mail Address

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE OF MEDICAL ASSISTANCE PROGRAMS

Provider Agreement for Outpatient Providers

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

_____

(hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The provider agrees to comply with all applicable State and Federal statutes and regulations, and policies which pertain to participation in the Pennsylvania Medical Assistance Program.

2. The provider agrees to keep any records necessary to disclose the extent of services the provider furnishes to recipients.

3. The provider agrees upon request, furnish to the Department, 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 and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program.

4. The provider agrees to 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.

5. The provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:

   A. the ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12–month period ending on the date of the request; and

   B. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5–year period ending on the date of the request.

6. The provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.

7. The provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the provider, and will provide to the Department any information needed for the Department to conduct a background check of the provider and its owners.

8. The provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the provider or is an agent or managing employee of the provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).

9. The provider agrees that if there is any change in the ownership or control of the provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the provider.

10. 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.

11. To the extent applicable, the provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, providers of home health care and personal care services and hospices as specified in 42 C.F.R. §489, subpart I.

PROVIDER ELIGIBILITY AGREEMENT

I have reviewed the information in this enrollment application and affirm on behalf of the provider seeking to enroll in the Pennsylvania Medical Assistance Program that the information submitted in or with this application is true, accurate and complete.

I understand that the provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the provider becomes aware that any of the information is not true, accurate or complete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities. I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the provider from the Pennsylvania Medical Assistance Program.

The provider represents and warrants that the person signing this application is a duly authorized representative of the provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the provider that is seeking to enroll in the Medical Assistance Program.

_____ _____

Provider – Original Signature **Date**

_____ _____

Printed Name **Title of Person Signing Provider Agreement if Not the Enrolling Provider**

Attachment 1

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 17a

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

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

This address is a:
☐ Mail-to ☐ Pay-to
☐ Home Office

E-Mail address:
*Required

Contact Name/Title:

Name:_____ Title: _____

Business Phone:
( )

Fax Number:
( )

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

This address is a:
☐ Mail-to ☐ Pay-to
☐ Home Office

E-Mail address:
*Required

Contact Name/Title:

Name:_____ Title: _____

Business Phone:
( )

Fax Number:
( )

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

This address is a:
☐ Mail-to ☐ Pay-to
☐ Home Office

E-Mail address:
*Required

Contact Name/Title:

Name:_____ Title: _____

Business Phone:
( )

Fax Number:
( )

Attachment 2

Note: To add ADDITIONAL service locations, copy this page as needed and fill out for each service location you wish to add.
A service location is defined as a physical street address where a practitioner:

1) Maintains an office, 2) Holds office hours/sets appointments and 3) Renders services.

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: ( )_____-_____

a. Does the office have exterior or interior steps leading to the main entrance doorway?
Yes ☐ No ☐ Exterior ☐ Interior ☐

b. If the answer to (a) is yes, does the office have a permanent or portable wheelchair ramp?
Yes ☐ No ☐ Permanent ☐ Portable ☐

c. If the answer to (a) 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 ☐

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

Has the provider named in Block 1 been screened for this location within the last 60 months by:

Medicare?	Yes	No
Children's Health Insurance Program (CHIP)?	Yes (Complete below)	No
Another state's Medicaid program?	Yes (Complete below)	No

_____ Screening State
_____ Screening Contact Phone Number
_____ Screening contact email address

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 Attachment 1.

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

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 from the service location on page 4, block 3 please provide the taxonomy(s) for this particular service location:

Taxonomy(s):_____(10 digits)_____(10 digits)_____(10 digits)

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

7. Provider Eligibility Program (PEP). See pages 4-12 for PEPs. **You must choose at least 1 PEP:**

a._____ b._____ c. _____

8. Is a CLIA certificate and a Dept. of Health Lab License associated with this Service Location? ☐ Yes ☐ No
If YES please provide a copy of both with this application.

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISe™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in 42 CFR Part 455 Subpart B.

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of $25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

a. An individual, agency, or organization to which a provider has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or

b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer or hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Ownership and Control Interest Disclosure

Note: Ownership and Control Interest information is required in accordance with Federal Regulations at 42 CFR, Part 455.

A. Please enter the full name, address, social security number, and date of birth of any person who is a managing employee or agent of the enrolling individual practitioner.

The following individual is a: ☐ **Managing Employee** ☐ **Agent**

Name: _____ _____ _____
(First Name) (Middle Name) (Last Name)

Social Security Number:_____Date of Birth: _____

Address:_____Suite/Apt: _____

_____ _____ _____ _____
(City) (State) (Zip Code) (+4)

a. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY THIS PAGE TO ADD ADDITIONAL MANAGING EMPLOYEES/AGENTS****

B. Please enter the full name and federal tax identification number of all subcontractors in which the enrolling individual practitioner has a direct or indirect ownership interest of 5% or more.

a. Name of Subcontractor: _____

Federal Tax ID of Subcontractor: _____

b. Please enter the percentage and ownership type that the enrolling individual practitioner has in the subcontractor.

☐ **Direct:**_____% (Percent of Ownership) ☐ **Indirect:**_____% (Percent of Ownership) _____ (Name of Entity Owned)

****ATTACH SEPARATE SHEET TO ADD ADDITIONAL SUBCONTRACTORS****

30. Has the enrolling individual practitioner been convicted of a criminal offense related to Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

☐ **Yes (Provide details below)** ☐ **No**

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

31. Has the enrolling individual practitioner had any significant business transactions with any wholly owned supplier or with any subcontractor during the preceding five year period?

☐ **Yes (Provide details below)** ☐ **No**

Name of Supplier/Subcontractor: _____

Social Security Number or Federal Tax ID:_____ Date of Birth: _____ (Individuals only)

Address:_____ Suite/Apt: _____

_____ (City) _____ (State) _____ (Zip Code) _____ (+4)

****ATTACH SEPARATE SHEET TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS****

Provider Enrollment Application Checklist

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are not accepted due to missing vital information. Please complete this checklist and **submit it with your application**. Incomplete applications will not be processed.

Document will be scanned – Please do NOT staple.

Did you remember to….

- **USE BLACK INK. (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.
- Ensure that you have entered the **correct number of digits** where specified.
- Attach a separate sheet listing the additional codes if you have more than 4 taxonomy codes.
- Indicate ***one* primary** provider type, provider specialty and sub-specialty(s), as applicable.
- If you are not a US Citizen, include a copy of your documentation from Department of Homeland Security that shows proof of authorization to work in the United States.
- Include proof of participation in your home state's Medicaid Program if you are an **out-of-state provider**.
- **Include a legible copy** of your:
  - Professional License

Also include any other certification, license, or permit that applies, including but not limited to:

  - DEA Certificate
  - CLIA certificate and Dept. of Health Lab license if applicable.
  - Diabetes Training Certificate
  - Tobacco Cessation Approval Form from the Department of Health
  - Hearing Aid Dispenser (HAD) Certificate
  - Maternal Fetal Medicine Specialist Telehealth Information Request Form found at: http://www.dhs.state.pa.us/cs/groups/webcontent/documents/form/s_002844.pdf
  - Mammography certificate, including the list of mammography certified members and their Promise 13 digit provider numbers.

- Enter **at least 1** Provider Eligibility Program (PEP).
- Include **proof of Board Certifications, if applicable**.
- Only the **person applying for enrollment** can sign and date the **provider agreement**. Signature stamp not accepted.

DHS Enrollment Unit
PO Box 8045
Harrisburg, PA 17105-8045
- or -
Fax: (717) 265-8284
- or -
Email: RA-ProvApp@pa.gov