PerformCARE®	Policy and Procedure
Name of Policy:	Processing Provider MA Enrollment Applications (In Lieu of and in Addition to Services and Out of Network Enrollment for Provider)
Policy Number:	PR-019
Contracts:	☒ All counties ☐ Capital Area ☐ Franklin / Fulton
Primary Stakeholder:	Provider Relations
Related Stakeholder(s):	All Departments
Applies to:	Associates
Original Effective Date:	10/01/02
Last Revision Date:	06/02/20
Last Review Date:	10/28/21
Next Review Date:	10/01/22

Policy: PerformCare has established procedures to process provider applications for MA enrollment (in Lieu of and in addition to services and Out of Network enrollment for Provider). This includes the required re-enrollment/ re-validation every 5 years. All Providers must have a Medical Assistance number to pay claims.

Purpose: To establish procedures for processing applications for MA enrollment of Provider in Lieu of and in addition to services and Out of Network enrollment for Providers and Out of Network Providers, including 5-year re-enrollment/re-validation.

Definitions: None

Acronyms: **BFFSP:** Bureau of Fee For Service Programs

Procedure:

1. The appropriate enrollment application will be mailed or emailed to the Provider with a standard cover letter. The enrollment package includes:
   - 1.1. The "HealthChoices Network Provider" Or "Out-Of-Network Provider" (as appropriate) Behavioral Health Enrollment Instructions and corresponding unnumbered Application Form.
   - 1.2. The DHS Provider Agreement.
   - 1.3. HealthChoices Behavioral Health Alternative Treatment Services program description narrative.

2. The Provider completes the application and returns to the Contracting Department of PerformCare.
3. The application will be reviewed by the Manager, Provider Network Operations or designee. Manager or designee will assure that the application is filled out completely and correctly.
4. Once the provider has been credentialed (*QI-CR-001 Credentialing and Re-credentialing Criteria-Facilities* and *QI-CR-002 Credentialing and Re-credentialing Criteria-Practitioners*), the Enrollment Application will be signed by the PerformCare Manager, Provider Network Operations or designee. The BH-MCO attestation form is also included with the materials.
5. The original document will be forwarded to the appropriate OMAP Department, or the provider will be given directions from PerformCare to submit the application on-line.
   5.1. BFFSP Provider Enrollment
   PO Box 8045
   Harrisburg, PA 17105-8045
   5.2. https://provider.enrollment.dpw.state.pa.us/

Related Policies: *QI-CR-001 Credentialing and Re-credentialing Criteria-Facilities*
QI-CR-002 Credentialing and Re-credentialing Criteria-Practitioners

Related Reports: None

Source Documents and References: None

Superseded Policies and/or Procedures: *PR-011 Processing New Provider Applications (Organizations and Facilities)*
PR-012 Processing New Provider Applications (Individual and Group Practice Providers)

Attachments: *Attachments are available electronically or by hard copy via Provider Relations Department.*

- *OMHSAS HealthChoices Behavioral Health Supplemental Services provider Enrollment Application*

Approved by:

Primary Stakeholder

Commonwealth of Pennsylvania - Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health In Lieu Of and In Addition To Services - Provider Enrollment Application Checklist

Required for all Applications:

- ☐ **Completed** copy of the HealthChoices Behavioral Health In Lieu Of and In Addition To Services Provider Enrollment Application
- ☐ DHS Provider Agreement for Outpatient Providers with original signature(s)
- ☐ **Completed** Ownership or Control Interest/Non-Profit Disclosure/Government Owned Entities Forms with information completed (as applicable) and with original signatures
- ☐ Verification of Tax ID name and number
- ☐ NPI Verification
- ☐ BH-MCO Attestation Form

Additional Requirements for:

11/110 MH – BSU Assessment Diagnostic
11/184 D&A Level of Care Assessment
21/138 D&A Intensive Case Management and Resource Coordination
- ☐ Field Office Attestation Form
- ☐ Service Description

11/110 MH Adult Residential Treatment Facility
11/110 MH LTSR
11/111 MH Assertive Community Treatment (ACT)
11/123 MH Psychiatric Rehabilitation Services
11/128 D&A Intensive Outpatient Program
11/129 D&A Partial Hospitalization Drug Free
11/131 D&A Inpatient Non-Hospital Drug Free Halfway House
11/132 D&A Inpatient Non-Hospital Detoxification
11/133 D&A Inpatient Non-Hospital Short Term (end-date 06/30/2022)
11/134 D&A Inpatient Non-Hospital Long Term (end-date 06/30/2022)
11/184 D&A Outpatient Treatment in an Alternative Setting
11/185 D&A Non-Hosp Residential Clinically Managed
- ☐ DHS Certificate of Compliance for MH services or Department of Drug & Alcohol Program License for D&A services
- ☐ 11/128 (IOP) and 11/184 (D&A Outpatient Treatment in an Alternative Setting) must first be enrolled in PROMISe™ as an Outpatient Drug and Alcohol Clinic provider (08/184) prior to enrolling as an In Lieu Of or In Addition To Services Provider

11/110 MH Adult Outpatient Treatment in an Alternative Setting
- ☐ DHS Certificate of Compliance
- ☐ Field Office SSRC Approval Letter
- ☐ Service Description

11/111 MH Community Treatment Team (CTT)
- ☐ Field Office SSRC Approval Letter
- ☐ Service Description

11/112 MH Outpatient Practitioner
11/127 D&A Outpatient Practitioner
- ☐ Department of State License
- ☐ Department of Drug & Alcohol Program License and/or waiver letter (PS 127) whichever is applicable
- ☐ Fee Assignment Form for Group Members, if applicable

11/119 Community MH Services – Other
- ☐ DHS Certificate of Compliance or Department of State License, whichever is applicable
- ☐ Field Office SSRC Approval Letter
- ☐ Service Description

11/184 D&A Intervention
- ☐ Field Office Attestation Form
- ☐ Service Description

11/184 D&A Services – Other

- ☐ Department of Drug and Alcohol Program License or Service Description, as applicable
- ☐ Field Office SSRC Approval Letter

11/084 – Methadone Maintenance

- ☐ Department of Drug & Alcohol Program Certificate of Approval for Methadone
- ☐ Department of Drug & Alcohol Program License

11/186 – D&A Non-Hosp Residential Medically Monitored

- ☐ Department of Drug & Alcohol Program License for Inpatient Non-Hospital
- ☐ must be on DDAP ASAM Level 3.7 Aligned Facilities list located at https://www.ddap.pa.gov/Professionals/Documents/ASAM%20Page/ASAM%20update/ASAM%203.7%20Aligned%20Providers.pdf

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health In Lieu Of and In Addition To Services
Provider Enrollment Application Instructions

Effective May 1, 2022, OMAP will only accept the current version of the HealthChoices Behavioral Health In Lieu Of and In Addition To Services Provider Enrollment Application. If OMAP receives an outdated version of any enrollment application, the BH-MCO will be contacted to let them know the enrollment application will not be processed and will be shredded.

Please Note the following important information:

- Applications will be scanned – please do not staple;
- Instruction pages should not be returned;
- Retroactive enrollment dates will only be considered within 30 days of receipt of application;
- Applications must be completed in black ink;
- Handwritten information must be legible;
- Applications must be completed by the provider representative who has the authority to submit applications on behalf of the provider;
- The individual who signs/dates the enrollment application/agreement must be the individual who has the authority to assure all information is true and accurate and will be accountable for adhering to Department/OMHSAS requirements.
- No corrections/changes should be made to the data contained in the provider enrollment application ***except*** by the provider representative responsible for completing the application. If a mistake is made or a change is needed, the provider representative must complete, initial and date the changed page;
- Modified provider enrollment applications will not be accepted;
- An enrollment application must be completed for each service location being enrolled;
- Out-of-State providers must submit proof of participation in their State's Medicaid Program;
- The BH-MCO Attestation form must be completed in its entirety by the BH-MCO.

1. In Lieu Of and In Addition To Services:

Check the type of In Lieu Of or In Addition To service(s) for which you are applying. As noted, attach a copy of your License/Certificate of Compliance/Certificate of Licensure or your tailored In Lieu Of or In Addition To Service Description (SD) and the OMHSAS SSRC approval letter, as applicable

2. Action Requested:

Check "Initial Enrollment" if you are:

a. requesting enrollment as a new provider;

b. expanding your enrollment to include a new or additional specialty type for an In Lieu Of or In Addition To service;

c. requesting to open a new service location (including a satellite location)

Check "Revalidation" if this is to revalidate your enrollment. Please complete the entire application.

Check "Service Location Change" if:

a. you have an existing PROMISe™ service location and you have moved to a new physical location

Check “Fee Assignment” if you are:

a. Adding this provider to an existing provider group. Fee Assignment may only be made between “like provider types”. If enrollee is a Group, attach a copy of your Corporation Papers

3. Enrollee’s Name:

List the applicant’s name (individual practitioner, facility or group) and date of birth and gender (if applicant is an individual). If operating under a fictitious business/doing-business-as (dba) name, attach copy of recorded/stamped fictitious business name statement/permit.

4. Tax Identification Information (TIN):

Enter your Social Security Number

Enter your Federal Tax ID Number (FEIN). **A copy of the FEIN (TIN) label or document generated by the Federal IRS containing the name, and IRS number of the entity applying for enrollment must accompany this application. A W-9 form will not be accepted.**

Enter the legal name as shown on the FEIN, and the corresponding current address, telephone and fax numbers and contact information. **(Note: Do not list tax information of entity to which payment will be made if said entity is not the enrollee.)**

5. National Provider Identifier (NPI) #:

List your 10 digit NPI # and taxonomy(s). Include a copy of your NPPES confirmation letter verifying your NPI #.
NPI (pa.gov)

6. Business Type:

Check the appropriate box for your business type (check one box only). Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, as applicable.

7. License:

Enter the license number, issuing state, issue date, and expiration date, as applicable. A copy of your license is required for your application to be processed.

8. BH-MCO:

Identify the BH-MCO with the network in which participation will occur.

9. Counties You Are Approved to Serve:

List each county you are approved to serve.

10. Language:

Indicate if any staff member can communicate with patients in another language in addition to English

11. Building Accessibility:

Answer the questions relating to the Americans with Disabilities Act (ADA)

12. Confidential Information:

The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions. If "Yes" is answered to any of the questions, provide all applicable documentation as requested. Sign and date the form.

- 12a – If you are enrolling as an individual provider, complete this section. Do not complete 12b.
- 12b – If you are enrolling as a facility/agency, complete this section. Do not complete 12a.

13. Physical Service Location:

List the physical address where services will be provided. A Post Office Box is not a valid service location.

14. Mail To Information:

Indicate the address of where you want correspondence to be mailed. (e.g. notification of enrollment)

15. Pay To Information:

Indicate address of where payments will be sent. Payments will be initiated via the BH-MCO.

16. Home Office Information:

Indicate the entity's headquarters address.

17. Sign and date the application, print your name and list your telephone number. The signature should be that of the individual applying for enrollment, or someone able to represent the facility applying for enrollment. Use black ink.

Additional Required Forms: - *Forward completed application to the Behavioral Health Managed Care Organization (BH-MCO) with which you are affiliated.* Also include as applicable:

- One Department of Human Services (DHS) Outpatient Provider Agreement with original signature and current date.
- Copy of Department of Drug and Alcohol Program (DDAP) Certificate of Licensure, DDAP Certificate of Approval for Methadone, DHS Certificate of Compliance, Department of State (DOS) Licensure or a tailored service description, as applicable
- Copy of OMHSAS Field Office letter denoting SSRC approval of the tailored service description, as applicable.
- Verification of Tax ID name and number using the Department issued requirements.
- Individual practitioners enrolling with a FEIN, must still provide their SSN.
- Completed Ownership or Control Interest Forms, as applicable to the business type identified in question 6.

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
HealthChoices Behavioral Health In Lieu Of and In Addition To Services
Provider Enrollment Application

1. In Lieu Of and In Addition Services: Check the service(s) below for which you are applying. Attach a copy of the required document(s) as identified below.

Residential and Housing Support Services – DHS Certificate of Compliance

☐ Adult Residential Treatment Facility	PT/PS 11/110
☐ Adult Outpatient Treatment in an Alternative Setting	PT/PS 11/110
☐ Long Term Structured Residence	PT/PS 11/110

Rehabilitative & Day Treatment Program Services – DHS Certificate of Compliance

Psychiatric Rehabilitation ☐ Site Based ☐ Mobile ☐ Clubhouse	PT/PS 11/123

Outpatient - Drug & Alcohol – DDAP Certificate of Licensure

☐ Methadone Maintenance – + DDAP Certificate of Approval for Methadone	PT/PS 11/084
☐ D&A Intensive Outpatient (IOP)	PT/PS 11/128
☐ D&A Outpatient in an Alternative Setting	PT/PS 11/184

Drug & Alcohol Inpatient Non-Hospital – DDAP Certificate of Licensure

☐ Drug-Free Halfway	PT/PS 11/131
☐ Detoxification	PT/PS 11/132
☐ Drug-Free Residential, Short Term (to be end-dated 06/30/2022)	PT/PS 11/133
☐ Drug Free Residential, Long Term (to be end-dated 06/30/2022)	PT/PS 11/134
☐ D&A Non-Hospital Residential Clinically Managed	PT/PS 11/185
☐ D&A Non-Hospital Residential Medically Monitored + must be on DDAP ASAM Level 3.7 Aligned Facilities list	PT/PS 11/186

https://www.ddap.pa.gov/Professionals/Documents/ASAM%20Page/ASAM%20update/ASAM%203.7%20Aligned%20Providers.pdf

Drug & Alcohol Partial Hospitalization – DDAP Certificate of Licensure

☐ Drug-Free	PT/PS 11/129

Drug and Alcohol Behavioral Health

☐ D&A Outpatient Practitioner	DDAP Certificate of Licensure & DOS Licensure	PT/PS 11/127
☐ D&A Services – Other	Service Description (SD) and FO SSRC approval letter	PT/PS 11/184
☐ D&A Intervention	SD & Field Office Attestation	PT/PS 11/184
☐ D&A Level of Care Assessment	SD & Field Office Attestation	PT/PS 11/184
☐ D&A Intensive Case Management	SD & Field Office Attestation	PT/PS 21/138
☐ D&A Resource Coordination	SD & Field Office Attestation	PT/PS 21/138

Mental Health General

☐ BSU Diagnostic Assessment	SD & Field Office Attestation	PT/PS 11/110
☐ Community Treatment Teams	SD and FO SSRC approval letter	PT/PS 11/111
☐ Assertive Community Treatment (ACT)	DHS Certificate of Compliance	PT/PS 11/111
☐ MH Outpatient Practitioner	DOS Licensure	PT/PS 11/112
☐ Community MH Services, Other	SD and FO SSRC approval letter	PT/PS 11/119

2. Action Requested - Check Boxes That Apply:

☐ Initial Enrollment for ☐ Individual ☐ Facility ☐ Group

☐ Revalidation ☐ Individual ☐ Facility ☐ Group PROMISe™ ID _____

☐ Service Location Change (include Service Location Change Form to close old location)

☐ Fee Assignment – Add this provider to an existing provider group. You must complete the HealthChoices Behavioral Health In Lieu Of and In Addition Services Fee Assignment Form.

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3. Enter Name of Enrollee:

Facility Name:

_____

Or

Last Name: _____ First: _____ Middle: _____

Date of Birth: __ __ __ __/ __ __ /__ __ Ex: (yyyy/mm/dd) Gender: ☐ Male ☐ Female

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4. Tax Identification Information

Social Security Number: ___ ___ ___- ___ ___- ___ ___ ___ ___

OR

Federal Tax ID Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

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

****Individual practitioners enrolling with a FEIN, must still provide their SSN**

Legal Name (must be same as denoted on tax ID): _____

Address: _____

City: _____ County: _____ State: _____ Zip Code (9 digit) _____

Telephone: (__ __ __) __ __ __-__ __ __ __ Fax: (__ __ __) __ __ __-__ __ __ __

Contact Name/Title: _____ Contact e-mail: _____

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5. National Provider Identifier (NPI) #: __ __ __ __ __ __ __ __ __ __

*A copy of the NPPES confirmation letter must be attached

Taxonomy(s): (10 digits) __

__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

NPI (pa.gov)

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6. Business Type:

☐ Corporation ☐ Not-for-Profit ☐ Government Owned ☐ Partnership

☐ Estate/Trust ☐ Sole Proprietorship

(Include corporation papers or business partnership agreement, as applicable)

7. License #:_____ Issuing State:____ Issue Date:__/__/_____ Expiration Date:__/__/_____

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

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8. Behavioral Health Managed Care Organization (BH-MCO):

Identify the BH-MCO with the network in which participation will occur.

_____ _____ _____ _____

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9. Counties You Are Approved to Serve:

_____ _____ _____ _____

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10. In addition to English, do you or your staff communicate with patients in another language: Yes ☐ No ☐

If yes, list language(s): _____ _____ _____ _____

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11. 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 ☐

d) Does the office have an official exemption from the U.S. Department of Justice excusing compliance with Title III of the Americans with Disabilities ACT (ADA)? Yes ☐ No ☐

*If yes, attach a copy of the exemption to your application.

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12. CONFIDENTIAL INFORMATION

- 12a – If you are enrolling as an individual provider, complete this section. Do not complete 12b.
- 12b – If you are enrolling as a facility/agency, complete this section. Do not complete 12a.

12a. FOR INDIVIDUAL APPLICANTS

Please indicate whether any of the following situations apply:

A. Have you ever 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. Have you ever 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 <u>MUST</u> 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 conditions(s) that poses a risk of harm to your patients
- Explanation of drug or chemical substance use

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 health 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

If you answered "Yes" to any of the questions above, you <u>MUST</u> 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 and date of conviction
- Categorization of offense (e.g. felony, misdemeanor)
- Date license was surrendered or withdrawn (if applicable)

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

<u>Notice to Providers Seeking to Re-enroll:</u>

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

12b. FOR FACILITY/AGENCY

Has 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 answering "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 this application. Include the following information as applicable to the situation:

1. Name and title of individual
2. Name of federal or state health care program
3. Name of licensing/certifying agency taking the action
4. Date of action
5. Type of action taken
6. Length of action
7. Basis for action
8. Disposition/State
9. Date license was surrendered
10. Name of court
11. Date of conviction
12. Offense(s) convicted of
13. Sentence(s)
14. Categorization of offense (e.g., felony, misdemeanor)

This form requires the original signature of the authorized agent or representative of the provider.

_____ _____

Title Printed Name

_____ _____

Original Signature Date

13. **Physical Service Location:**

_____
Street (Note: List physical street address. A PO Box is not acceptable.)

_____ _____ _____
City State Zip (9 digit) County

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

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

14. **Mail To Information:**

_____
Street

_____ _____
City State Zip (9 digit) County

_____
Contact Name/Title

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

15. **Pay To Information:**

_____
Street

_____ _____
City State Zip (9 digit) County

_____
Contact Name/Title

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

16**. Home Office Information:**

_____
Street

_____ _____
City State Zip (9 digit) County

_____
Contact Name/Title

(__ __ __) __ __ __ - __ __ __ __ _____
Phone E-mail

17.

_____ _____ (____)_____ _____
Provider's Signature Printed Name Telephone Date

Commonwealth of Pennsylvania
Department of Human Services
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 the paragraph above and any information regarding payments claimed by the Provider for furnishing services under the Pennsylvania Medical Assistance Program.

4. To the extent applicable, the Provider agrees to comply with the advance directive requirements for hospitals, nursing facilities, Providers of home health care and personal care services and hospices as specified in 42 C.F.R. § 489, subpart I.

5. 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.

6. 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.

7. 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.

8. 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.

9. 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).

10. 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.

11. 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.

The Provider represents and warrants that the person signing this agreement is a duly authorized representative of the Provider and has the authority to enter into a legal, valid, and binding obligation on behalf of the Provider.

PROVIDER ELIGIBILITY AGREEMENT

I have reviewed the information in this enrollment application and affirm that the information submitted in or with this application is true, accurate and complete.

I understand that I am responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if I 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 my enrollment in the Pennsylvania Medical Assistance Program.

_____ _____

Provider - Original Signature Date

_____

Name – Please Type or Print

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health In Lieu Of and In Addition To Services
Fee Assignment Form for Group Members Instructions

Date: enter today's date

Group 13-Digit Provider ID: enter the 13-digit provider ID of the group you want to assign payment to

Group Name: enter the group name

Contact Name: enter a contact name that can be contacted for any questions related to this enrollment

Contact Phone: enter the phone number of the above contact person

This form can be used for up to five individual practitioners assigning payment to the same group. Each individual practitioner assigning payment must enter their printed name, 13-digit provider id number and effective date to be used for assigning payment to the group. The individual practitioner must also sign the form. Stamped signatures are not acceptable.

Commonwealth of Pennsylvania
Office of Mental Health and Substance Abuse Services
HealthChoices Behavioral Health In Lieu Of and In Addition To Services
Fee Assignment Form for Group Members

Date: _____

Group 13-Digit Provider ID: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Group Name: _____

Contact Name: _____

Contact Phone: (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Note: By signing, I am agreeing to assign my fees to the Group and Service Location, listed above.

1. _____ _____
Printed Name of Individual Provider Assigning Payment — Original Signature of Individual Provider Assigning Payments (No Stamp)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
13 Digit Individual Provider Number — Effective Date

2. _____ _____
Printed Name of Individual Provider Assigning Payment — Original Signature of Individual Provider Assigning Payments (No Stamp)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
13 Digit Individual Provider Number — Effective Date

3. _____ _____
Printed Name of Individual Provider Assigning Payment — Original Signature of Individual Provider Assigning Payments (No Stamp)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
13 Digit Individual Provider Number — Effective Date

4. _____ _____
Printed Name of Individual Provider Assigning Payment — Original Signature of Individual Provider Assigning Payments (No Stamp)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
13 Digit Individual Provider Number — Effective Date

5. _____ _____
Printed Name of Individual Provider Assigning Payment — Original Signature of Individual Provider Assigning Payments (No Stamp)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ _____
13 Digit Individual Provider Number — Effective Date