INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ PROVIDER ENROLLMENT GROUP 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 their home State's Medicaid Program.

1. Enter the complete name of the group.

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

2b. 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.

2c. If this is a name change, indicate the old name and the new name. **To verify your updated name, a copy of a document generated by the Federal IRS listing your group name and FEIN must accompany your application.**

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

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

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

6. Enter your 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 your IRS number 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 documentation.

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.

13a. Enter your IRS address. This address is where your 1099 tax documents will be sent.

132b-f. Enter the contact information for the IRS address.

14. Check the appropriate box for the business type of the group 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.

15a. 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. See block #19 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 15a.**

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

15b-c. Answer question, if yes, enter you 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.

15d. 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.**

15e-h. Enter contact information.

15i. Indicate whether you or your staff is able to communicate with patients in any language other than English.

15j. If applicable, list the additional languages in which you or your staff can communicate.

15k. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **See the PEP Descriptions and the requirements for your provider type (included with the instructions).**

16a-e. Complete ALL confidential information questions, A through E.
If you answer "Yes" to any of the questions, provide a detailed explanation (on a separate piece of paper) and attach it to your application.

17. Sign the application and print your name, title, and date **(The signature should be that of the person authorized to represent the group applying for enrollment). Use black ink.**

18. Block #18 of the application may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in15a. **This sheet cannot be used to add a service location.**
*You must fill out a new application to add a service location.

18a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.

18b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.

18c. Enter the e-mail address of the contact person for this address.

18d-g. Enter the contact information for this address.

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

ATTENTION ODP-ID PROVIDERS:

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

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

THIS SPACE INTENTIONALLY LEFT BLANK

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 your 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 - (866) 539-7689

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 - (866) 539-7689

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 - (866) 539-7689

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™ PROVIDER ENROLLMENT GROUP APPLICATION

1. Enter Complete Group Name:

_____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment

b. ☐ Revalidation

c. ☐ Check here if previously enrolled in Medical Assistance (MA).
Enter Provider Number (if known): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **(13 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), if applicable:

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.**

12. 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 documents with this application.

13a. IRS Address: **Note**: This is the address where your 1099 tax document will be sent.

Street: _____ Room/Suite:_____

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

County:_____

13b. Contact Name/Title:

Name: _____

Title: _____

13c. Contact E-Mail Address:

13d. Contact Phone:

( )

13e. Contact Toll-Free Phone:

( )

13f. Contact Fax Number:

( )

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

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

15a. 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**

Do you bill for a mobile unit from this location? ☐ **Yes** ☐ **No**

Mobile Medical Unit? ☐ Yes ☐ No
Mobile Dental Unit? ☐ Yes ☐ No

Check all applicable boxes. This service location is also a: ☐ **Pay-to** ☐ **Mail-to** ☐ **Home Office**

If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #19.

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

15b. 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.state.pa.us/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.

15c. 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.

15d. Check this block only if you wish your Medicare claims to crossover to this service location. ☐

15e. Contact Name: _____ Contact Phone: _____

Title: _____

15f. Toll-Free Phone:	15g. Fax Number:	15h.Contact E-Mail address:
( )	( )	

15i. In addition to English do you or your staff communicate with patients in another language? Yes ☐ No ☐	15j. If "Yes", list language(s): _____ _____

15l. Provider Eligibility Program (PEP). Refer to PEP descriptions and requirements (included with application). **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

This Space Intentionally Left Blank

16. **CONFIDENTIAL INFORMATION**

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, 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 (i.e. Misdemeanor)

17.

This form requires the original signature of the authorized representative of the group applying for enrollment.

_____ _____

Title Printed Name

_____ _____

Original Signature Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 15a

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

18 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:

Group Members

Date: _____ **Group 13-Digit Provider #: _____**

Group Name: _____

Contact Name: _____ Contact Phone: _____

Note: By Signing, I am agreeing to assign my fees to the Group named, and the service location number listed above. To verify fee-assignment compatibility between provider types, please call the Enrollment Hotline at 1-800-537-8862 prompt 1.

	Printed Name	Signature (No Stamp)	Provider Number (13-Digit)	Effective Date
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

The service location(s) MUST be physical street addresses.

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

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:**_____% ☐ **Indirect:**_____% _____
   (Percent of Ownership) (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 returned. Please complete this checklist and **submit it with your application**. Incomplete applications will be returned. **Applications will be scanned – please 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 ***one* primary** provider type, provider specialty and sub-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
  - ❑ 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 the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the group applying for enrollment.
- ❑ Enter **at least 1** Provider Eligibility Program (PEP).
- ❑ Only the **person authorized to represent the group applying for enrollment** can sign and date the Confidential Information Sheet. Signature stamp not accepted.
- ❑ If you are adding a provider to the group, enter the individual's PROMISe™ 13- digit provider number. The 4-digit service location code must correspond with a valid active street address. We will not assign fees to a service location listed as a P.O. Box.
  •Fee assignments may only be made between "like provider types". Call the Enrollment Hotline for verification at 1-800-537-8862 prompt 1.

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