INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™
INDIVIDUAL PRACTITIONER ENROLLMENT APPLICATION
Graduate Medical or Osteopathic Trainee

Table of Contents

Applications must be typed or completed in black ink, or they will not be accepted.
All sections must be completed in full; if left blank, application will be rejected.
Applications will be scanned - please do NOT staple.

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

1. Enter your complete name.

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

2a. If this is an initial enrollment, check this box.

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

2c. If you are reactivating a provider number, indicate the PROMISe™ **9 digit** provider number you wish to have reactivated and complete the application as an initial enrollment. (See page 19 for requirements for providers seeking to re-enroll.)

2d. If you are adding a provider to an existing group, enter the PROMISe™ 13 digit group provider number. The 4-digit service location code must correspond with a valid active street address**.**

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

3. **Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes.**

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

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

6. Enter your primary specialty name and code number. (**Specialty 301, Graduate Medical or Osteopathic Trainee)**.

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

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

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

10. Enter your date of birth.

11. Enter your gender

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

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

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

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

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

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

17a. Enter a valid service location address. **The address must be a physical location, not a post office box. The zip code must contain 9 digits and the phone number must be for the service location. Refer to Attachment 1 of the application to list an additional address(es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 17a.**
Please indicate if the physical address is handicap accessible
Please indicate if the physical address is an FQHC or RHC location
Please indicate if the physical address has been screened by one of the listed entities
****IF YOU ARE ENROLLING AS AN ORGERING, REFERRING AND PRESCRIBING PROVIDER, PLEASE INDICATE YOUR PRIMARY SERVICE LOCATION HERE**
***NOTE* you can sign up for the Electronic Funds Transfer Direct Deposit Option by following the link below:**
http://www.dhs.pa.gov/provider/electronicfundstransferdirectdepositinformation/index.htm

17b. If you wish Medicare claims to crossover to this service location check this box. **Note: This crossover can be added to only one service location.**

17c. Answer question, if yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins please call the phone number listed.

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

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

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

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

18. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **Ordering, Referring, Prescribing only providers must use ENP PEP**

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

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

Please Provide the Information requested in questions 20-27.

20a-c. Enter Board Certification Information. **(If applicable)**

21a-f. Enter Education Information.

22a-f. Enter Training Information.

23a-f. Enter any additional Training Information.

24a-e. Enter Liability Insurance Information.

25. Enter your work history.

26a-f. If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of **paper) and attach it to your application.**

Questions 27 a-i (Page 18) must be completed.

27a-i. If you answer "Yes" to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application

- **Sign and Date the Authorization and Attestation. A valid e-mail address is also required. (Page 12)**

- **The individual applying for enrollment must sign and date the Provider Agreement (Page 13-14) included with the application.**

- **Attachment 1 –** This page may be used to add a mail-to, pay-to, and or home office address to the **Page 15** previously defined service location address listed in 17a. **This sheet cannot be used to add a service location.**
- Enter the corresponding mail-to, pay-to, and/or home office address.
- Indicate whether you are adding a mail-to, pay-to, and/or home office address.
- Enter the e-mail address of the contact person for this address.
- Enter the contact information for this address including a valid e-mail address.
- **Attachment 2 -** This page may be used to add additional service locations**.** **Page 16** **Please note – Medicare crossover can only be selected on <u>one</u> of your service locations.**

- **Attachment 3 – This attachment is a REQUIRED document. Please complete fully; attach additional pages if necessary. Page 17-19 When completed, review the checklist on page 27 for a list of the most common reasons enrollment applications are not accepted.**

Provider Eligibility Program (PEP) Descriptions

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

ALL ORDERING, REFFERING AND PRESCRIBING PROVIDERS MUST INDICATE ENROLLED NOT PAID (ENP) AS THE PEP.

Other enrolling providers should indicate Fee for Service (FFS) PEP

PROMISe™ INDIVIDUAL PRACTITIONER ENROLLMENT APPLICATION

1. Enter Individual Name of Enrollee:

Last Name: _____First: _____MI: _____

2. Action Request: Check Boxes that Apply:

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

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

2d. ☐ Fee Assignment — Add this provider to existing provider group. Specify group provider number:

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

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

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

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

___ ___ ___ ___ / ___ ___ / ___ ___

5. Provider Type Number and Description:

Number: **31** **(2 digits)**
Description: **PHYSICIAN**

6. Primary Specialty and Code (See requirements page):
Specialty: **Graduate Medical or Osteopathic Trainee**

Code Number: 301 **(3 digits)**

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

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

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

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

9. Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___

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

___ ___ ___ ___ / ___ ___ / ___ ___

11. Gender
Male ☐ Female ☐

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

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

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

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

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

---

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

b. Initial issue Date: _____ Expiration date_____

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

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

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

Street: _____ Room/Suite:_____

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

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

17a. Service Location Address: **(A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)**

Street: _____ Room/Suite:_____

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

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

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

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

Has the provider named in question 1 been screened for this location within the last 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 Attachment 1.

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

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

17c. Would you like to receive E-Mail notification of new bulletins? Yes ☐ *No ☐

E-Mail address is **required if answered YES** to receive notification of MA bulletins: _____

*By answering **NO** you are agreeing to be responsible to check for new MABs on your own by visiting the following website: http://www.dhs.pa.gov/publications/bulletinsearch **OR** by signing up to receive notifications of new MABs through the MA Electronic Bulletins Listserv

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

17d. Once enrolled, you can retrieve RAs from PROMISe™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

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

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

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

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

18. Provider Eligibility Program (PEP). See pages 4-11 for PEP descriptions.

a. ENP – Enrolled Not Paid b. _____ c. _____

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

Credentialing Information

Please Provide the Information requested in questions 20-27.

20. Board certification: Are you Board Certified? ☐ Yes* ☐ No
***If YES you MUST attach a copy of your board certification**

a. **Primary specialty** **Graduate Medical or Osteopathic Trainee**

Name of certifying board _____

b. **Secondary specialty** _____

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

21. Education

a. Please provide the highest degree awarded. Mark one of the following:

- Doctorate ☐ masters ☐ bachelors ☐ other ☐ **please specify below**
- _____

b. School name_____

c. Degree type awarded_____
(Example: Doctor of Medicine, Doctor of Osteopathy, Doctor of Dental Medicine, Doctor of Podiatry, Bachelor of Science in Nursing)

d. Start date (yyyy/mm/dd)_____

e. Completion date (yyyy/mm/dd)_____

f. School address:

- Address L1_____
- Address L2_____
- City_____ State_____ Zip code_____

---

22. Training

a. Please provide all relevant training. Mark one of the following:

- Internship ☐ residency ☐ other ☐ **please specify below**
- _____

b. School/institution name_____

c. Program type_____
(Example: rotating, emergency medicine, surgery)

d. Start date (yyyy/mm/dd)_____

e. Completion date (yyyy/mm/dd)_____

f. School/institution address:

- Address L1_____
- Address L2_____

City _____ State _____ Zip Code _____

23. Additional training: (to document multiple instances of your additional training – please provide the information below on an attached sheet)

a. Please provide all relevant training. Mark one of the following:

- Internship ☐ residency ☐ other ☐ **please specify below**
- _____

b. School/institution name_____

c. Program type_____
(Example: rotating, emergency medicine, surgery)

d. Start date (yyyy/mm/dd) _____

e. Completion date (yyyy/mm/dd)_____

f. School address:
- Address L1_____
- Address L2_____
- City_____ State_____ Zip code_____

---

24. Professional Liability Insurance

a. Carrier Name: _____

b. Amount of Insurance _____

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

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

e. **For providers whose primary practice is in Pennsylvania, do you participate with the Medical Care Availability and Reduction of Error Act (MCare)?** Yes ☐ No ☐
Please include a copy of your "Acknowledgment of Insurance and Surcharge/Assessment Paid"

---

25. Work History – Please complete below or include a copy of your curriculum vitae.

Starting with your current practice, list all employment since completion of post-graduate training. Explain any gaps in the chronology.

Employer/Practice	**Location City and State**	**Dates (inclusive) Month and Year**
_____	_____	_____
_____	_____	_____
_____	_____	_____

26. Have you ever:

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

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

27. Have you or anyone in your employ ever:

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

C. Had a controlled drug license withdrawn?

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

If ☐ Yes, please attach details ☐ No

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

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

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

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

Notice to Providers Seeking to Re-enroll:

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

AUTHORIZATION AND ATTESTATION

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

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

_____ _____

Original Signature **Date**

_____

(Name – Please Type or Print)

_____ _____

E-Mail Address - *Required

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

Provider Agreement for Outpatient Providers

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

_____

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

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

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

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

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

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

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

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

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

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

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

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

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

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.

_____ _____

(Provider – Original Signature) **(Date)**

_____

(Name – Please Type or Print)

Attachment 1

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

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

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

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

Contact Name/Title:

Name: _____ Title: _____

Business Phone: ( )	Fax Number: ( )

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

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

Contact Name/Title:

Name: _____ Title: _____

Business Phone: ( )	Fax Number: ( )

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

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

Contact Name/Title:

Name: _____ Title: _____

Business Phone: ( )	Fax Number: ( )

Attachment 2

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

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

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

Street: _____ Room/Suite:_____

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

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

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

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

c. If the answer to (a) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes ☐ No ☐
No exterior steps ☐ No interior steps ☐
Permanent ramp ☐ Portable ramp ☐

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

Has the provider named in Block 1 been screened for this location within the last 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 Attachment 1.

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

2. Add rendering provider to : ☐ Existing provider group number : ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ (13 digits)

Add rendering provider to: ☐ new provider group applicant group name: _____

3. Specialty(s) and Code(s), if applicable:
Specialty: _____
Code Number: ___ ___ ___ **(3 digits)**

4. Sub-Specialty(s) and Code(s), if applicable:
Sub-Specialty(s): _____
Code Number(s): ___ ___ ___ / ___ ___ ___ (**3 digits)**

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

Taxonomy(s): __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits) __ __ __ __ __ __ __ __ __ __ (10 digits)

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

7. Provider Eligibility Program (PEP). See pages 4-11 for PEPs. **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

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

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

Provider Disclosure Statement Definitions

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

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

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

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

Subcontractor means:

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

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

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

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

Ownership and Control Interest Disclosure

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

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

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

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

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

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

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

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

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

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

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

a. Name of Subcontractor: _____

Federal Tax ID of Subcontractor: _____

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

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

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

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

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

Description of Offense: _____

_____

_____

_____

_____

Attach separate sheet, if necessary

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

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

Name of Supplier/Subcontractor: _____

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

Address: _____ Suite/Apt: _____

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

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

Provider Enrollment Application Checklist

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

Document will be scanned – Please do NOT staple.

Did you remember to….

- ❑ **USE BLACK INK. (Application must be typed or printed in black ink.)**
- ❑ **Complete all spaces** as required on the application with either your correct information or N/A.
- ❑ Ensure that you have entered the **correct number of digits** where specified.
- ❑ Attach a separate sheet listing the additional codes if you have more than 4 taxonomy codes.
- ❑ Indicate ***one* primary** provider type, provider specialty and sub-specialty(s), as applicable.
- ❑ If you are not a US Citizen, include documentation from Department of Homeland Security that shows proof of authorization to work in the United States.
- ❑ Include proof of participation in your home state's Medicaid Program if you are an **out-of-state provider**.
- ❑ **Include a legible copy** of your:
  - ❑ Professional License

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

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

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

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