**GA DEPT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**

# Provider Enrollment Application Instructions

## A. Applicant: *Use this application if you do not have an existing Georgia Medicaid provider number.*

1. If the applicant is an individual practitioner, give the applicant's name. The practice name is optional. If you complete section 1, you will need to skip sections 2a and 2b.

2a. If the applicant is not an individual practitioner, give the business name. The "legal business name" is required. The "doing business as" name is optional. If you complete section 2, you should not have completed section 1. Facility Type valid values:

| | | | | | |
|---|---|---|---|---|---|
| 0 | Government | 1 | Non-profit or Religious | 2 | Sole Proprietorship |
| 3 | Investor Owned | 4 | Public | 5 | Private - For Profit |
| 6 | Private - Not for Profit | 8 | Not Applicable | 9 | Other |

3. This "Office Manager" information is required in order to obtain a web portal user id for members of your office staff.

## B. Address Information:

1. The Office (Physical) Address is required for all providers. This is the street address from where you intend to provide services to Medicaid and/or PeachCare for Kids members. **Post office boxes are not allowed**.

2. The Mailing Address is optional. Use this field if you receive postal mail at an address other than the address provided above. Post office boxes are allowed.

3. The Pay-to Address is the address where you would like remittance advices, and other payment information, sent. This address is obtained from the W-9 form that you are required to submit.

## C. Detailed Information:

1. This section should **only** be filled out by individual practitioners (those applicants that completed section A1 above).
   a. Social security number is required.
   b. Date of birth is required.
   c. If you are applying to be a Georgia Better Health Care primary care physician, you are required to have either hospital admitting privileges or a formal arrangement with a physician who has hospital admitting privileges. This information should be provided on the GBHC Addendum. For all other applicants, this information is optional.

2. This information is required of applicants attempting to participate in the following categories of service: Hospital (010, 070), Swing-beds (080), Nursing Homes (110, 140, 150, 160, 170, 180).

3. This section may apply to all applicants.
   a. This number is assigned by the Internal Revenue Service and should match the number provided on the W-9.
   b. Enter the National Provider Identification number (if applicable)
   c. Enter the Georgia Medicaid Payee Provider I.D. # associated with the practice, electronic funds transfer information and remit medium. Leave blank if a Payee Provider # has not been established.
   d. Provide Medicare participation information. Your Medicare information **must** be on file if you wish to receive Medicare crossover payments.
   e. Provide information regarding participation in other state's Medicaid programs.
   f. Indicate any languages that are spoken at the practice location. Place a check in the box next to the primary language.

| | | | | | |
|---|---|---|---|---|---|
| BA | Bangla | CC | Cambodian/Campuchean | CH | Chinese (Mandarin) |
| CZ | Czech | EN | English | FA | Farsi |
| FP | Filipino | FR | French | GE | German |
| HI | Hindi | IN | Indian | IT | Italian |

| | | | | | |
|---|---|---|---|---|---|
| JA | Japanese | KO | Korean | LA | Laotian |
| NA | Navajo | PO | Portuguese | RU | Russian |
| SA | Slavic | SL | American Sign Language | SP | Spanish |
| SW | Swahili | TA | Taiwanese | TU | Turkish |
| VN | Vietnamese | ZZ | Other | | |

g. Special needs valid values:

| | | | | | |
|---|---|---|---|---|---|
| AD | Attention Disorders | AL | Allergic Disease | AR | Arthritis |
| AS | Asthma | CD | Cardiology | CR | Counseling Referral |
| DB | Diabetes | DI | Dialysis | EK | Electrocardiogram |
| EN | Endoscopy | ES | Emergency Services | FP | Family Planning |
| GE | Geriatric | GI | Gastro | HI | HIV/AIDS |
| HM | Holter Monitor | HY | Hypertension | LA | Laboratory |
| LS | Laser Surgery | MW | Mid-Wifery | NS | Norplant |
| OB | OB/GYN | OS | Office Surgery | UR | Urology |
| OX | Office X-Ray | PA | Physical Accessibility | PD | Pediatrics |
| PF | Pulmonary Function Test | PM | Pain Management | RH | Rheumatology |
| RT | Respiratory Therapy | SU | Surgery | TE | Telemedicine |
| TL | Telegu | OT | Other Special Needs | | |

h. Attach a copy of proof of liability insurance. Required for participation in Durable Medical Equipment (320), Orthotics and Prosthetics/Hearing Services (330), Ambulance Services (370, 371), and Georgia Better Health Care (850).

## D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type valid values:

| | | | |
|---|---|---|---|
| 100 | Behavioral Health & Social Ser | 110 | Chiropractors (Medicare Only) |
| 120 | Dentist Service Providers | 130 | Dietary and Nutritional Service |
| 140 | Emergency Medical Service Provider | 150 | Eye and Vision Providers |
| 160 | Nursing Services | 170 | Other Service Providers |
| 180 | Pharmacy | 200 | Physicians / Osteopaths |
| 210 | Podiatrists | 220 | Respiratory, Rehab, & Restoration |
| 230 | Speech, Language, & Hearing Se | 240 | Technologists, & Technicians |
| 250 | Agencies | 251 | Public Health Agencies |
| 260 | Ambulatory | 270 | Hospital Units |
| 280 | Hospital | 290 | Laboratories |
| 300 | Managed Care Organizations | 310 | Nursing Facilities |
| 320 | Residential Treatment Facilities | 330 | Medical Supplier |
| 340 | Transportation | 360 | Nurse Practitioners / Physician |
| 370 | Nursing Related Services | 380 | Home and Community Based Services |

2. Practice Type valid values:

| | | | | | |
|---|---|---|---|---|---|
| C | Corporation | G | Group Practice (Private) | H | Hospital Based Physician |
| I | Individual Practitioner | L | Public Clinics | M | Health Maintenance Org |
| T | Teaching Provider | R | Pre-Paid Group Practice Plan | P | Partnership / Professional Assoc |
| N | Not Applicable | O | Other | | |

3. Categories of Service valid values:

| | | | |
|---|---|---|---|
| 740 | Advanced Nurse Practitioners | 660 | Independent Care Waiver Services |
| 670 | Ambulatory Surg / Birthing Center | 230 | Independent Laboratory |
| 910 | Childbirth Education Program | 820 | Licensed Clinical Social Worker - Medicare Only |
| 960 | Children's Intervention, School Based | 680 | Mental Retardation Waiver Program |
| 840 | Children's Intervention Services | 480 | Nurse Midwifery |
| 560 | Chiropractics - Medicare Only | 170 | Nursing Facilities, Int Care-Stated Owned-MR |
| 590 | Community Care Services | 180 | Nursing Facility, Int Care for MR |
| 681 | Community Habilitation and Support | 160 | Nursing Facilities, Intermediate Care |
| 440 | Community Mental Health Services | 150 | Nursing Facility, Intermediate Care-State Owned |
| 460 | Dental Program – Adult | 110 | Nursing Facilities, Skilled Care |
| 450 | Dental Program - under 21 | 140 | Nursing Facility, Skilled Care - State Owned |
| 790 | Diagnostic Screening and Prevention (Health Depts. Only) | 490 | Oral Maxillofacial Surgery (Dentists Only) |
| 721 | Dialysis Services – Professional | 330 | Orthotics & Prosthetics / Hearing Services |
| 720 | Dialysis Services – Technical | 761 | Perinatal Targeted Case Mgt |
| 320 | Durable Medical Equipment | 300 | Pharmacies |
| 800 | Early Intervention Case Mgmt | 410 | Physical Therapy - Medicare Only |
| 970 | GAPP- Case Management | 430 | Physician Services |
| 971 | GAPP – In-Home Private Duty Nursing | 431 | Physician's Assistant Services |
| 972 | GAPP-Medically Fragile Daycare | 550 | Podiatry - Medicare Only |
| 371 | Emergency Air Ambulance | 730 | Pregnancy Related Services |
| 370 | Emergency Ground Ambulance | 570 | Psychological Services (Psychologists) |
| 270 | Family Planning Services | 420 | Rehabilitation Therapy – Medicare Only |
| 850 | Georgia Better Health Care | 540 | Rural Health Clinic, Federally Qualified |

600 Health Check Services
200 Home Health Services (Agency)
690 Hospice
010 Hospital – Inpatient (Facility)
070 Hospital – Outpatient (Facility)
080 Hospital - Swing-bed (Facility)
542 Rural Health Clinic, Free Standing
541 Rural Health Clinic, Hospital-based
930 SOURCE
400 Speech Therapy - Medicare Only
762 Targeted Case Management for Adults with AIDS
870 Therapeutic Residential Intervention Svc
470 Vision Care

4. Group Code valid values:

| | | | |
|---|---|---|---|
| G | Group Owner Only | I | Individual |
| M | Group Member | O | Group Owner / Member |
| N | None | | |

5. Specialty Codes valid values:
Please see attached list

## E. License and Certification Information:

1. License information may be required based on the Category of Service for which you are applying.

2. Were you ever licensed in another state?

3. Certification information may be required based on the Category of Service for which you are applying.

4. Clinical Laboratory Improvement Amendment certification is required if you will bill laboratory procedure codes at this location.

5. Pharmacies are required to provide Drug Enforcement Agency permit information. Physicians who possess DEA permits are also required to provide this information.

6. Pharmacy applicants are required to provide this information. Pharmacy Class Code valid values:

| | | | |
|---|---|---|---|
| A | Retail Chain Pharmacy | R | Retail Pharmacy |
| H | Hospital Pharmacy | C | Clinic Pharmacy |

## F. Exclusion / Sanction Information:

1-4. Please provide accurate information regarding previous and current exclusions and sanctions.

## G. Correspondence Medium Information:

1. Receiving letters (including rosters, if applicable) by paper is ONLY available to individuals who are not capable of receiving information in an electronic format.

2. Receiving bulletins by paper is ONLY available to individuals who are not capable of receiving information in an electronic format.

3. Receiving remittance advices by paper is ONLY available to individuals who are not capable of receiving information in an electronic format. The x12-835 option requires that you have a contract with a clearinghouse.

4. Submitting point-of-sale claims is ONLY allowed for pharmacy providers.

## H. Signatures and Contact Information:

1. Please provide contact information for the person who will be able to answer questions regarding this application.

2. Applications for individual practitioners must be signed by the applicant. Facility applications should be signed by the administrator.

## Provider Enrollment Application Instructions – D5

Specialty Codes valid values

| | | | | | |
|---|---|---|---|---|---|
| 001 | Acupuncture Medicine | 002 | Addictionologist | 003 | Administrative Medicine |
| 004 | Adolescent Medicine | 005 | Adult Day Health Care | 006 | Aerospace Medicine |
| 008 | Allergy | 009 | Allergy and Immunology | 010 | Alternative Living Services |
| 011 | Ambulance Company, Licensed | 012 | Ambulance Company, non-license | 013 | Ambulatory Surgery |
| 014 | Anatomic Pathology | 015 | Anesthesiology | 016 | Anesthesiology Critical Care M |
| 017 | Athletic Trainer, Certified | 018 | Audiologist | 019 | Audiology Services |
| 020 | Aviation Medicine | 021 | Behavioral Mgmt Svcs, Pediatri | 022 | Birthing Center |
| 024 | Broncho-Esophogology | 025 | Cardiac Electrophysiology | 027 | Cardiology |
| 028 | Cardiovascular Disease | 029 | Cardiovascular Surgery | 030 | Case Management |
| 031 | Cert Registered Nurse Anesthet | 033 | Child Birth Education | 034 | Chiropractics Examiner |
| 038 | Clinical Pharmacology | 039 | Colon and Rectal Surgery | 040 | Community Health Centers |
| 041 | Counselor, Professional | 042 | Critical Care Medicine | 043 | Cytopathology |
| 044 | Day Habilitation | 045 | Day Treatment Services | 046 | Dedicated Case Management |
| 047 | Dentistry, General Practice | 048 | Dermatology | 049 | Dermatopathology |
| 050 | Dermatology Immunology / Diag | 051 | Diabetes | 054 | Diagnostic Radiology |
| 055 | Dialysis, Professional | 056 | Dialysis, Technical | 057 | Disproportionate Share Hospita |
| 058 | Durable Medical Equipment Supp | 059 | Ear, Nose, Throat | 060 | Early Intervention, Agency |
| 061 | Early Intervention, Individual | 062 | Emergency Medicine | 063 | Emergency Treatment Facility |
| 064 | Emergency Response System | 065 | Endocrinology | 066 | Endodontics |
| 067 | Environmental Modifications | 069 | Eye, Ear Nose, Throat | 071 | Family Planning |
| 072 | Family Practice | 073 | Family Practice Geriatric Medi | 074 | Gastroenterology |
| 075 | General Practice | 076 | General Surgery | 077 | Geriatrics |
| 078 | Geriatric Psychiatry | 079 | Clinic or other Group Practice | 080 | Gynecology |
| 081 | Hand Surgery | 082 | Health Check, Health Dept | 083 | Health Check, Other |
| 084 | Hematology | 085 | Hematology/Oncology | 086 | Home Delivered Meals |
| 087 | Home Delivered Services | 088 | Home Health Agency | 090 | Hospice Facility |
| 091 | Hospital, Regular General | 092 | Hospital, Military | 093 | Hospital, Psychiatric, Freesta |
| 094 | Hospital, Specialized Long Ter | 095 | Hyperbaric Facility, Freestand | 097 | Immunology |
| 098 | Immunopathology | 099 | Independent Lab | 100 | Infectious Diseases |
| 102 | Internal Medicine | 103 | Internal Medicine Critical Car | 105 | Laryngology |
| 107 | Licensed Clinical Social Worke | 108 | Licensed Dietician | 111 | Maternal and Fetal Medicine |
| 112 | Maxillo-Facial Surgery | 115 | Medical Toxicology | 117 | Migrant Health |
| 118 | Molecular Genetics, Clinical | 119 | Neonatology | 120 | Neonat-Perinatal Medicine |
| 121 | Neopathology | 122 | Neoplastic Oncology | 123 | Nephrology |
| 124 | Neurology | 125 | Neurological Surgery | 126 | Neuro-Opthalmology |
| 127 | Neuropathology | 128 | Neuropsychology, Clinical | 129 | Neurophysiology, Clinical |
| 130 | Neuroradiology | 133 | Nuclear Cardiology | 134 | Nuclear Medicine |
| 135 | Nuclear Radiology | 136 | Nurse Midwife, Contracted | 137 | Nurse Midwife, Non-Contracted |
| 138 | Nurse Practitioner, Adult | 139 | Nurse Pract, Family Health | 140 | Nurse Practitioner, General |
| 141 | Nurse Practitioner, Geriatric | 142 | Nurse Practitioner, OB/GYN | 143 | Nurse Practitioner, Pediatric |
| 144 | Nursing Home / Domiciliary Fac | 145 | Nutrition | 146 | Obstetrics |
| 147 | Obstetrics & Gynecology | 148 | Obs & Gynecology Crit Care | 149 | Occupational Medicine |
| 151 | Occupational Therapy | 152 | Ocularists | 153 | Oncology |
| 154 | Ophthalmology | 155 | Optometry | 156 | Oral Maxillofacial Surgery |
| 157 | Oral Surgery | 159 | Orthodontics | 160 | Orthodontic Prosthetics, Non A |
| 161 | Orthopedic Surgery | 162 | Orthopedic Hand Surgery | 163 | Orthotists |
| 164 | Osteopathy | 165 | Otolaryngology | 166 | Otology, Laryngology, Rhinolog |
| 167 | Pain Management | 168 | Pathology | 170 | Pediatrics |
| 171 | Pediatric Allergy | 172 | Pediatric Cardiology | 173 | Pediatric Developmental & Beha |
| 175 | Pediatric Emergency Medicine | 176 | Pediatric Endocrinology | 177 | Pediatric Gastroenterology |
| 178 | Pediatric Hematology-Oncology | 179 | Pediatric Infectious Disease | 180 | Pediatric Internal Medicine |
| 181 | Pediatric Nephrology | 182 | Pediatric Neurology | 183 | Pediatric Neurosurgery |
| 184 | Pediatric Pathology | 185 | Pediatric Pulmonology | 186 | Pediatric Rheumatology |
| 187 | Pediatric Sports and Fitness M | 188 | Pediatric Surgery | 189 | Pediatric Ophthalmology |
| 190 | Pediatric Orthopedics | 191 | Pediatric Otol, Laryng, Rhin | 192 | Pediatric Urology |
| 193 | Pedodontics | 194 | Perinatology | 195 | Periodontics |
| 196 | Periph Vascular Disease | 197 | Personal Support | 198 | Pharmacy |
| 199 | Pharmacy Supplies | 200 | Physical Medicine Rehab | 201 | Physical Therapist |
| 203 | Physician Assistant | 204 | Physician Assistant, Anesthesi | 205 | Plastic Surgery |
| 206 | Plastic Surgery Hand Surgery | 207 | Podiatry | 208 | Practical Nurse, Licensed |
| 209 | Pregnancy Related Services | 210 | Pregnant Substance Abuse Day T | 211 | Preventative Medicine |
| 212 | Proctology | 213 | Professional Nurse | 214 | Prosthetists |
| 215 | Prosthodontics | 218 | Psychiatric Nurse | 219 | Psychiatric Social Worker |
| 220 | Psychiatry, Board Certified | 221 | Psychiatry, Child/Adol | 222 | Psychology |
| 223 | Public Health | 224 | Public Health Dentistry | 225 | Pulmonary Medicine |
| 227 | Radiation Oncology | 228 | Radiation Therapy | 229 | Radioisopic Pathology |
| 230 | Radioisotopic Pathology | 232 | Radiology | 234 | Registered Nurse |
| 236 | Rehab Services, DSPS | 239 | Rehabilitation Medicine | 240 | Renal Dialysis Center |
| 241 | Reproductive Endocrinology | 242 | Residential Modification Servi | 243 | Respite Care, In Home |
| 244 | Respite Care, Out of Home | 245 | Rheumatology | 246 | Rural Health |
| 247 | School Nurse | 248 | Skilled Nursing / Extended Car | 249 | Skilled Nurse Services |

| | | | | | |
|---|---|---|---|---|---|
| 251 | Speech-Language Pathology | 252 | Speech Therapy | 253 | Sports Medicine |
| 254 | Internal Sports Medicine | 255 | Substance Abuse Treatment Faci | 256 | Surgical Oncology |
| 257 | Surgery | 258 | Surgery, Critical Care | 259 | Supported Employment |
| 260 | Swingbed Hospital | 261 | Targeted Case Management | 262 | Therapeutic Radiology |
| 263 | Thoracic Surgery | 264 | Transplant Surgery | 265 | Transplant Surgery, Liver |
| 266 | Traumatic Brain Injury | 268 | Urology | 269 | Vascular Surgery |
| 272 | Residential Training and Super | 273 | Medical Supplies | 274 | Institutional Based |
| 275 | Vehicle Adaptation | 276 | Day Support Services | 278 | Presumptive Eligibility |
| 279 | Pediatric Plastic Surgery | 280 | Pediatric Dermatology | 281 | Pediatric Ear, Nose, Throat |
| 282 | Pediatric Interventional Radiology | 283 | Pediatric Medical Toxicology | 284 | Pediatric Neurodevelopment |
| 285 | Pediatric Rehab Medicine | 286 | Pediatric Radiology | 289 | Behavioral Management |
| 290 | Interventional Radiology | 291 | Hospice Based Physicians | 294 | Natural Support Enhancement |
| 295 | Natural Support Therapy | | | | |

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**
**PROVIDER ENROLLMENT APPLICATION**

## A. Applicant:

### 1. Individual Practitioners ONLY

First M.I. Last Suffix (Jr, III, etc.) Title (MD, RN, etc)

Name of your practice (if applicable): _____

### 2a. Facility/Agency ONLY: (Must be Signed by the Administrator)

Legal Business Name

"Doing Business As" Name

Type of Facility (see instructions for list of valid values.) State Where Incorporated

**2b.** Does this organization operate other sites, locations or units? No; Yes
Where: _____

**3.** Office Manager Information:

Name

Email Address Social Security Number Date of Birth

POA ID#:(if available) _____

## B. Address Information:

### 1. Office (Physical) Address:

Street Address **(P.O. Box Not Acceptable)** Suite No.

City County State Zip Code (+ 4)

(_____)_____ (_____)_____
Office Telephone Number Office Fax Number

(_____)_____
After Hours Telephone Number

Office E-mail Address (if available) Office Website Address (if available)

Is this location open 24 hours? No; Yes Is this location TDD/TTY equipped? No; Yes

**2. Mailing Address** (if different from physical address):

Street Address /PO Box | Suite No.

City | County | State | Zip Code + 4

(_____)_____ (_____)_____

Alternate Telephone Number | Alternate Fax Number

Alternate E-mail Address (if available) | Alternate Website Address (if available)

**3. Pay-to Address**: The pay-to address should be placed on the W-9 form.

## C. Detailed Information:

**1. Individual only:**

a. Social Security #: _____ b. Date of Birth: _____

c. **Hospital Admitting Privileges (past or current) or alternative arrangement*** (Please use an additional sheet if necesarry):

| Provider Name | | | |
|---|---|---|---|
| Name of Hospital | City/State | Begin Date | End Date |
| | | | |
| | | | |
| Alternative arrangement: | | | |

| Provider Name | | | |
|---|---|---|---|
| Name of Hospital | City/State | Begin Date | End Date |
| | | | |
| | | | |
| Alternative arrangement: | | | |

| Provider Name | | | |
|---|---|---|---|
| Name of Hospital | City/State | Begin Date | End Date |
| | | | |
| | | | |
| Alternative arrangement: | | | |

***GBHC PCPs must have hospital admitting privileges, or must have a formal arrangement with a physician who does have hospital admitting privileges and who agrees to abide by the GBHC authorization requirements.**

**2. Bed Data** – How many of your beds are for:

Intermediate Care: _____ Skilled Care: _____ Inpatient: _____ Mental Retardation: _____

**3. All applicants:**

a. Federal Employer ID#: _____ b. NPI #: _____

c. Existing Georgia Medicaid Payee Provider #: _____

d. Does this applicant have Medicare certification? *(Please attach a copy of your Medicare certification award letter.)*

Medicare Provider Number _____ Effective Date _____

Part A or Part B? _____ Medicare Carrier/Intermediary Name _____

**Medicare ONLY** *( For billing Crossover Claims only.)* UPIN #: _____

e. Has the applicant ever participated in another state's Medicaid program? No; Yes If yes, list state(s) and provider number(s). Attach additional sheets if necessary.

| Medicaid Number | State | Type of Service(s) Provided | Active | Inactive |
|---|---|---|---|---|
| | | | | |
| | | | | |

f. Languages spoken (Please put a check by the primary language):

_____ _____ _____

g. Special Needs (What special needs are accommodated at this provider location?)(see instructions for valid code values):

_____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____

h. Liability Insurance amount: _____
(required for certain programs) (attach a copy of proof of insurance)

## D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type Code: _____
2. Practice Type Code: _____
3. Category (ies) of Service: _____ _____ _____
4. Group Code: _____
5. Specialty Code(s): _____ _____ _____ _____

## E. License and Certification Information:

### 1. License Information for state of practice (Attach a copy):

a. _____
License Number Type Effective Date Expiration Date

b. If the applicant is an individual practitioner:
Do you have public board orders? No; Yes If yes, date of the last order?: _____

Are you: Board Eligible; Board Certified Specialty: _____

### 2. License/Certification information from other states (attach additional sheets if necessary):

| State | License Number | Type | Effective Date | Expiration Date |
|---|---|---|---|---|

**3. Certification Information (Attach a copy):**

| Type | Certification Number | Effective Date | Expiration Date |
|---|---|---|---|
| Type | Certification Number | Effective Date | Expiration Date |

**4. CLIA Certification Information** (attach copy of certificate for this location):

| Number | Certification Type | Effective Date | Expiration Date |
|---|---|---|---|

CLIA FEIN _____ CLIA SSN _____

**5. DEA Permit Number**: _____
All schedules? No; Yes; Not applicable

**6. Pharmacies Only**:
Drug Store Type: Proprietary; Non-Proprietary Pharmacy Class Code: _____

National Council for Prescription Drug Programs (NCPDP) Number: _____

## F. Exclusion / Sanction Information:

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.
   No; Yes (If "yes", please attach details)

2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
   No; Yes (If "yes", please attach details)

   Has any member of your practice had a recoupment of over $5,000 in any 18 month period?
   No; Yes (If "yes", please attach details)

3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
   No; Yes

   If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

| First | M.I. | Last | Title (if applicable) | Relationship |
|---|---|---|---|---|

4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
   No; Yes (If "yes", please attach detailed explanation and disposition of case)

## G. Correspondence Medium Information:

*This section of the application provides you with the opportunity to select your preferred method for receiving various forms of information from the Department. Selecting a choice is optional. If no choice is provided, your file will be defaulted to the standard options; but may be changed at any time. You are not guaranteed or restricted by your choice. Please note: In most cases, "paper" is ONLY available to individuals who are not capable of receiving information in an electronic format.*

1. Letter Medium: *Please select your preferred method for receiving letters from the Department:*
   Email Fax Paper Web Portal message center

2. Bulletin Medium: *Please select your preferred method for receiving notices and other bulletins from the Department:*
   Paper Web Portal message center

3. Remit Medium: *Please select your preferred method for receiving remittance advices from the Department:*
   Paper Web Portal message center
   X-12-835 via Clearinghouse

4. Billing Medium: *Please select your preferred method for submitting claims to the Department: (NOTE – WINASAP requires special software, which is available through the ACS Billing Office. For more information, call 1-800-987-6715)*

   Point of Sale Batch Web Portal claims submission area Paper
   WINASAP*/Dial-up

## H. Signatures and Contact Information:

### 1. Contact Person Information

List the contact person in your office who may answer questions regarding this application:

_____
Contact Person Title

_____
Mailing Address (if different from enrolling address)

_____

_____
Telephone Number Fax Number E-Mail Address (if available)

### 2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Category(ies) of Service indicated herein.

_____
Printed Name of Applicant

_____ _____
Signature of Applicant Date

**DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**

# STATEMENT OF PARTICIPATION

**THIS STATEMENT OF PARTICIPATION** between the State of Georgia, Department of Community Health, Division of Medical Assistance (the "Department") and the undersigned Provider becomes effective on the date of enrollment indicated by the Department.

**WHEREAS**, the Department is charged with the administration of the Georgia State Plan for Medical Assistance (the "Medicaid program") in accordance with the requirements of Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. § 49-4-1 *et seq*., and seeks to enroll qualified health care providers ("Providers") to render services to eligible Medicaid recipients;

**WHEREAS**, Provider affirms that all prerequisites, certification and/or licensure requirements and other necessary qualifications have been met in Provider's area(s) of specialty as required by law in the State of Georgia to render health care services to patients; and,

**WHEREAS**, Provider desires to enroll in the Medicaid program to render Covered Services to eligible Medicaid recipients under certain category(ies) of service, and seeks reimbursement for rendering such services.

**NOW THEREFORE**, in consideration of the mutual covenants and promises contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree to the terms and conditions named herein as follows:

## 1. THE DEPARTMENT'S OBLIGATIONS

A. Legal Compliance. The Department shall adhere to all applicable provisions of federal and state laws and regulations, Rules of the Department, and all of the Department's Policies and Procedures manuals governing the Medicaid program, and any amendments thereto (collectively, the "Department's requirements").

B. Reimbursement to Providers. The Department shall reimburse Provider for claims that are submitted in compliance with the Department's requirements, and in such amounts allowed under the Medicaid program as administered by the Department.

C. Modifications to Department's Policies and Procedures. The Department shall notify Provider of modifications to the provisions contained in the Policies and Procedures manual(s) for the category(ies) of service in which the Provider is enrolled by disseminating such notices to the address(es) at which Provider is then registered with the Department. Public notice of significant changes in the Department's methods and standards for setting payment rates for Covered Services will be given in accordance with the Rules governing the Department.

## 2. PROVIDER'S OBLIGATIONS

A. Legal Compliance. Provider shall comply with all of the Department's requirements applicable to the category(ies) of service in which Provider participates under this Statement of Participation, including Part I, Part II and the applicable Part III manuals. The term "Provider" shall include those persons or entities performing services under the supervision or other direction of Provider, and all acts or omissions of such persons or entities shall be attributed to Provider.

B. Provider Enrollment and Continued Participation. Provider shall comply with the Department's requirements to enroll and continue participating as a Provider in the Medicaid program, including but not limited to completion of all enrollment forms, cooperation with site audits, and the following:

1. Certification of Provider Information. Provider certifies that all statements and information furnished to the Department for enrollment and continued participation are true and complete, and recognizes that the Department will rely on such information to evaluate Provider's participation under the Medicaid program. Provider shall give the Department written updates to information previously submitted, and advance notice of changes when required by the Department in this Statement of Participation and the Department's requirements.

2. Disclosure.

    a. Business Transactions. Within thirty-five (35) days of a request, Provider shall submit to the U.S. Department of Health and Human Services or the Department full and complete information about (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and (b) any significant business transactions between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request. Failure to disclose information as requested will result in denial of reimbursement from the date after which the information is due until the day before it is supplied.

    b. General Disclosure. Provider authorizes the Department to request, copy, access, use and share Provider's records and other information as may be necessary for the Department to determine the appropriateness of Provider's participation in or termination from the Medicaid program, subject to any applicable state or federal laws which may deem such records or parts of such records privileged or confidential. Provider's records and information may be requested from or exchanged with any source, including but not limited to the Composite State Board of Medical Examiners, any federal or state governmental agency, accreditation agency, licensing agency, regulatory body, certifying agency, or any other person or entity, subject to any applicable state or federal law limiting the distribution of such information. Provider's authorization to request, copy, access, use and share records and other information includes but is not limited to disclosure of ownership or control interests, and of any criminal offenses related to any federal or state health care program. This disclosure provision shall exclude sanctions against Provider that are protected by private order of the issuing board or agency.

3. License/Certification. Provider shall possess and maintain in good standing and without restriction valid professional, occupational, facility or other license and/or certification that is necessary for rendering Covered Services in the selected category(ies) of service, and as required by the Department. Provider shall provide the Department with written copies of licenses and/or certifications upon request. Except where disclosure is protected by private order of the issuing board or agency, Provider shall inform the Department promptly in writing of any restriction or adverse action against Provider's license and/or certification.

4. Hold Harmless. Provider releases from liability and holds harmless the Department, its agents, and any and all individuals and entities who, in good faith, furnish or release information for any acts performed and statements made or released in connection with the evaluation of Provider under the Medicaid program including the services rendered by Provider, and other matters pertinent to Provider's status and duties in connection with this Statement of Participation. This provision shall survive termination or expiration of this Statement of Participation for any reason.

    A. Claims Submission; Certification of Claims. Provider shall submit claims for Covered Services rendered to eligible Medicaid recipients in the form and format designated by the Department. For each claim submitted by or on behalf of Provider, Provider shall certify each claim for truth, accuracy and completeness, and shall be responsible for research and correction of all billing discrepancies without cost to the Department. This provision shall survive termination or expiration of this Statement of Participation for any reason.

    B. Recipient Records. Provider shall maintain in an orderly manner and ensure the confidentiality of all original source documents, medical records, identifying recipient data, and any copies thereof, as may be necessary to fully substantiate the nature and extent of all

services provided. Records shall be retained for a minimum of five (5) years from the date of service, or longer as required by state or federal law. Upon request by the Department, its agent, and any authorized agency including but not limited to the U.S. Department of Health and Human Services, the Comptroller General, the State Auditor, State Attorney General's Office or office of any Georgia District Attorney and their authorized representatives, Provider shall disclose and provide legible copies to the requestor, or permit the requestor to copy, without cost, all Medicaid-related documents, records or data. This provision shall apply to all records regardless of the enrollment status of Provider, subject to any applicable state or federal laws that may deem such records or parts of such records privileged or confidential. Provider's failure to abide by this provision may constitute grounds for disallowance of all applicable charges, recoupment of corresponding payments, and/or termination of Provider's participation. This provision shall survive termination or expiration of this Statement of Participation for any reason.

C. Covered Services. Provider shall render Covered Services, as defined in the Department's Policies and Procedures manuals, to eligible Medicaid recipients that are medically necessary as defined by the Department, within the parameters permitted by Provider's license or certification, and within the category(ies) of service indicated in the Provider Enrollment documents. By submitting claims for reimbursement, Provider certifies that Covered Services were rendered in the amount, duration, scope and frequency indicated on the claims. Provider shall not discriminate against any recipient on the basis of race, color, national origin, religion, sex, marital status, age, disability, health status, or source of payment.

D. Reimbursement for Covered Services. Reimbursement for Covered Services performed shall be made in a form and format designated by the Department. Payment shall be made in conformity with the provisions of the Medicaid program, applicable federal and state laws, rules and regulations promulgated by the U.S. Department of Health and Human Services and the State of Georgia, and the Department's Policies and Procedures manuals in effect on the date the service was rendered. Such reimbursement shall constitute payment in full for Covered Services rendered, and Provider shall not bill, accept or seek payment from eligible Medicaid recipients, except for applicable co-payments, co-insurance or deductibles required by the Department. Without cost to the Department or its agents, Provider agrees to cooperate with refund and recoupment efforts to the Department, and shall assist in recovering any amounts for which a third party may be liable. Provider agrees that the Department shall not reimburse any claim, or portion thereof, for services rendered prior to the effective date of enrollment indicated by the Department or for which federal financial participation is not available.

Provider acknowledges that payment of claims submitted by or on behalf of Provider will be from federal and state funds, and the Department may withhold, recoup or recover payments as a result of Provider's failure to abide by the Department's requirements. This provision shall survive termination or expiration of this Statement of Participation for any reason.

E. Prohibition on Reassignment. Provider acknowledges and agrees that the payee or billing service designated by Provider to receive payments or to process claims is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Furthermore, payment to the payee or billing service for services rendered shall be related to the cost of processing, and shall not be based on the payments due to Provider or based upon the percentage of claims processed.

F. Indemnification. Provider shall indemnify and hold harmless the Department and its agents from all causes of action, claims, suits, judgments, or damages, including court costs and attorneys' fees, arising out of the misconduct, negligence or omissions of Provider in the course of participating in the Medicaid program, including but not limited to the provision of services to an eligible Medicaid recipient or a person believed to be a recipient. If and to the extent such damage or loss (including costs and expenses) is covered by any funds established and maintained by the State of Georgia, Provider agrees to reimburse the funds for such monies paid out by such funds. This provision shall survive termination or expiration of this

Statement of Participation for any reason.

## 3. TERM; TERMINATION

A. Term. Unless otherwise renewed and subject to the Department's requirements for continued participation, this Statement of Participation shall expire automatically at 11:59 p.m. on June 30 of each year. The Department, in its sole discretion, has the option to renew this Agreement for an additional fiscal year, and if exercised, the Department shall issue written notice to Provider prior to the end of the then-current fiscal year. The Department has the right to terminate this Agreement at any time with or without cause under applicable laws, rules or regulations.

B. Termination by Provider. Unless otherwise authorized by the Department or by law, Provider shall give ten (10) days prior written notice to the Department of voluntary termination.

C. Termination under Other Programs. The Department may terminate and take other action against Provider under the Medicaid program when adverse action is taken against Provider under any other plan or program, including but not limited to exclusions from or licensure restrictions or conditions by other federal or state authorities, plans or programs. The Department shall issue written notice of termination to Provider to be effective on the date indicated therein. The Department also may notify other state and federal authorities, plans or programs of Provider's enrollment status in the Medicaid program, including other plans or programs within the Department. Termination under the Medicaid program may result in Provider's termination under other federal and state plans or programs.

D. Termination for Unavailability of Funds. Notwithstanding any other provision hereof, in the event that funds are no longer appropriated for the Department, Division of Medical Assistance by the General Assembly of the State of Georgia or from the Congress of the United States of America, or in the event that the sum of all obligations of the Department incurred pursuant to the Medicaid program equals or exceeds the balance of such sources available to the Department for "Medical Assistance Benefits" for the fiscal year in which this Statement of Participation is effective less one hundred dollars ($100.00), then this Statement of Participation shall terminate immediately without further obligation to or by the Department. The certification by the Commissioner of the Department of the occurrence of either of the events stated above shall be conclusive. The Department will attempt to provide Provider with ten (10) days notice of the possible occurrence of events described in this provision.

## 4. GENERAL PROVISIONS

A. Notice. All mailed notices shall be issued to the Provider's address on record with the Department as of the date of such notice.

B. Waiver of Breach. Waiver of breach of any provision of this Statement of Participation shall not be deemed a waiver of any other breach of the same or different provision of this Statement of Participation.

C. Conflict of Interest. The parties certify that the provisions of O.C.G.A. § 45-10-20 *et seq.,* as amended, and 41 U.S.C. § 423 regarding conflicts of interest have not and will not be violated in any respect.

D. Headings. The headings of sections and provisions contained herein are for reference purposes only and shall not affect in any way the meaning or interpretation of this Statement of Participation.

E. Governing Law. This Statement of Participation shall be governed by and construed in accordance with the laws of the State of Georgia.

F. Assignment. Provider may not assign any right or obligation under this Agreement without the prior written consent of the Department.

G. Amendments. Except as otherwise specifically provided herein, amendments or modifications to

this Statement of Participation shall be in writing and signed by each party.

H. Provider-Patient Relationship. Nothing in this Statement of Participation shall be construed to interfere with or in any way alter any Provider-patient relationship or interfere with the obligations of Provider to exercise independent medical judgment in rendering health care services to patients or in governing the level of care of a patient.

I. Independent Relationship. This Statement of Participation establishes the means and terms of reimbursement between the Department and Provider, but does not prescribe the conduct of any medical or other professional practice. No provision in this Statement of Participation is intended to create or shall be deemed or construed to create any relationship between the Department and Provider other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Statement of Participation. Neither the Department nor Provider is or shall be considered an employer, employee, agent, partner or joint venture of the other.

J. Binding Authority. Each party acknowledges that it has the full power and authority to enter into and perform this Statement of Participation and the person signing on behalf of each party has been properly authorized and empowered to enter into this Statement of Participation.

K. Entire Agreement. This Statement of Participation, together with the Department's Policies and Procedures manuals, all enrollment documents, and any amendments thereto, shall constitute the entire agreement between the parties with respect to the subject matter contained herein, and shall supersede all previous communications, representations, or agreements, either verbal or written, between the parties.

**IN WITNESS WHEREOF**, Provider executes this Statement of Participation in person, or as an authorized party on behalf of an entity, to become effective on the date indicated by the Department.

Accepted and authorized on this _____ day of _____, in the year _____

_____**("Provider")**
(Printed Name of Enrolling Provider)

Provider's Signature: _____

_____
(Printed name and title of Authorized Agent (for non-individual practitioners only)

Authorized Agent's Signature: _____

**DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE (the "Department")**

Accepted and authorized on this _____ day of _____, in the year _____

BY: _____
DIRECTOR, DIVISION OF MEDICAL ASSISTANCE

**INTERNAL REVENUE SERVICE FORM W-9**

**REQUEST FOR TAXPAYER**
**IDENTIFICATION NUMBER AND CERTIFICATION**

The Internal Revenue Service (IRS) Form W-9 provides information pertaining to your Taxpayer Identification Number (TIN) and Payee name. All Payee information is captured from the W-9. The Department uses this information to issue payments and report provider year-end earnings to the IRS.

**THE INFORMATION ON THE W-9 MUST MATCH THE INFORMATION REGISTERED WITH THE IRS.**

If you have multiple locations and use a different TIN for the other locations, you must submit a separate W-9 for each TIN.

Note: If the Payee listed on the W-9 is different from the applicant, please complete and submit the Power of Attorney for Payee.

*The Department reserves the right to request confirmation of the Taxpayer Identification Number. Acceptable forms of confirmation are a copy of the applicant's Social Security card, Federal Tax Deposit Coupon (Form 8109), or other correspondence from the IRS.*

Submit all materials to:

GHP Provider Enrollment
Post Office Box 4000
McRae, Georgia 31055-4000

Form **W-9**
(Rev. January 2003)
Department of the Treasury
Internal Revenue Service

# Request for Taxpayer Identification Number and Certification

**Give form to the requester. Do not send to the IRS.**

**Print or type** See **Specific Instructions** on page 2.

Name

Business name, if different from above

Check appropriate box: ☐ Individual/ Sole proprietor ☐ Corporation ☐ Partnership ☐ Other ► ..... ☐ Exempt from backup withholding

Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

City, state, and ZIP code

List account number(s) here (optional)

## Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. For individuals, this is your social security number (SSN). **However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3.** For other entities, it is your employer identification number (EIN). If you do not have a number, see **How to get a TIN** on page 3.

**Note:** *If the account is in more than one name, see the chart on page 4 for guidelines on whose number to enter.*

**Social security number**
| | | – | | – | | | | |

**or**

**Employer identification number**
| | | – | | | | | | |

## Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), **and**
2. I am not subject to backup withholding because: **(a)** I am exempt from backup withholding, or **(b)** I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or **(c)** the IRS has notified me that I am no longer subject to backup withholding, **and**
3. I am a U.S. person (including a U.S. resident alien).

**Certification instructions.** You must cross out item **2** above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item **2** does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN. (See the instructions on page 4.)

**Sign Here** **Signature of U.S. person** ► **Date** ►

## Purpose of Form

A person who is required to file an information return with the IRS, must obtain your correct taxpayer identification number (TIN) to report, for example, income paid to you, real estate transactions, mortgage interest you paid, acquisition or abandonment of secured property, cancellation of debt, or contributions you made to an IRA.

**U.S. person.** Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN to the person requesting it (the requester) and, when applicable, to:

**1.** Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

**2.** Certify that you are not subject to backup withholding, or

**3.** Claim exemption from backup withholding if you are a U.S. exempt payee.

**Note:** *If a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.*

**Foreign person.** If you are a foreign person, use the appropriate Form W-8 (see **Pub. 515,** Withholding of Tax on Nonresident Aliens and Foreign Entities).

**Nonresident alien who becomes a resident alien.** Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the recipient has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement that specifies the following five items:

**1.** The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

**2.** The treaty article addressing the income.

**3.** The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

**4.** The type and amount of income that qualifies for the exemption from tax.

**5.** Sufficient facts to justify the exemption from tax under the terms of the treaty article.

***Example.*** Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a **nonresident alien or a foreign entity** not subject to backup withholding, give the requester the appropriate completed Form W-8.

**What is backup withholding?** Persons making certain payments to you must under certain conditions withhold and pay to the IRS 30% of such payments (29% **after** December 31, 2003; 28% **after** December 31, 2005). This is called "backup withholding." Payments that may be subject to backup withholding include interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will **not** be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

**Payments you receive will be subject to backup withholding if:**

**1.** You do not furnish your TIN to the requester, or

**2.** You do not certify your TIN when required (see the Part II instructions on page 4 for details), or

**3.** The IRS tells the requester that you furnished an incorrect TIN, or

**4.** The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

**5.** You do not certify to the requester that you are not subject to backup withholding under **4** above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See the instructions below and the separate **Instructions for the Requester of Form W-9.**

## Penalties

**Failure to furnish TIN.** If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

**Civil penalty for false information with respect to withholding.** If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

**Criminal penalty for falsifying information.** Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

**Misuse of TINs.** If the requester discloses or uses TINs in violation of Federal law, the requester may be subject to civil and criminal penalties.

# Specific Instructions

## Name

If you are an individual, you must generally enter the name shown on your social security card. However, if you have changed your last name, for instance, due to marriage without informing the Social Security Administration of the name change, enter your first name, the last name shown on your social security card, and your new last name.

If the account is in joint names, list first, and then circle, the name of the person or entity whose number you entered in Part I of the form.

**Sole proprietor.** Enter your **individual** name as shown on your social security card on the "Name" line. You may enter your business, trade, or "doing business as (DBA)" name on the "Business name" line.

**Limited liability company (LLC).** If you are a single-member LLC (including a foreign LLC with a domestic owner) that is disregarded as an entity separate from its owner under Treasury regulations section 301.7701-3, **enter the owner's name on the "Name" line.** Enter the LLC's name on the "Business name" line.

**Other entities.** Enter your business name as shown on required Federal tax documents on the "Name" line. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on the "Business name" line.

**Note:** *You are requested to check the appropriate box for your status (individual/sole proprietor, corporation, etc.).*

## Exempt From Backup Withholding

If you are exempt, enter your name as described above and check the appropriate box for your status, then check the "Exempt from backup withholding" box in the line following the business name, sign and date the form.

Generally, individuals (including sole proprietors) are not exempt from backup withholding. Corporations are exempt from backup withholding for certain payments, such as interest and dividends.

**Note:** *If you are exempt from backup withholding, you should still complete this form to avoid possible erroneous backup withholding.*

**Exempt payees.** Backup withholding is **not required** on any payments made to the following payees:

**1.** An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2);

**2.** The United States or any of its agencies or instrumentalities;

**3.** A state, the District of Columbia, a possession of the United States, or any of their political subdivisions or instrumentalities;

**4.** A foreign government or any of its political subdivisions, agencies, or instrumentalities; or

**5.** An international organization or any of its agencies or instrumentalities.

Other payees that **may be exempt** from backup withholding include:

**6.** A corporation;

**7.** A foreign central bank of issue;

**8.** A dealer in securities or commodities required to register in the United States, the District of Columbia, or a possession of the United States;

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**
**Additional Location Application Form**

**A. Applicant:**

**1. Current Rendering Provider Number(s):**_____

**2. Payee Provider Number (if known):** _____

First M.I. Last Suffix (Jr, III, etc.) Title (MD, RN, etc)

Social Security #: _____ Practitioner's D.O.B.: _____

Practice or Business Name (if applicable):

**3. Pharmacies ONLY:**

Legal Business Name

"Doing Business As" Name

Does this organization operate other sites, locations or units? No; Yes Where: _____

c. Drug Store Type: Proprietary; Non-Proprietary d. Pharmacy Class Code: _____

**4. Office Manager's Information:**

Name

Email Address Social Security Number Date of Birth

**B. Address Information:**

**1. Office (Physical) Address:**

Street Address **(P.O. Box Not Acceptable)** Suite No.

City County State Zip Code (+ 4)

(____)_____(____)_____
Office Telephone Number Office Fax Number

(____)_____
After Hours Telephone Number

Office E-mail Address (if available) Office Website Address (if available)

Is this location open 24 hours? No; Yes Is this location TDD/TTY equipped? No; Yes

**2. Mailing Address** (if different from physical address):

Street Address /PO Box _____ Suite No. _____

_____

City _____ County _____ State _____ Zip Code + 4 _____

(_____)_____ (_____)_____

Alternate Telephone Number Alternate Fax Number

Alternate E-mail Address (if available) Alternate Website Address (if available)

**3. Pay-to Address**: The pay-to address should be placed on the W-9 form.

## C. Detailed Information:

1. Federal Employer ID#: _____ 2. UPIN#: _____

3. Does this applicant have Medicare certification? *(Please attach a copy of your Medicare certification award letter.)*

Medicare Provider Number _____ Effective Date _____

Medicare Carrier/Intermediary Name _____

Medicare ONLY *(Check this box if you intend to bill Crossovers only.)*

4. Languages spoken at this location (Please put a check by the primary language)(*see instructions for valid code values*):

❑_____ ❑_____ ❑_____ ❑_____

5. Special Needs (What special needs are accommodated at this provider location?)(*see instructions for valid code values*):

_____ _____ _____ _____ _____

6. Liability Insurance amount: _____
(required for certain programs) (*attach a copy of proof of insurance*)

## D. Program Enrollment Information (see instructions for valid code values):

1. Provider Type Code: _____ 2. Practice Type Code: _____

3. Category(ies) of Service: _____ _____ _____ 4. Group Code: _____

5. Specialty Code(s): _____ _____ _____ _____

## E. License and Certification Information:

### 1. License Information for state of practice (Attach a copy):

a. _____
License Number Type Effective Date Expiration Date

b. Do you have public board orders? No; Yes If yes, date of the last order: _____

Are you: Board Eligible; Board Certified Specialty: _____

**2. Certification Information (Attach a copy):**

| Type | Certification Number | Effective Date | Expiration Date |
|---|---|---|---|

## F. Exclusion / Sanction Information:

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.
   No; Yes (If "yes", please attach details)

2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
   No; Yes (If "yes", please attach details)

   Has any member of your practice had a recoupment of over $5,000 in any 18 month period?
   No; Yes (If "yes", please attach details)

3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
   No; Yes

   If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

| First | M.I. | Last | Title (if applicable) | Relationship |
|---|---|---|---|---|

4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
   No; Yes (If "yes", please attach detailed explanation and disposition of case)

## G. Signatures and Contact Information:

### 1. Contact Person Information

List the contact person in your office who may answer questions regarding this application:

Contact Person _____ Title _____

Mailing Address (if different from enrolling address) _____

Telephone Number _____ Fax Number _____ E-Mail Address (if available) _____

### 2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I, II, and III (if applicable), for the Category(ies) of Service indicated herein.

Printed Name of Applicant _____

Signature of Applicant _____ Date _____

**GA DEPT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**

# Physician's Assistant Application Instructions

***Complete this form only if you are enrolling a physician's assistant (PA) or a physician's assistant anesthesiologist assistant (PAAA) with a sponsoring physician who is already enrolled in Georgia Medicaid. All information pertains to the physician's assistant, unless otherwise indicated.***

## A. Applicant: Enter the National Provider Identification Number

1. Enter the name, Social Security # and date of birth of the PA / PAAA.
2. Enter the name and Georgia Medicaid provider number of the sponsoring physician.

## B. Address Information:

1. Enter the physical address, phone and fax numbers of this location. **A post office box is unacceptable**.
2. Enter the mailing address (if different from the physical address).
3. The Pay-to address should be listed on the IRS form W-9. Enter the established Payee Provider number for this practice and the Federal Employee Identification number.

## C. Program Enrollment Information:

The provider type and COS are defaulted for PA/PAAA providers. Please indicate the appropriate provider specialty. Valid values are 203-Physician Assistant or 204-Physician Assistant, Anesthesiology.

Health Check – Attach a copy of the Vaccines for Children approval notice.

## D. License and Certification Information:

Enter the PA/PAAA's license information issued by the state in which this practice is located.

## E. Exclusion / Sanction Information:

Respond to the questions as requested and attach any additional documentation.

## F. Signatures and Contact Information:

1. Enter the name and contact information of the person in your office the Department may contact if there are any questions regarding this application.

2. The applicant and the sponsoring physician must sign the application.

**Please attach the following documentation:**

1. **A copy of the PA/PAAA's license**
2. **Approval notice from the Composite State Board of Medical Examiners**
3. **Power of Attorney for Payee (completed by the physician's assistant)**
4. **Statement of Participation**
5. **Internal Revenue Service form W-9***
6. **EFT Agreement***

**NOTE:** **** These forms are not necessary when valid payee provider # is entered in section A.***

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**

# Physician's Assistant Application Form

**A. Applicant:** **NPI:**

**1.**

Name: First M.I. Last Suffix (Jr, III, etc.)

Social Security #: _____ Practitioner's D.O.B.: _____

**2. Sponsoring Physician:** _____
Sponsoring Physician's Georgia Medicaid Provider

Name: First M.I. Last Suffix (Jr, III, etc.)

**B. Address Information:**

**1. Office (Physical) Address:**

Name of practice

Street Address **(P.O. Box Not Acceptable)** Suite No.

City County State Zip Code (+ 4)

(_____)_____ (_____)_____
Office Telephone Number Office Fax Number

(_____)_____
After Hours Telephone Number

Office E-mail Address (if available) Office Website Address (if available)

**2. Mailing Address** (if different from physical address):

Street Address /PO Box Suite No.

City County State Zip Code + 4

(_____)_____ (_____)_____
Alternate Telephone Number Alternate Fax Number

Alternate E-mail Address (if available) Alternate Website Address (if available)

**3. Pay-to Address**: The pay-to address should be placed on the W-9 form.

_____ _____
Georgia Medicaid Payee Provider Number Federal Employer Identification Number *(Attach W-9)*

**C. Program Enrollment Information:**

Provider Type Code: **360** Category of Service: **431** Specialty Code(s): ☐ PA (203) **or** ☐ PAAA (204)

☐ Health Check – Category of Service: 600 (attach VFC approval notice)

Does this applicant participate in the Medicare program? *(Please attach a copy of your Medicare certification award letter.)*

Medicare Provider Number | Medicare Carrier/Intermediary Name | Effective Date

## D. License and Certification Information:

### 1. License Information for state of practice (Attach a copy):

a. _____
License Number | Type | Effective Date | Expiration Date

b. Do you have public board orders? No; Yes If yes, date of the last order: _____

## E. Exclusion / Sanction Information:

1. Has the applicant ever had any adverse legal actions imposed by Medicare, Medicaid, or any other Federal or State agency or program, or any licensing or certification agency? Attach a copy of any relevant final dispositions.
   No; Yes (If "yes", please attach details)

2. Has any member of your practice ever been placed on prepayment review status by Georgia Medicaid?
   No; Yes (If "yes", please attach details)

   Has any member of your practice had a recoupment of over $5,000 in any 18 month period?
   No; Yes (If "yes", please attach details)

3. Has any family or household member(s) of the applicant who has ownership or control interest in the applicant ever been convicted or assessed fines or penalties for any health related crimes or misconduct, or excluded from any Federal or State health care program due to fraud, obstruction of an investigation, a controlled substance violation or any other crime or misconduct?
   No; Yes

   If Yes, furnish name and relationship of relative/household member(s) below. Attach additional sheets if necessary.

   _____
   First | M.I. | Last | Title (if applicable) | Relationship

4. Have you or this facility been involved in malpractice litigation within the last ten (10) years?
   No; Yes (If "yes", please attach detailed explanation and disposition of case)

## F. Signatures and Contact Information:

### 1. Contact Person Information

_____
Contact Person | Title

_____
Mailing Address (if different from enrolling address)

_____
Telephone Number | Fax Number | E-Mail Address (if available)

### 2. Certification and Signature

To the best of my knowledge, the information supplied in this document is true, accurate and complete and is hereby released to the Georgia Department of Community Health, Division of Medical Assistance for the purpose of issuing a Medicaid provider number. I understand that falsification, omission or misrepresentation of any information in this enrollment package will result in a denial of enrollment, the closure of current enrollment, and the denial of future enrollment requests, and may be punishable by criminal, civil or other administrative actions. I understand that my signature certifies that I have read the manuals, Parts I and II for the Category of Service indicated herein.

_____ _____
Signature of Physician's Assistant | Date

_____ _____
Signature of Sponsoring Physician | Date

**POWER OF ATTORNEY FOR PAYEE**

**KNOW ALL MEN BY THESE PRESENTS, THAT:**

Provider, _____ hereby appoints
*(Print Provider's Name)*

_____, _____,
*(Print Payee's Name)* *(Taxpayer Identification Number)*

as attorney-in-fact for the benefit of Provider and in Provider's name, place, and stead for the following purpose:

**To receive, as Payee, any reimbursement from the Department of Community Health, Division of Medical Assistance to which Provider may be entitled as an enrolled provider.**

**Provider agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.**

**Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.**

**IN WITNESS WHEREOF**, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This _____ day of _____, in the year _____.

_____
Printed Name of Provider

**By:**

_____
Signature of Provider or Facility Administrator

_____
Title of Authorized Representative

Sworn to and subscribed before me

this _____ day of _____,

in the year _____.

_____
(Notary Public)

My Commission expires: _____

# GEORGIA DEPARTMENT OF COMMUNITY HEALTH
# ELECTRONIC FUNDS TRANSFER AGREEMENT

**Providers who receive payment of claims under the Title XIX (Medicaid) program in Georgia must agree to the following terms and conditions:**

1. Legal Compliance. Provider shall abide by all federal and state laws governing the Medicaid program.

2. EFT Information. Provider will submit EFT information on form DMA-406 that includes the Payee, name of the bank, transit number, account number and a bank letter or voided check on the account to which funds will be transferred.

2. Non-Provider Payee. If the Payee indicated on the EFT Information form DMA-406 is different from the enrolled Provider, Provider must submit to the Department an original signed and notarized Power of Attorney for Payee, DMA-253G. Designation of a payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.

3. Acceptance of Funds. Provider agrees that evidence of credit to the proper account by Payee's bank pursuant to an EFT is sufficient to show acceptance of medical assistance payments under the Medicaid program within the meaning of the Official Code of Georgia Annotated, Section 49-4-146.1(b)(2). Provider certifies by such acceptance that Provider presented the claims for the services shown on the Remittance Advice issued by the Department, and that the services were rendered by or under the supervision of Provider. Provider understands that payment will be from federal and state funds and that any falsification, or concealment of a material fact, may be prosecuted under federal and state laws.

4. Notice of Changes. Provider will notify the Department in writing at least ten (10) days in advance of any changes in Payee, Payee's name or address, or bank account name or number (supported by a bank letter or voided check on the new account).

5. Alternate Payment Methods. For good cause (including but not limited to recovering overpayments from subsequent requests for claims payments), the Department may substitute payment by check for EFT until the cause requiring the substitution has been satisfied as determined by the Department. Payment by check will be made to the address for payments on record with the Department.

6. Incorporated Document. This EFT Agreement is incorporated into the Statement of Participation and shall not modify or eliminate any provision of the Statement of Participation (including applicable Policies and Procedures manuals of the Department) except as specifically provided herein.

7. Expiration or Termination of EFT. Violation of these terms may cause termination by the Department of EFT and/or the Statement of Participation. Expiration or termination of the Statement of Participation for any reason will terminate EFT automatically. The Department will give written notice of termination to Provider.

Payee Provider's Name: _____

Payee Provider's Georgia Medicaid Number: _____

Bank Routing and Transit Number (9 digits): _____

Bank Account Number: _____

_____ _____

Signature of Provider or Authorized Representative of the Provider Date

**GEORGIA DEPARTMENT OF COMMUNITY HEALTH**
**DIVISION OF MEDICAL ASSISTANCE**
**Additional Location Addendum for Individual Practitioner**
*(To be submitted with form DMA-001)*

**A. Applicant:**

**1. Name**: _____

Office Administrator's ID#: _____ (if available)

**B. Address Information:**

**1. Office (Physical) Address:**

_____
Street Address **(P.O. Box Not Acceptable)** Suite No.

_____

_____
City County State Zip Code (+ 4)

(____)_____(____)_____
Office Telephone Number Office Fax Number

(____)_____
After Hours Telephone Number

_____
Office E-mail Address (if available) Office Website Address (if available)

Is this location open 24 hours? ❑ No ❑ Yes Is this location TDD/TTY equipped? ❑ No ❑ Yes

**FOR DEPARMENTAL USE ONLY**

Enterprise I.D. #: _____ Location Alpha: _____

Payee#: _____

_____