

Requirements For Provider Type 01 – Medical Rehabilitation

Specialty Types

Please choose your Specialty and Code.

012- Inpatient Medical Rehabilitation Hospital

014- Medical Rehabilitation Unit

Provider Eligibility Program (PEPs)

Please choose the appropriate PEP(s) from the following:

- Fee-For-Service
- Non- Waiver Mental Retardation Base Programs
- Pennsylvania Department of Aging Waiver (PDA) and Bridge Program

Send your required documents to:

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

- or -

Fax: (717) 265-8284

- or -

Email: RA-ProvApp@pa.gov

**DOCUMENTS REQUIRED FOR THE ENROLLMENT OF
MEDICAL REHABILITATION UNIT, IN-STATE MEDICAL REHABILITATION HOSPITAL, AND OUT-OF-
STATE MEDICAL REHABILITATION HOSPITAL**

DOCUMENT REQUIRED	PROVIDER TYPE TO BE ENROLLED		
	Medical Rehabilitation Unit	In-State Medical Rehabilitation Hospital	Out-of-State Medical Rehabilitation Hospital
A copy of an acceptable utilization review plan, written according to the requirements in State Regulations § 1163.473 and Federal Regulations at 42 CFR 456.100. The utilization review plan must be signed by an executive officer.	X	X	
A copy of your transfer agreement with a skilled nursing facility, a psychiatric facility, a private psychiatric hospital, and/or an acute care hospital	X	X	
A signed copy of the Office of Medical Assistance Programs' Required Provider Agreement for Inpatient Hospitals and Residential Treatment Facilities signed by an executive officer.	X	X	X
One signed copy of the Office of Medical Assistance Programs' Provider Enrollment Base Application.	X	X	X
A copy of the license issued by the Office of Drug and Alcohol Programs.		X	X
A copy of your certification from the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or Det Norske Veritas Healthcare, Inc. or the Commission on Accreditation of Rehabilitation Facilities substantiating that your facility meets JCAHO rehabilitation standards.	X	X	X
A copy of the Ownership/Control Interest Form		X	X
A copy of projected cost report (MA 336).	X	X	
A copy of your Medicare certification.	X	X	X
A copy of the confirmation of your application to Medicare requesting exclusion for the unit from the Medicare Prospective Payment System.	X	X	
A copy of the Provider Participation Approval Letter from the Bureau of Fee-for-Service Programs or Letter of Nonreviewability	X	X	
A copy of your most recent Home state Medicaid rate letter for your rehabilitation hospital	Out-of-State		X

Contact Person: _____

Title: _____

Telephone Number: _____