INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™ PROVIDER ENROLLMENT BASE 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 your State's Medicaid Program.

1. **Enter the complete name of Medical Supplier.**

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 name and SSN or FEIN must accompany your application. (i.e. SSN, W-2 or tax label).

2d. If this is a change of ownership with no change in the IRS number, complete the "Ownership or Control Interest" sheet.

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.dpw.state.pa.us/provider/doingbusinesswithdpw/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 Social Security Number**. A copy of your Social Security card, W-2, or document generated by the Federal IRS containing your Social Security Number must accompany your application. If completing #8, do not complete #9. Refer to the checklist for additional requirements.

9. **Enter your Tax Identification Number (TIN).** A copy of the 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. If completing #9, do not complete #8.

10. **Enter your legal name as it is filed with the IRS and as it appears on IRS generated documents..**

11a. **Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).**

11b. **Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.**

12a. **Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.**

12b. **If applicable, enter the statement/permit number and the name.** Attach a legible copy of the recorded/stamped fictitious business name statement/permit.

13. **Enter your date of birth.**

14. **Enter your gender.**

15. **Enter the title/degree you currently hold.**

16a. **Enter your IRS address. This address is where your 1099 tax documents will be sent.**

16b-f. **Enter the contact information for the IRS address.**

17. **Check the appropriate box for the business type of the individual or facility 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.**

18. **Enter your license number (if applicable), issuing state, issue date, and expiration date.**
*****A copy of your license must be included with the application.

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

20. **Enter your CMS number.**

*A copy of your CMS certification must be included with the application.

21a. **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 block #25 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 21a.

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

21b-c. **Answer question, if yes, enter your 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.**

21d. **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.

21e-h. **Enter contact information.**

21i. **Indicate whether you or your staff is able to communicate with patients in any language other than English.**

21j. **If applicable, list the additional languages in which you or your staff can communicate.**

21k. **Answer questions 1 through 4 pertaining to the Americans with Disabilities Act (ADA).**

21l. **Enter the appropriate Provider Eligibility Program(s) (PEP(s)).** Refer to the PEP Descriptions and the requirements for your provider type.

22. **Indicate whether you retain any managing employees or agents.**

****IF "yes" complete Attachment I. Form found here:**
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf

23a-e. **The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions, A through E.**

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. (Refer to the Confidential Information sheet).

23f. Include responses to 23F, 1 to 14, if you answered YES to any of the questions in 23A-E.

24. **Sign the application and print your name, title, and date** (The signature should be that of the individual applying for enrollment or someone able to represent the facility applying for enrollment). Use black ink.

25. **This page, beginning with block #25, may be used to add a mail-to, pay-to, and/or home office address to the** previously defined **service location address listed in 21a.** This sheet cannot be used to add a service location.

25a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.

25b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.

25c. Enter the e-mail address of the contact person for this address.

25d-g. Enter the contact information for this address.

- **Use page 13 to add additional service locations upon** the INITIAL ENROLLMENT OF AN INDIVIDUAL.
- Facilities must complete a new base application to add additional service locations to their file.
- The individual applying for enrollment or a representative of the facility applying for enrollment must complete the Provider Agreement included with the application.

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 mail to:

DPW Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program (PEP) code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to consumers of that program. Providers should use the following PEP codes when enrolling in PROMIS*e*™ and should use the descriptions in this document to determine which PEP code to use when enrolling in PROMIS*e*™.

Adult Autism Waiver—Contact Number: (866) 539-7689; Email: ra-odpautismwaiver@pa.gov ;
Website: http://www.dpw.state.pa.us/foradults/autismservices/adultautismwaiver/index.htm

The AAW is designed to help adults with an autism spectrum disorder participate in their communities in the way that they want to, based on their individual needs. It is a statewide home and community-based waiver. To become an AAW provider, contact the Bureau of Autism Services and an enrollment representative will reply by phone or by sending an electronic "Provider Packet." The packet includes necessary links, information and instructions on how to become an enrolled provider.

Aging Waiver – Contact Number: (717) 772-2570 or (800) 932-0939

Providers should enroll in the Aging Waiver if they would like to provide home- and community-based services to Nursing Facility Clinically Eligible (NFCE) individuals age 60 or over. Services provided in this PEP are personal care, respite, transportation, adult day care, durable medical equipment (DME) and supplies, environmental modifications, home health care, home delivered meals, personal emergency response services, counseling, and personal assistance services (attendant care).

AIDS Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Providers may enroll in the AIDS waiver to provide home- and community-based services to individuals 21 and older with AIDS or Symptomatic HIV Disease. Services provided are Home Health care, Homemaker, Nutritional Consultation and Supplements and Specialized Medical Equipment and Supplies. Providers in non-mandatory Managed Care Counties must be approved by the Waiver Enrollment Unit of the Bureau of Provider Support in the Office of Long Term Living. Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

Attendant Care Waiver/ Act 150 Program - Contact Number: (717) 772-2570 or (800) 932-0939

A Home and community based program developed for mentally-alert Pennsylvanians with physical disabilities. Services provided through the Attendant Care Waiver include:

- Attendant Care (Agency and Consumer Model), such as:
  - Assisting a person to get in and out of bed, wheelchair and/or motor vehicles
  - Assisting a person to perform routine bodily functions
  - Assistance with cognitive tasks including managing finances, planning activities, and making decisions
  - Companion-type services, including assistance with transportation, letter writing, reading mail, and escort
  - Financial Management Services
  - Homemaker type services, such as shopping, laundry, cleaning, and seasonal chores
- Personal Emergency Response System (Installation and Maintenance)
- Service Coordination

Providers in mandatory Managed Care Counties should apply to be a provider with the Managed Care entity in their area.

BHHC – Contact Number: (800) 433-4459
Assignment of BH HC reflects an enrollment in PROMISe to serve in-plan supplemental HealthChoices clients. This PEP is not considered an entitlement for funding from any MHMR Program, nor a guarantee of a definitive number of referrals.

COMMCARE Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

Home and community based program developed for individuals who experience a medically determinable diagnosis of traumatic brain injury (TBI). Services provided through the COMMCARE Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Community Integration
- Educational Services
- Financial Management Services
- Habilitation and Support
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistance Services
- Personal Emergency Response System (Installation and Maintenance)
- Prevocational Services
- Respite (Consumer or Agency Model)
- Service Coordination
- Structured Day Program
- Supported Employment
- Therapeutic & Counseling Services
- Transportation

Consolidated Waiver – (888) 565-9435

Home and Community-Based program developed for Pennsylvania residents age 3 and older with a medically determined diagnosis of mental retardation. The Consolidated Waiver is designed to provide services to eligible persons with mental retardation so that they can remain in the community

Fee-for-Service (FFS) - Contact Number: (800) 537-8862 – Option 1

A comprehensive set of Medical Assistance services which include reimbursement for direct inpatient and outpatient, physical health, and behavioral health services to consumers through components of the Medical Assistance Program. If you are trying to provide services under the Managed Care and/or FFS programs, you should select the FFS PEP.

If you are requesting enrollment to be a provider of a HealthChoices Supplemental Service(s) for Behavioral Health, contact the BH-MCO with which you will be doing business as this application is not applicable.

Healthy Beginnings Plus (HBP) - Contact Number: (717) 772-6127

Healthy Beginnings Plus (HBP) is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance, to have a positive prenatal care experience. HBP expands the scope of maternity services that can be reimbursed by the Medical Assistance Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the HBP program. Services covered by HBP include childbirth and parenting classes, nutritional and psychosocial counseling, smoking cessation counseling, home health services and other individualized client services. Please note: A separate HBP enrollment application must be completed to add this program to your eligibility.

Independence Waiver - Contact Number: (717) 772-2570 or (800) 932-0939

The Independence waiver provides services to persons with physical disabilities to allow them to live in the community and remain as independent as possible. Services provided through the Independence Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Adult Daily Living
- Community Integration
- Educational Services
- Financial Management Services
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistant Services
- Personal Emergency Response System (Installation and Maintenance)
- Respite Care
- Service Coordination
- Therapeutic & Counseling Services
- Transportation Services

Living Independently for Elders (LIFE) – Contact Number: (717) 772-2570 or (800) 932-0939

Providers should enroll as a provider under the Long Living Independently for Elders (LIFE) if they plan to provide long-term care services to Nursing Facility Clinically Eligible (NFCE) individuals age 55 or over. All providers in this PEP must be approved by the Division of LTC Client Services and have an existing agreement with the Department to provide services under the national Program of All-inclusive Care for the Elderly (PACE) model under either federal PACE provider Status or under Prepaid Health Plan Authority. The goal is to maintain individuals in the community, but services are also provided in institutional settings when appropriate. Providers manage and provide an all-inclusive package of services to enrolled recipients and are reimbursed a monthly capitation payment for services provided.

Mental Retardation Base Program (MR Base Program) - Contact Number: (888) 565-9435

The MR Base Program is a program that is designed for Pennsylvania residents of any age who have a medically determined diagnosis of mental retardation.

OBRA Waiver - Contact Number: **(717) 772-2570 or (800) 932-0939**

Services provided through the OBRA Waiver include:

- Accessibility Adaptations, Equipment, Tech & Med Supplies
- Adult Daily Living
- Community Integration
- Educational Services
- Financial Management Services
- Home Health (RN, LPN, Physical/Occupational/Speech Therapy)
- Personal Assistant Services
- Personal Emergency Response System (Installation and Maintenance)
- Prevocational Services
- Respite Care
- Service Coordination
- Supported Employment Services
- Therapeutic & Counseling Services
- Transportation Services

Person/family Directed Support Waiver (Per/Family Services) – Contact Number: (888) -565-9435

The Person/Family Directed Support Waiver is a Home and Community-Based waiver program that is designed for Pennsylvania residents age 3 and older with a medically determined diagnosis of Mental Retardation. This waiver is designed to prevent the institutionalization of individuals with mental retardation who do not require Office of Developmental Programs licensed community residential services and allows these individuals to remain in the community.

ATTENTION OMR PROVIDERS: Fax completed application to ODP @ 717-783-5141 or mail to: Office of Mental Retardation Room 413 Health and Welfare Building Harrisburg, PA 17101 Attn: Provider Enrollment

PROMISe™ PROVIDER ENROLLMENT BASE APPLICATION

1. Enter Name of Medical Supplier:

_____

2. Action Request: Check Boxes that Apply:

a. ☐ Initial Enrollment: ☐ Individual ☐ Facility

b. ☐ Check here if previously enrolled in Medical Assistance (MA).
Enter Provider Number (if known): ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ **(13 digits)**
(Complete the application as an initial enrollment.)

c. ☐ Name Change: (Name change only. Must match IRS generated documentation.)

Old Name: _____

New Name: _____

d. ☐ Change of Ownership
☐ **NO** change in IRS number (Complete the "Ownership or Control Interest" form.)
☐ **Change** in IRS number (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. Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___
*** A copy of a document generated by the Federal IRS with your name and SSN must accompany this application.**

9. Federal Tax ID Number: **(If #8 is completed, DO NOT** complete this item.)
___ ___ ___ ___ ___ ___ ___ ___ ___ **(9 digits)**
***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application.**

10. Legal Name Shown on Attached Document:

11a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?

☐ Yes ☐ No

11b. If so, list the MCO(s):

_____

_____

12a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?

☐ Yes ☐ No

12b. 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.**

13. Date of Birth: yyyy / mm / dd (2004/07/31)	14. Gender:	15. Title/Degree as it appears on license:
__ __ __ __ /__ __ /__ __	Male ☐ Female ☐	

16a. IRS Address: **Note**: This is the address where your 1099 tax document will be sent.

Street: _____ Room/Suite:_____

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

County:_____

16b. Contact Name/Title:	16c. Contact E-Mail Address:
Name: _____ Title: _____	

16d. Contact Phone:	16e. Contact Toll-Free Phone:	16f. Contact Fax Number:
( )	( )	( )

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

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

18.

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

c. Issue Date: _____ d. Expiration Date: _____

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

19. Drug Enforcement Agency (DEA) Number: _____

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

20. CMS Certification number: _____

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

Note: NEW individual providers only- To add additional service locations upon INITIAL enrollment only, refer to page 13. Copy as needed and fill out for each service location you wish to add.

21a. 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: ( ) _____ - _____

Is this address an active Rural Health Clinic or FQHC? ☐ **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 #25.

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

21b. 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.dpw.state.pa.us/publications/bulletinsearch/index.htm OR by signing up to receive notification of new MABs through the Listserv option on the DPW website: http://www.dpw.state.pa.us/provider/index.htm (select 'eBulletins' Listserv option to join).

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

21c 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.

21d. Check this block only if you wish your Medicare claims to crossover to this service location. ☐

21e. Contact Name: _____ Contact Phone: _____

Title: _____

21f. Contact Toll-Free Phone:	21g. Contact Fax Number:	21h. Contact E-Mail address:
( )	( )	

21i. In addition to English do you or your staff communicate with patients in another language?	21j. If "Yes", list language(s):
Yes ☐ No ☐	_____ _____

21k. (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 ☐

(4) 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)? If yes, attach a copy of the exemption to your application.

Yes ☐ No ☐

21l. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

22. Does the provider retain any managing employees or agents? ☐ **Yes *** ☐ **No**

IF "YES" please complete Attachment I (Managing Employee or Agent Disclosure Form) this form can be found on the enrollment website or by following this link:
http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf

23. **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

23F.

If you answered "Yes" to any of the questions listed above, you <u>MUST</u> 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 (e.g. felony, misdemeanor)

24. This form requires the original signature of the individual applying for enrollment.

_____ _____

Title Printed Name

_____ _____

Original Signature Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 21a

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

25 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: ( )

Note: NEW individual providers only- To add additional service locations upon INITIAL enrollment copy this page as needed and fill out for each service location you wish to add.

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: ( ) _____ - _____

Is this address an active Rural Health Clinic or FQHC? ☐ **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 #25.

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(s) from the service location on page 1, block 3 please provide the taxonomy(s) for this particular service location:
Taxonomy(s): _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _ (10 digits) _ _ _ _ _ _ _ _ _ _(10 digits)

6. 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.

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

8. Contact Name: _____ Contact Phone: _____

Title: _____

9. Contact Toll-Free Phone:
( )

10. Contact Fax Number:
( )

11. Contact E-Mail address:

12. (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 ☐
(4) 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)? If yes, attach a copy of the exemption to your application.
Yes ☐ No ☐

13. Provider Eligibility Program (PEP). Refer to PEP descriptions included in the instructions. **You must choose at least 1 PEP:**

a. _____ b. _____ c. _____

Provider Agreement for Pharmacy and Medical Suppliers

This Agreement, made by and between the Department of Public Welfare (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:

I. **PROVIDER RESPONSIBILITIES**

A. The Provider agrees to participate in the Pennsylvania Medical Assistance Program (the "Program"), and in the course of such participation to comply with all federal and Pennsylvania laws generally and specifically governing participation in the Program. The foregoing include but are not limited to: 42 U.S.C. § 1396 et seq., 62 P.S. §§441-451, 42 C.F.R. §§431-481 and the regulations adopted by the Department of Public Welfare (the "Department"). The Provider agrees to be knowledgeable of and to comply with applicable rules, regulations, rates and fee schedules promulgated under such laws and any amendments thereto.

B. The submission by or on behalf of the Provider of any claim for payment under this Program shall constitute certification by the Provider that:

1. the services or items for which payment is claimed were actually provided by the Provider to the person identified as the Recipient; and

2. the claim does not exceed the Provider's usual charge for the same items or equivalent services provided to persons who are not Medical Assistance recipients.

C. The Provider agrees to maintain all records necessary to disclose the extent of services the Provider furnishes to recipients.

D. The Provider agrees to furnish the Department of Public Welfare, the Department of Health and Human Services and the Medicaid Fraud Control Unit with any information it may request regarding payments claimed by the Provider for furnishing services.

E. The Provider agrees to furnish the Department of Public Welfare, the Department of Health and Human Services and the Medicaid Fraud Control Unit within thirty-five (35) days of request, information related to business transactions which shall include full and complete information about:

1. 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

2. any significant business transactions between the Provider and any supplier wholly owned by the Provider, or between the Provider and any subcontractor of the Provider, during the five-year period ending on the date of the request.

F. The Provider represents that the information submitted in or with the application for enrollment to participate in the Medical Assistance Program and from which this contract ensued is true, accurate and complete. The Provider agrees further that such representation shall be a continuing one and that

the Provider shall notify the Department, in writing, within fifteen (15) days of its occurrence, of any fact which arises or is discovered subsequent to the date of the application which affects the truth, accuracy or completeness of such representation.

G. The Provider agrees to comply with the Commonwealth's Contract Compliance Regulations as set forth at 16 Pa. Code §49.101.

H. This Agreement is specific to the Provider and may not be assigned by the Provider without prior written approval by the Department.

I. The Provider recognizes that in actual economic practice, overcharges by its suppliers, manufacturers and suppliers to manufacturers resulting from violations of state or federal antitrust laws are, in fact, borne by the Commonwealth of Pennsylvania. The Provider assigns, and shall require its suppliers, manufacturers and suppliers to manufacture to assign, to the Commonwealth of Pennsylvania all rights, title, and interest in and to any claim the Provider, its suppliers, the manufacturers or suppliers to manufacturers now have or may hereafter acquire under state or federal antitrust laws relating to products which are subject to this contract.

II. DEPARTMENT'S RESPONSIBILITIES

A. The Department agrees to reimburse the Provider in accordance with all applicable federal and state statutes and regulations for services covered under the Pennsylvania Medical Assistance Program which are rendered to Medical Assistance eligible individuals.

B. The Department will adjust payment to the Provider for the amount of any disapproved cost or expenditure in connection with this Agreement.

C. The Department shall make a good faith effort to mail to all providers, no less than five (5) days before implementation, all final regulations and bulletins.

D. The Department shall provide to the Pharmacy Subcommittee copies of all final drafts of proposed rules and regulations before such proposed regulations are published so that pharmacies have a sufficient time to comment on them before publication.

III. EFFECTIVE DATE AND TERM OF AGREEMENT

The Provider must sign and submit copies of this Agreement to the Department. The Department in turn will sign and return one copy to the Provider, thus indicating official enrollment in the Program. The effective date of this Agreement shall be the date on which it is signed by the Department. This Agreement shall remain in effect until terminated by either party. Termination of this Agreement shall not relieve the Provider of his/her obligation to retain records and make restitution of overpayments for services or items furnished prior to termination.

IV. **TERMINATION OF AGREEMENT**

A. This Agreement may be terminated by either party upon thirty (30) days advance written notice to the other party.

B. In the event a Provider is terminated or suspended for cause from the program and such termination or suspension shall have been determined to have been done without just cause, then the Provider shall be reimbursed for all services rendered during the period of the unjust termination or suspension, so long as the Provider complied with all rules and regulations during the period of termination or suspension.

V. **DISPUTES**

All questions or disputes arising between the parties hereto respecting payment pursuant to this Agreement shall be referred to the Bureau of Hearings and Appeals of the Department for adjudication.

_____ _____

Provider **(Date)**
(Owner or Authorized Agent)
(Original Signature)

_____

(Name – Please Type or Print)

PROVIDER ELIGIBILITY AGREEMENT

In consideration of the use of the eligibility transactions, I/we agree to the following:

I/we will not use or disclose any information provided under this agreement except as may be necessary to fulfill our responsibilities under this agreement. We will ensure that each person authorized to access the Department's eligibility database signs the operator agreement attached or on the reverse of this form and we will not permit any other persons except those expressly authorized by us to have access to this data. We agree that we do not act and we will not be deemed to act as agents, officers, or employees of the Department. We shall indemnify, save harmless, and defend the Department against all claims which may arise from acts of omission on our part or on the part of our employees or agents relating to this agreement. We agree to obtain, install, and maintain, at our expense, any terminals, data connections, communication circuits, and related workstation equipment which are compatible and are used to access the Department's data communication network. We will provide at our expense adequate electrical power, space, environment, and furniture for all data network components. We agree to provide the Department and its authorized representatives access to our workstation(s) during our normal business hours. We agree that we are responsible for all recurring monthly telecommunications costs associated with access to the Department's eligibility database.

Specialty Code

Please choose from the following for specialty and code:

250- Medical Supplies	252- Orthotist	220- Hearing Aid Dispenser
251- Prosthetist	253- Optician	

Provider Eligibility Program (PEPs)

Please choose one or more of the following PEP(s):

- Fee-for-Service
- Adult Autism Waiver
- OBRA- See PEP descriptions (Included with instructions) for additional requirements.
- Independence Waiver- See PEP descriptions (Included with instructions) for additional requirements.
- COMMCARE Waiver- See PEP descriptions (Included with instructions) for additional requirements.
- Michael Dallas Waiver- See PEP descriptions (Included with instructions) for additional requirements.
- AIDS Waiver- See PEP descriptions (Included with instructions) for additional requirements.
- Pennsylvania Department of Aging Waiver and Bridge Program- See PEP descriptions (Included with instructions) for additional requirements.

Additional Required Documents For Provider Type 25

The following documents and supporting information are required by the Bureau of Fee-for-Service Programs for enrollment:

- Provider Enrollment Base Application.
- **You MUST complete the Provider Disclosure/Ownership or Control interest form. This form can be found on the enrollment website or by following this link:** http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf
- Signed Pharmacy and Medical Supplier Provider Agreement.
- Ownership and Control Interest Form.
- Document generated by the Federal IRS showing Name and Tax ID number.
- Copy of the NPPES Confirmation letter that shows the NPI Number(s) and Taxonomy(s) assigned to the Medical Supplier applying for enrollment.
- Copy of certificate of registration from Department of Health
- Copy of DEA Certificate.
- Proof of home state Medicaid participation (out of state DME suppliers only).

Submittal Address

After completion of all enrollment documents, send the complete package to:

DPW – Provider Enrollment Unit
P.O. Box 8045
Harrisburg, PA 17105-8045

Provider Enrollment Base Application Checklist

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.

Please remember applications will be scanned - 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.
- ❑ **Complete the Provider Disclosure/Ownership or Control interest form; found here: http://www.dpw.state.pa.us/ucmprd/groups/webcontent/documents/form/p_011861.pdf**
- ❑ 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 a copy of your **Social Security card, W-2 or any document generated by the Federal IRS** showing your name and SS number. If the Social Security card states "Valid for work only with INS authorization", please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- ❑ 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
  - ❑ 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 your **DEA certificate**, if applicable.
- ❑ Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the entity applying for enrollment.
- ❑ Enter **at least 1** Provider Eligibility Program (PEP).
- ❑ Show proof of home state Medicaid participation (out of state providers only).
- ❑ Only the **person applying for enrollment or a representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement. Signature stamp not accepted.**

When completed, review the "Did You Remember…" Checklist included with the application.

Then 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:

DPW Enrollment Unit PO Box 8045 Harrisburg, PA 17105-8045