Requirements for Provider Type 08 - Clinic

Specialty Code

- 074 – Mobile Mental Health Treatment
- 076 – Peer Support Services
- 082 – Independent Medical/Surgical Clinic
- 083 – Family Planning Clinic
- 084 – Methadone Maintenance
- 086 – Dental Clinic
- 110 – Psychiatric Outpatient
- 163 – Nurse Family Partnership
- 184 – Outpatient Drug and Alcohol Clinic
- 370 – Tobacco Cessation
- 558 – BSC-ASD
- 808 – Psychiatric Outpatient Therapeutic Staff Support
- 809 – Psychiatric Outpatient Mobile Therapy
- 810 – Psychiatric Outpatient Behavioral Specialist Consultant
- 811 – Psychiatric Outpatient Summer Therapeutic Activity Program

Provider Eligibility Program (PEP)

- Fee-for-Service
- Healthy Beginnings + (can be associated with Independent Medical/Surgical Clinics 08-082 only)

Required Documents for Provider Type 08:

The following documents and supporting information are required by the Bureau of Fee-For-Service Programs to enroll any 08 Specialty type (please ensure all documents are legible):

- Completed application for the enrollment of a Facility/Agency—application must include:
    - Signed Provider Agreement with original signature of an authorized representative;
    - Completed Ownership or Control Interest Disclosure form; and
    - If the application is for an **Independent Medical/Surgical Clinic (08-082)** or **Peer Support Services (08-076)**, submit the supplements that follow this requirements page
- Signed statement by the clinic Medical Director indicating affiliation with the clinic (see sample on next page)
    - The Medical Director must be a PA Medicaid-participating physician; and
    - A current copy of the Department of State license must accompany the letter
- Documentation generated by IRS showing both the Provider's legal name and FEIN—documentation must come from IRS; this Department does not accept W-9s
- If Provider is tax-exempt, submit IRS 501 (c)(3) letter confirming this status
- If application is for an Out-of-State Provider, submit proof of current home state Medicaid participation

- Copy of Corporation papers issued by Department of State Corporation Bureau or business partnership agreement
- If Provider operates under a fictitious name, submit copy of D/B/A filing with Department of State Corporation Bureau
- Clinical Laboratory Improvement Amendments (CLIA) certificate and PA Department of Health clinical lab permit, if applicable – *note that the PA DOH clinical lab permit requirement applies to both In-State and Out-of-State providers*

Psychiatric Outpatient Clinics (08-110) must submit copy of Certificate of Compliance issued by Department of Human Services. If applying for the 076 specialty (Mobile Mental Health Treatment), a copy of the service description approval granted by OMHSAS must accompany the application.

Drug and Alcohol Clinics (08-184) must submit copy of license issued by the Department of Drug and Alcohol Programs.

Specialties 558 and 808-811 a copy of the approved service description (submitted to and approved by the Office of Mental Health and Substance Abuse Children's Bureau of Children's Behavioral Health Services) must accompany the application. For additional information specific to service description approvals, contact the Bureau of Children's Behavioral Health Services via e-mail at RA_BHRS@pa.gov or by calling (717) 705-8289.

The following is a sample Medical Director Letter to be used for illustrative purposes.

_ _/_ _/_ _ _ _

I, Physician's Name, serve as the Medical Director of Name of Enrolling Clinic, located at Street Address. I am a licensed physician who participates in the Pennsylvania Medicaid Program, and my Provider ID number is: _ _ _ _ _ _ _ _ _. Attached is a copy of my current Department of State license.

Original Signature of Medical Director

Independent Medical/Surgical Clinics (08-082) should apply online via our Electronic Provider Portal at https://provider.enrollment.dpw.state.pa.us . All other Specialties are encouraged to apply via the Provider Portal as well. If circumstances do not allow online submission, send the application and all documents to:

DHS Provider Enrollment

PO Box 8045

Harrisburg, PA 17105-8045

Fax: (717) 265-8284

E-mail: RA-ProvApp@pa.gov

ADDITIONAL INFORMATION FOR INDEPENDENT MEDICAL CLINIC ONLY

1. CLINIC NAME AND ADDRESS:

Name:

Street Address:

City: **State:** **Zip Code:**

2. TYPE OF STATE OR FEDERAL FUNDS RECEIVING OR INITIAL STARTUP FUNDS RECEIVED:

INITIAL START UP FUNDS RECEIVED/CURRENT FUNDS RECEIVING

Fund Type	State or Federal Funds (Please check one)	Amount Received
_____	❑ State ❑ Federal	$_____
_____	❑ State ❑ Federal	$_____
_____	❑ State ❑ Federal	$_____
_____	❑ State ❑ Federal	$_____

3. DOES CLINIC PROVIDE COMPREHENSIVE MEDICAL SERVICES FOR A MINIMUM OF FORTY (40) HOURS PER WEEK?

❑ YES ❑ NO

4. ARE SERVICES PROVIDED DIRECTLY BY A PHYSICIAN OR UNDER THE SUPERVISION OF A PHYSICIAN DURING SCHEDULED HOURS OF OPERATION?

❑ YES ❑ NO

5. IF A PHYSICIAN DOES NOT PROVIDE THE SERVICES DIRECTLY, ARE SERVICES PROVIDED BY A CERTIFIED REGISTERED NURSE PRACTITIONER OR A PHYSICIAN ASSISTANT DURING SCHEDULED HOURS OR OPERATION?

❑ YES ❑ NO

6. LIST OF PHYSICIANS, CRNPs AND PHYSICIAN ASSISTANTS WHO STAFF THE CLINIC:

Name:	**Name:**
Name:	**Name:**
Name:	**Name:**
Name:	**Name:**
Name:	**Name:**
Name:	**Name:**

7. DO YOU HAVE A CURRENT FEE SCHEDULE FOR BILLING ALL THIRD PARTY AND PRIVATE PAYERS?

☐ YES ☐ NO

8. WHAT IS YOUR LOWEST CHARGE PER VISIT?

$ _____

9. DO YOU LIMIT THE NUMBER OF PATIENTS YOU SERVE BY VIRTUE OF PAYMENT SOURCE?

☐ YES ☐ NO

10. INCLUDE A STATEMENT CONFIRMING THE PROCEDURE THE CLINIC FOLLOWS FOR A PATIENT REFERRAL PROCESS THAT ENSURES FOLLOW-UP TREATMENT BY OTHER PHYSICIANS OR APPROPRIATE SPECIALISTS.

_____

_____

11. INCLUDE A STATEMENT THAT THE CLINIC PROVIDES DIRECT EMERGENCY MEDICAL CARE, THROUGH FORMAL AGREEMENTS, AND PROVIDES FOR ACCESS TO HEALTH CARE FOR MEDICAL EMERGENCIES DURING AND AFTER THE CLINIC'S REGULARLY SCHEDULED HOURS.

_____

_____

ADDENDUM – PEER SUPPORT SERVICES (Specialty 076)

In addition to all the above-listed requirements, providers requesting peer support services must submit their application to the OMHSAS Field Office along with:

- Copy of the Certificate of Compliance (as applicable)
- Copy of the peer support service description
- Signed supplemental provider agreement for peer support services
- Copy of the subcontract agreement (for subcontracted providers only)

Submit the information to the appropriate OMHSAS Field Office:

OMHSAS - Scranton Field Office
Scranton State Office Bldg
100 Lackawanna Avenue, Room 321
Scranton PA 18503-1939

OMHSAS - Pittsburgh Field Office
301 5th Avenue, Suite 480
Pittsburgh PA 15222

OMHSAS – Southeast Field Office
Norristown State Hospital
1001 Sterigere Street, Bldg. #48
2nd Floor Room 208
Norristown PA 19401

OMHSAS – Harrisburg Field Office
Commonwealth Tower – 12th Floor
PO Box 2675
Harrisburg PA 17105-2675

PENNSYLVANIA DEPARTMENT OF HUMAN SERVICES
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
SUPPLEMENTAL PROVIDER AGREEMENT FOR THE
DELIVERY OF PEER SUPPORT SERVICES

This Supplemental Provider Agreement sets forth the responsibilities of the peer support services provider (Provider), which are in addition to those set forth in the Medical Assistance Outpatient Provider Agreement and addendums to that agreement, and the Provider handbooks and supplements.

The Provider agrees to deliver services in accordance with the service description approved by the Office of Mental Health and Substance Abuse Services (OMHSAS) and the revised Peer Support Standards found in the provider handbook.

The Provider agrees to deliver services to individuals who meet all eligibility criteria including, age requirements, presence or history of serious mental illness (SMI) or serious emotional disturbance (SED) that results in a functional impairment, a written recommendation from a licensed practitioner of the healing arts (LPHA), and chooses to receive Peer Support.

I hereby agree to comply with the terms of the Peer Support Services Bulletin, the Medical Assistance Provider Handbook, and all requirements that govern participation in the Medical Assistance Program:

_____ _____
Provider Name (please type or print) Provider signature

_____
Date

_____

_____

_____
Provider Address (please type or print)