INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™
PROVIDER ENROLLMENT DME 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 Pharmacy/Medical Supplier.

2a. Check if this is the initial enrollment.

2b. Check if this is a revalidation.

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.

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 apply for enrollment. Refer to:
http://www.dhs.pa.gov/provider/frequentlyaskedquestions/nationalprovideridentifiernpifrequentlyaskedquestions/index.htm

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 specialty name and code number. See the requirements for your provider type.

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

8. 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.

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

10a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).

10b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.

11a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.

11b. If applicable, enter the statement/permit number and the name. Attach a legible copy of the recorded/stamped fictitious business name statement/permit.

12a. Enter your IRS address. This address is where your 1099 tax documents will be sent.

12b-f. Enter the contact information for the IRS address.

13. 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.

14. Enter your license number (if applicable), 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 (if applicable).
*A copy of your DEA certificate must be included with the application.

16. Enter your CMS number if applicable.

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.**
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
***Refer to #20 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 17a.**

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-c. 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.

17d. 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.

17e-h. Enter contact information.

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.

17k. Enter the appropriate Provider Eligibility Program(s) (PEP(s)).
Refer to the PEP Descriptions and the requirements for your provider type.

18a-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).

19. 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.**

20. This page, beginning with #20, 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.**

20a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.

20b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.

20c. Enter the e-mail address of the contact person for this address.

20d-g. Enter the contact information for this address.

- **Facilities must complete a new application to add additional service locations to their file.**
- The 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 submit to:

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

- or -

Fax: (717) 265-8284

- or -

Email: RA-ProvApp@pa.gov

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.

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

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

PROMISe™ PROVIDER ENROLLMENT DME APPLICATION

1. Enter Name of DME:

_____

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): _ _ _____ _ _____**(9 digits)**
(Complete the application as an initial enrollment.)

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. Specialty(s) and Code(s):

Specialty: _____

Code Number: _ _____**(3 digits)**

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

Sub-Specialty(s): _____

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

8. Federal Tax ID Number:

___ _____ _____ _ _ **(9 digits)**

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

9. Legal Name Shown on Attached Document:

10a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

☐ Yes ☐ No

10b. If so, list the MCO(s):

_____

_____

11a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?

☐ Yes ☐ No

11b. 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.**

12a. IRS Address: **Note**: This is the address where your 1099 tax document will be sent.

Street: _____ Room/Suite: _____

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

12b. Contact Name/Title:

Name: _____

Title: _____

12c. Contact E-Mail Address:

12d. Contact Phone:
( )

12e. Contact Toll-Free Phone:
( )

12f. Contact Fax Number:
( )

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

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

14.

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.**

15. 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.**

16. CMS Certification number (if applicable): _____

THIS SPACE INTENTIONALLY LEFT BLANK

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: ( )_____-_____

(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 ☐

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 12 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 block #20.

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. 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/index.htm **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.

17c. 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.

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

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

17e. Contact Name: _____ Contact Phone:_____

Title: _____

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

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

17k. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least 1 PEP:**

a._____ b. _____ c. _____

18. Have you, any agent, or managing employee ever:

A. 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

B. 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

C. Had a controlled drug license withdrawn?

☐ Yes ☐ No

D. 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

E. 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

If you answered "Yes" to any of the questions listed above, you MUST 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)

19. 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 17a

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

20 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: ( )

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES

Provider Agreement for Pharmacy and Medical Suppliers

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:

I. PROVIDER RESPONSIBILITIES

A. The Provider agrees to participate in the Pennsylvania Medical Assistance Program (the "Program"), and in the course of such participation to comply with all federal and Pennsylvania laws generally and specifically governing participation in the Program. The foregoing include but are not limited to: 42 U.S.C. § 1396 et seq., 62 P.S. §§441-451, 42 C.F.R. §§431-481 and the regulations adopted by the Department of Human Services (the "Department"). The Provider agrees to be knowledgeable of and to comply with applicable rules, regulations, rates and fee schedules promulgated under such laws and any amendments thereto.

B. The submission by or on behalf of the Provider of any claim for payment under this Program shall constitute certification by the Provider that:

1. the services or items for which payment is claimed were actually provided by the Provider to the person identified as the Beneficiary; and

2. the claim does not exceed the Provider's usual charge for the same items or equivalent services provided to persons who are not Medical Assistance recipients.

C. The Provider agrees to maintain all records necessary to disclose the extent of services the Provider furnishes to recipients.

D. The Provider agrees to furnish the Department, the Department of Health and Human Services and the Medicaid Fraud Control Unit with any information it may request regarding payments claimed by the Provider for furnishing services.

E. 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:

1. 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

2. 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.

F. 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.

G. 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.

H. 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).

I. 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.

J. The Provider agrees that the information submitted in or with the application for enrollment to participate in the Medical Assistance Program and from which this contract ensued is true, accurate and complete. The Provider agrees further that such representation shall be a continuing one and that the Provider shall notify the Department, in writing, within fifteen (15) days of its occurrence, of any fact which arises or is discovered subsequent to the date of the application which affects the truth, accuracy or completeness of such representation.

K. The Provider agrees to comply with the Commonwealth's Contract Compliance Regulations as set forth at 16 Pa. Code §49.101.

L. This Agreement is specific to the Provider and may not be assigned by the Provider without prior written approval by the Department.

M. The Provider agrees that in actual economic practice, overcharges by its suppliers, manufacturers and suppliers to manufacturers resulting from violations of state or federal antitrust laws are, in fact, borne by the Commonwealth of Pennsylvania. The Provider assigns, and shall require its suppliers, manufacturers and suppliers to manufacture to assign, to the Commonwealth of Pennsylvania all rights, title, and interest in and to any claim the Provider, its suppliers, the manufacturers or suppliers to manufacturers now have or may hereafter acquire under state or federal antitrust laws relating to products which are subject to this contract.

II. DEPARTMENT'SRESPONSIBILITIES

A. The Department will reimburse the Provider in accordance with all applicable federal and state statutes and regulations for services covered under the Pennsylvania Medical Assistance Program which are rendered to Medical Assistance eligible individuals.

B. The Department will adjust payment to the Provider for the amount of any disapproved cost or expenditure in connection with this Agreement.

C. The Department will make a good faith effort to mail to all providers, no less than five (5) days before implementation, all final regulations and bulletins.

D. The Department will provide to the Pharmacy Subcommittee copies of all final drafts of proposed rules and regulations before such proposed regulations are published so that pharmacies have a sufficient time to comment on them before publication.

III. EFFECTIVE DATE AND TERM OF AGREEMENT

The Provider must sign and submit a copy of this Agreement to the Department. This Agreement shall remain in effect until terminated by either party. Termination of this Agreement shall not relieve the Provider of his/her obligation to retain records and make restitution of overpayments for services or items furnished prior to termination.

IV. TERMINATION OF AGREEMENT

A. This Agreement may be terminated by either party upon thirty (30) days advance written notice to the other party.

B. In the event a Provider is terminated or suspended for cause from the program and such termination or suspension shall have been determined to have been done without just cause, then the Provider shall be reimbursed for all services rendered during the period of the unjust termination or suspension, so long as the Provider complied with all rules and regulations during the period of termination or suspension.

V. DISPUTES

All questions or disputes arising between the parties hereto respecting payment pursuant to this Agreement shall be referred to the Bureau of Hearings and Appeals of the Department for adjudication.

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 agreement 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.

Original Signature of Provider or Representative	**Date**
Printed Name	**Title of Person Signing Agreement**

In consideration of the use of the eligibility transactions, I/we agree to the following:

I/we will not use or disclose any information provided under this agreement except as may be necessary to fulfill our responsibilities under this agreement. We will ensure that each person authorized to access the Department's eligibility database signs the operator agreement attached or on the reverse of this form and we will not permit any other persons except those expressly authorized by us to have access to this data. We agree that we do not act and we will not be deemed to act as agents, officers, or employees of the Department. We shall indemnify, save harmless, and defend the Department against all claims which may arise from acts of omission on our part or on the part of our employees or agents relating to this agreement. We agree to obtain, install, and maintain, at our expense, any terminals, data connections, communication circuits, and related workstation equipment which are compatible and are used to access the Department's data communication network. We will provide at our expense adequate electrical power, space, environment, and furniture for all data network components. We agree to provide the Department and its authorized representatives access to our workstation(s) during our normal business hours. We agree that we are responsible for all recurring monthly telecommunications costs associated with access to the Department's eligibility database.

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.

Disclosing entity means a Medicaid provider (other than an individual practitioner or a group of practitioners), or a fiscal agent.

Other Disclosing entity means any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);

b. Any Medicare intermediary or carrier; and

c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not the share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

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.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

a. Has an ownership interest totaling 5 percent or more in a disclosing entity.

b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.

c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.

d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:

If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.

e. Is an officer or director of a disclosing entity that is organized as a corporation; or,

f. Is a partner in the disclosing entity that is organized as a partnership.

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 disclosing entity 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 the Federal Regulations at 42 CFR, Part 455.

Name of disclosing entity: _____

13-digit PROMISe™ Provider Number: _____

Contact Name (for questions on this form): _____

Contact Phone: (_____)_____-_____ Contact Email Address: _____

Section I: Managing Employee or Agent Disclosure

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 disclosing entity.

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)

1. 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**

2. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION I A TO ADD ADDITIONAL MANAGING EMPLOYEES/AGENTS****

Section II: Ownership and Control

If the provider is organized as a corporation, partnership, estate trust or is a government entity that is organized as a corporation, complete this section.

In completing this section, an individual with at least 5% direct or indirect ownership interest includes individuals that have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity and individuals who own an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

INDIVIDUALS WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

A. Please enter the full name, social security number, date of birth, and address of individuals with an ownership or control interest in the disclosing entity and all officers, partners, and directors.

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

Social Security Number:_____Date of Birth: _____

Address:_____Suite/Apt: _____

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

1. a. If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity.

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

b. If the individual listed above is an officer or director, what position does the individual hold?

☐ **President**
☐ **Vice President**
☐ **Secretary**
☐ **Treasurer**
☐ **Chairman**
Vice Chairman
Director
☐ **Officer**
☐ **Member**

2. a. Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?

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

Name:_____ Relationship: _____
Attach separate sheet, if necessary

Section II: (cont.)

b. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

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

Name:_____ Relationship: _____

Attach separate sheet, if necessary

3. Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

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

Name: _____

Address:_____Suite/Apt: _____

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

Attach separate sheet, if necessary

4. 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**

5. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION II A TO ADD ADDITIONAL INDIVIDUALS****

Section II: (cont.)

CORPORATE ENTITIES WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

B. Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

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

1. Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

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

2. Please enter any additional business locations and PO Boxes for the corporate entity listed above.

Address: _____ Suite/Apt: _____

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

Attach separate sheet, if necessary

3. Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

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

Name: _____

Address: _____ Suite/Apt: _____

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

Attach separate sheet, if necessary

****COPY SECTION II B TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS

C. Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

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

Social Security Number:_____ Date of Birth: _____

Address:_____ Suite/Apt: _____

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

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

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

   c. Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

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

   d. Is the individual listed above the spouse, parent, child, or sibling of any other individuals with at least 5% direct or indirect ownership or control interest in the disclosing entity?

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

   Name:_____ Relationship: _____

   e. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

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

   Name:_____ Relationship: _____

Section II: (cont.)

f. 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**

g. Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS****

D. Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

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

1. a. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

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

b. Please enter the percentage and ownership type that the corporate entity listed above has in the subcontractor.

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

****COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

E. Please enter the full name, tax identification number, and primary business address of all subcontractors in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

1. a. Name of Subcontractor: _____

   Federal Tax ID of Subcontractor: _____

   b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

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

****COPY SECTION II E TO ADD ADDITIONAL SUBCONTRACTORS OF THE DISCLOSING ENTITY****

OWNERSHIP OR CONTROL INTEREST IN OTHER ENTITIES

F. Does the disclosing entity have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

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

Name: _____

Address: _____ Suite/Apt: _____

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

****COPY SECTION II F TO ADD ADDITIONAL ENTITIES****

SIGNIFICANT BUSINESS TRANSACTIONS

G. Has the disclosing entity 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)

****COPY SECTION II G TO ADD ADDITIONAL SIGNIFICANT BUSINESS TRANSACTIONS****

Section III: Non-Profit Organization Disclosure (Not Organized as a Corporation)

If the disclosing entity is a non-profit organized as a corporation, please complete Section II

A. Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

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

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

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

1. What position is held by the individual listed above?

☐ **President**	☐ **Chairman**	☐ **Member**
☐ **Vice President**	**Vice Chairman**	
☐ **Secretary**	**Director**	
☐ **Treasurer**	☐ **Officer**	

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

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

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

****COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS****

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are rejected. 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.
- 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 provider type and provider specialty(s), as applicable.
- 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 Department of Health Laboratory Permit associated with the service location.
  - 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 **representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement. Signature stamp not accepted.**

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:

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

- or -

Fax: (717) 265-8284

- or -

Email: RA-ProvApp@pa.gov