Thank you for choosing to participate in the Alabama Medicaid Program. The Alabama Medicaid Agency and EDS appreciate your interest in the Medicaid Program, and welcome the opportunity to work with you to provide health care services to Alabama Medicaid recipients.

About the Application Packet

The application packet contains the following:

Basic Application Material

(To be completed by all providers)
Alabama Medicaid Provider Type/Specialty Identification Form
Alabama Medicaid Provider Enrollment Application
Alabama Medicaid Provider Agreement

Additional Enrollment Forms

(To be reviewed by all providers and completed as applicable)
Corporate Board of Directors Resolution
W-9 Taxpayer Identification Number Request
Medicaid Audit Information
Electronic Funds Transfer Authorization Agreement
Electronic Explanation of Payment (EOP) Agreement
EPSDT Agreement
Statement of Compliance (Two Copies)
Physiological Laboratory Certification

Reference Materials

(Helpful information that can assist you in completing the enrollment application)
Check List of Required Forms
Frequently Asked Questions (FAQs)
Frequently Used Terms
Contact List
Alabama Medicaid Participation Requirements
Table of County Codes (in-state and bordering states)

How to Complete the Application

1. *Identify your provider type and specialty on the Alabama Medicaid Provider Type and Specialty Identification form.*
2. *Review the Alabama Medicaid Participation Requirements in the Reference Materials section to ensure you meet the minimum enrollment requirements to participate in the Alabama Medicaid program.*
3. *Complete the Alabama Medicaid Provider Enrollment Application.* ***Please type or print legibly using black ink only.***
4. *Read, complete, and sign the Alabama Medicaid Agency Provider Agreement form.* ***Signatures on Section VI – Signature Page, Provider Agreement and Statement of Compliance Forms must be original signatures.***
5. *Review Section III, Required Attachments, of your enrollment application and include any applicable attachments.*
6. *Review the forms in the Additional Enrollment Forms section to determine which apply to you. In this section, all providers must complete at a minimum, the W-9 and EFT Agreement forms. Other forms may be required, depending on the provider's circumstance. Read the purpose of each form to determine whether you should complete the form and return it with the application.*
7. *Review the Required Forms Check List located in the Reference Materials section to ensure you have completed your application correctly and have included all required attachments.*
8. *Make a copy of the application for your files. Send the original application to:*

Alabama Department of Mental Health and Mental Retardation
ATTN: Robert Wynn
100 N Union Street
RSA Building, Suite 430
Montgomery, Alabama 36104

Alabama Medicaid Provider Enrollment

Basic Application Materials

Alabama Medicaid Provider Type/Specialty Identification Form
Alabama Medicaid Provider Enrollment Application
Alabama Medicaid Provider Agreement

ALABAMA MEDICAID PROVIDER TYPE AND SPECIALTY IDENTIFICATION FORM

Please circle the appropriate specialty codes to ensure proper enrollment.

PROVIDER TYPE	SPECIALTY
11 Department of Mental Health	111 Mental Health Clinic (DMR) Rehab Services 860 Substance Abuse

ALABAMA MEDICAID PROVIDER ENROLLMENT APPLICATION

***All Information must be completed in the space below each block or marked "N/A."**
*Original signature is required. Copies or stamped signatures are not acceptable.

ALL APPLICANTS MUST FILL OUT ACCORDINGLY

Please Check Applicable Boxes

APPLICANT ENROLLING AS: (Please check ONE)
- ☐ Individual
- ☐ Group/Payee
- ☐ Facility/Organization

ACTION REQUEST: (Please check ONE)
- ☐ Initial Enrollment
- ☐ Re-certification
- ☐ Change of Ownership
- ☐ Additional Locations

Please Check Applicable Boxes

APPLICATION TYPE: (Please check ONE)

The item selected in this area, relates to the performing provider name indicated on the line below.

- ☐ Individual Practitioner (0)
- ☐ Sole Proprietorship (1)
- ☐ Government-owned (2)
- ☐ Business Corporation, for profit (3)
- ☐ Business Corporation, non-profit (4)
- ☐ Private, for profit (5)
- ☐ Private, non-profit (6)
- ☐ Partnership (7)
- ☐ Trust (8)
- ☐ Chain (9)

SECTION 1 – GENERAL INFORMATION

Note: Please refer to Frequently Used Terms in the Reference Materials for definitions

Group/Company or Last Name First Initial Title/Degree (as appears on license)

(This is the name of the provider who performs the service. If enrolling a group/payee or facility, indicate that name here.)

Physical Address –(PROVIDER PHYSICAL STREET ADDRESS – See County Codes in Reference Materials Section)
Number Street Room/Suite City State ZIP County Code

Social Security Number (For individual enrollment only) Professional License No. **(C)** Issue Date

Resident License Number: Limited License Number:

Medicare Intermediary/Carrier Medicare Number Medicare Certification Date **(C)**

Employer's Tax ID Number Legal Name According To The IRS

(Tax information submitted in this section must match that which is indicated on the W-9 tax form in this application.)

Driver's License Number & Issuer: Driver's License Expiration Date

DEA Number: **(C)** CLIA Number: **(C)** Date of Birth:

Business Phone Toll-free Phone Fax Number

Contact Name Contact's Phone Contact's Fax Number

Payee Name

(This is the name of the provider who receives the payment. If this information differs from the provider who performs the services, a group application will be required. Please contact, Provider Enrollment regarding exceptions at 1-888-223-3630 or (334) 215-0111.)

Payee Address – (PROVIDER'S PAYEE/MAILING ADDRESS)
Number Street Room/Suite City State ZIP County Code

Payee Phone Toll-free Phone Fax Number

Nine-digit Alabama Medicaid payee number if applying to join an existing group:

SECTION 1 – GENERAL INFORMATION – Cont.

Do you plan on using a billing agent to submit your Medicaid claims? ☐ Yes ☐ No
If yes, provide the following information about the billing agent:
Billing agent name: _____

Address: _____

Tax ID No.: _____

Contact person name: _____

Telephone No.: (_____) _____ _____

List all Alabama Medicaid provider numbers under which you have billed in the past 12 months:
(attach additional sheets if necessary)

_____

_____

_____

Answer These Questions if Applicable

Facilities Only:	Yes	No	N/A
Is this a freestanding (independent) facility?	☐	☐	☐
Is this a hospital-based facility?	☐	☐	☐
Is this an ESRD facility?	☐	☐	☐

Pharmacies Only:	Yes	No	N/A
Is this a retail pharmacy?	☐	☐	☐
Is this an institutional pharmacy (hospital pharmacy with outpatient prescription services or nursing facility pharmacy)?	☐	☐	☐
Is this a government-run pharmacy?	☐	☐	☐

If the pharmacy is enrolling as a result of a change in ownership, please indicate the previous name and previously assigned provider number of that facility.

_____ _____
Pharmacy Name Previously Assigned Medicaid Number

Physician-employed Practitioners

_____ _____
Collaborating/Employing/Supervising Physician's Name Alabama Medicaid Provider Number

Independent Rural Health Clinics Only: **(Check all that apply)**	Yes	No
Family Planning	☐	☐
Prenatal	☐	☐
EPSDT (**Must** complete EPSDT Agreement)	☐	☐

SECTION II – UNIQUE STATUS INFORMATION

Do you want to be enrolled as:	Yes	No
An EPSDT Screening Provider? (**Must** complete EPSDT agreement)	☐	☐
A Plan First Provider? (**Must** complete the Plan First Enrollment form and Agreement)	☐	☐

SECTION IV – DISCLOSURE INFORMATION

Complete EITHER Section IV or Section V

This section must be filled out by individuals enrolling as providers.

List all contractual relationships with medical entities and the provider numbers of those entities:
(Attach additional sheets if necessary.)

_____
_____
_____
_____

If provider and payee are not the same, describe the business and financial relationship between the two.

_____

Have you ever been excluded, debarred, suspended or sanctioned from any state or federal program?
☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Is your license currently suspended or restricted? ☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred and any adverse action against your license: (attach additional sheets if necessary)

_____
_____
_____
_____

Have you ever been convicted of a crime? (excluding minor traffic citations) ☐ Yes ☐ No

Convicted means that:

1) A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post trial motion or appeal, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2) A Federal, State or local court has made a finding of guilt against an individual or entity;
3) A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
4) An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____
_____
_____
_____

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ☐ Yes ☐ No

SECTION V – DISCLOSURE INFORMATION

Complete EITHER Section IV or Section V

Providers who operate as a corporation, organization, institution, agency, partnership, professional association, or similar entity must complete the following information for each of the following individuals: (Make additional copies as necessary)

Owners	Officers
Agents	Directors
Managing Employees	Shareholders with 5% or more controlling interest

This form must be completed for anyone who holds one of the above listed positions.

The completion of this section is required to establish a new group or payee.

Name:	Title:
Home Address:	Business Address:
Social Security Number:	Employer's Tax ID:
Driver's License Number & Issuer:	Driver's License Expiration Date:
Date of Birth:	Sex: ☐ Male ☐ Female
Previous Home Address:	Previous Business Address:

If provider and payee are not the same, describe the business and financial relationship between the two.

_____
_____
_____

List all contractual relationships with medical entities and the provider numbers of those entities: (attach additional sheets if necessary)

_____
_____
_____

Are you related as spouse, parent, child, or sibling to any other owner, officer, agent, managing employee, director or shareholder? ☐ Yes ☐ No If yes, please give names and relationships (Attach additional pages if necessary):

Name	Relationship

DISCLOSURE INFORMATION – Cont.

Have you ever been excluded, debarred, or sanctioned from any state or federal program? ☐ Yes ☐ No
If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Is your license currently suspended or restricted? ☐ Yes ☐ No

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license: (attach additional sheets if necessary)

_____

_____

_____

Have you ever been convicted of a crime? (excluding minor traffic citations) ☐ Yes ☐ No

Convicted means that:

1. A judgement of conviction has been entered against an individual or entity by a Federal, State or local court, regardless of whether:
   a) There is a post-trial motion or appeal pending, or
   b) The judgement of conviction or other record related to the criminal conduct has been expunged or otherwise removed;
2. A Federal, State or local court has made a finding of guilt against an individual or entity;
3. A Federal, State or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or
4. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgement of conviction has been withheld.

If yes, please fully explain the details including dates, the state where the incident occurred, and any adverse action against your license:

_____

_____

_____

_____

Do you have any outstanding criminal fines, restitution orders, or overpayments identified in this state or any other state? ☐ Yes ☐ No

SECTION VI - SIGNATURE

Must be signed with an original signature

To the best of my knowledge, the information supplied on this document is accurate and complete and is hereby released to EDS and the Alabama Medicaid Agency for the purpose of issuing a Medicaid provider number.

I hereby authorize, consent to, and request the release to the Alabama Medicaid Agency of any and all records concerning me, including, but not limited to, employment records, government records, and professional licensing records, and any other information requested by the Alabama Medicaid Agency for purposes of acting on my application to be an enrolled provider under the Alabama Medicaid program.

Signature of applicant (or an authorized representative if you are enrolling as a provider group/supplier)

_____

Signature

_____ _____

Title Date

Out of State Providers:

Indicate date(s) of service From: _____ To:_____

Do Not Write In This Area

(For Office Use Only)

_____

Date**:**_____

Initials: _____

QC Date: _____

QC Initials_____

SECTION VI - SIGNATURE (Continue)

Penalties for Falsifying information on the Medicaid Health Care Provider / Supplier Enrollment Application

1. 18 U.S.C. § 1001 authorizes criminal penalties against an individual who in any matter within jurisdiction of any depart or agency of the United States knowingly and willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or make any false, fictitious or fraudulent statements or representations, or makes any false writing or document knowing the same to contain any false, fictitious of fraudulent statement or entry.

   Individual offenders are subject to fines of up to $250,000 and imprisonment for up to five years. Offenders that are organizations are subject to fines of up to $500,000. 18 U.S.C. § 3571 Section 3571(d) also authorizes fines of up to twice the gross gain derived by the offender if it is greater than the amount specifically authorized by the sentencing statute.

2. Section 1128B(a)(1) of the Social Security Act authorizes criminal penalties against an individual who "knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a program under a Federal health care program.

   The offender is subject to fines of up to $25,000 and/or imprisonment for up to five years.

3. The Civil False Claims Act, 31 U.S.C. § 3729 imposes civil liability, in part, on any person who:

   a) knowingly presents, or causes to be presented, to an officer or an employee of the United States Government a false or fraudulent claim for payment or approval;
   b) knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government; or
   c) conspire to defraud the Government by getting a false or fraudulent claim allowed or paid.

4. Section 1128B(a)(1) of the Social Security Act imposes civil liability, in part, on any person (including an organization, agency or other entity) that knowingly presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency…

   A claim…that the Secretary determines is for a medical or other item or service that the person knows or should know:

   a) was not provided as claimed; and/or
   b) the claim is false or fraudulent.

   This provision authorizes a civil monetary penalty of up to $10,000 per each item or service, an assessment of up to 3 times the amount claimed, and exclusion from participation in the Medicare program and State health care programs.

5. The Government may assert common law claims such as "common law fraud," "money paid by mistake," and "unjust enrichment." **Remedies include compensatory and punitive damages, restitution and recovery of the amount of the unjust profit.**

PROVIDER AGREEMENT

**Name of Provider _____ *Medicaid Provider ID _____

**(Doing Business As) _____ **Medicare Provider ID _____

**Service Site_____ **Mailing Address _____

_____ _____

*Please list additional provider numbers on the Addendum Statement for this Agreement. New applicants should leave this space blank.

As a condition for participation as a provider under the Alabama Medicaid Program (MEDICAID), the provider (Provider) agrees to comply with all terms and conditions of this Agreement.

I. ALL PROVIDERS

1.1 Agreement and Documents Constituting Agreement.

A copy of the current *Alabama Medicaid Provider Manual* and the *Alabama Medicaid Administrative Code* has been or will be furnished to the Provider. This Agreement is deemed to include the applicable provisions of the State Plan, *Alabama Medicaid Administrative Code*, and *Alabama Medicaid Provider Manual*, as amended, and all State and Federal laws and regulations. If this Agreement is deemed to be in violation of any of said provisions, then this Agreement is deemed amended so as to comply therewith. Invalidity of any portion of this Agreement shall not affect the validity, effectiveness, or enforceability of any other provision. Provider agrees to comply with all of the requirements of the above authorities governing or regulating MEDICAID. Provider is responsible for ensuring that employees or agents acting on behalf of the Provider comply with all of the requirements of the above authorities.

1.2 State and Federal Regulatory Requirements.

1.2.1 Provider has not been excluded or debarred from participation in any program under Title XVIII (Medicare) or any program under Title XIX (Medicaid) under any of the provisions of Section 1128(A) or (B) of the Social Security Act (42 U.S.C. § 1320a-7), or Executive Order 12549. Provider also has not been excluded or debarred from participation in any other state or federal health-care program. Provider must notify MEDICAID or its agent within ten (10) business days of the time it receives notice that any action is being taken against Provider or any person defined under the provisions of Section 1128(A) or (B), which could result in exclusion from the Medicaid program

1.2.2 Provider agrees to disclose information on ownership and control, information related to business transactions, and information on persons convicted of crimes in accordance with 42 C.F.R. Part 455, Subpart B, and provide such information on request to MEDICAID, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. Provider agrees to keep its application for participation in the Medicaid program current by informing MEDICAID or its agent in writing of any changes to the information contained in its application, including, but not limited to, changes in ownership or control, federal tax identification number, or provider business addresses, at least thirty (30) business days prior to making such changes. Provider also agrees to notify MEDICAID or its agent within ten (10) business days of any restriction placed on or suspension of the Provider's license or certificate to provide medical services, and Provider must provide to MEDICAID complete information related to any such suspension or restriction.

1.2.3 This Agreement is subject to all state and federal laws and regulations relating to fraud and abuse in health care and the Medicaid program. As required by 42 C.F.R. §431.107, Provider agrees to keep any and all records necessary to disclose the extent of services provided by the Provider to individuals in the Medicaid program and any information relating to payments claimed by the Provider for furnishing Medicaid services. Provider also agrees to provide, on request, access to records required to be maintained under 42 C.F.R. §431.107 and copies of those records free of charge to MEDICAID, its agent, the Alabama Attorney General's Medicaid Fraud Control Unit, and/or the United States Department of Health and Human Services. All such records shall be maintained for a period of at least three years plus the current year. However, if audit, litigation, or other action by or on behalf of the State of Alabama or the Federal Government has begun but is not completed at the end of the above time period, or if audit findings, litigation, or other action has not been resolved at the end of the above time period, said records shall be retained until resolution and finality thereof.

1.2.4 The Alabama Attorney General's Medicaid Fraud Control Unit, Alabama Medicaid Investigators, and internal and external auditors for the state/federal government and/or MEDICAID may conduct interviews of Provider employees, subcontractors and its employees, witnesses, and recipients without the Provider's representative or Provider's legal counsel present unless the person voluntarily requests that the representative be present. Provider's employees, subcontractors and its employees, witnesses, and recipients must not be coerced by Provider or Provider's representative to accept representation by the Provider, and Provider agrees that no retaliation will occur to a person who denies the Provider's offer of representation. Nothing in this agreement limits a person's right to counsel of his or her choice. Requests for interviews are to be complied with, in the form and the manner requested. Provider will ensure by contract or other means that its employees and subcontractors over whom the Provider has control cooperate fully in any investigation conducted by the Alabama Attorney General's Medicaid Fraud Control Unit and/or MEDICAID. Subcontractors are those persons or entities who provide medical goods or services for which the Provider bills the Medicaid program or who provide billing, administrative, or management services in connection with Medicaid-covered services.

1.2.5 Provider must not exclude or deny aid, care, service or other benefits available under MEDICAID or in any other way discriminate against a person because of that person's race, color, national origin, gender, age, disability, political or religious affiliation or belief. Provider must provide services to Medicaid recipients in the same manner, by the same methods, and at the same level and quality as provided to the general public.

1.2.6 Provider agrees to comply with all state and federal laws relating to the preparation and filing of cost reports, audit requirements, and inspection and monitoring of facilities, quality, utilization, and records.

1.2.7 Under no circumstances shall any commitments by MEDICAID constitute a debt of the State of Alabama as prohibited by Article XI, Section 213, Constitution of Alabama of 1901, as amended by Amendment 26. It is further agreed that if any provision of this Agreement shall contravene any statute or Constitutional provision or amendment, whether now in effect or which may, during the course of the Agreement, be enacted, then that conflicting provision in the Agreement shall be deemed null and void. The Provider’s sole remedy for the settlement of any and all disputes arising under the terms of this Agreement shall be limited to the filing of a claim against Medicaid with the Board of Adjustment for the State of Alabama.

1.2.8 In the event litigation is had concerning any part of this Agreement, whether initiated by Provider or MEDICAID, it is agreed that such litigation shall be had and conducted in either the Circuit Court of Montgomery County, Alabama, or the United States District Court for the Middle District of Alabama, Northern Division, according to the jurisdiction of those respective courts. This provision is not intended to, nor shall it operate to, enlarge the jurisdiction of either of said courts, but is merely an agreement and stipulation as to venue.

1.3 Claims and Encounter Data

1.3.1 Provider agrees to submit claims for payment in accordance with billing guidelines and procedures promulgated by MEDICAID, including electronic claims. Provider certifies that information submitted regarding claims or encounter data will be true, accurate, complete, and that such information can be verified by source documents from which data entry is made by the Provider. Further, Provider understands that any falsification or concealment of a material fact may be prosecuted under state and/or federal laws.

1.3.2 Provider must submit encounter data required by MEDICAID or any managed care organization to document services provided, even if the Provider is paid under a capitated fee arrangement.

1.3.3 All claims or encounters submitted by Provider must be for services actually rendered by Provider. Physician providers must submit claims for services rendered by another in accordance with MEDICAID rules regarding providers practicing under physician supervision. Claims must be submitted in the manner and in the form set forth in the *Alabama Medicaid Provider Manual*, and within the time limits established by MEDICAID for submission of claims. Claims for payment or encounter data submitted by the provider to a managed care entity or MEDICAID are governed by the Provider's contract with the managed care entity. Provider understands and agrees that MEDICAID is not liable or responsible for payment for any Medicaid-covered services provided under the managed care Provider contract, or any agreement other than this Medicaid Provider Agreement.

1.3.4 Federal and state law prohibits Provider from charging a recipient or any financially responsible relative or representative of the recipient for Medicaid-covered services, except where a copayment is authorized under the Medicaid State Plan. (42 C.F.R. §447.20). The provider (or its staff) must advise each recipient when MEDICAID payment will not be accepted prior to services being rendered, and the recipient must be notified of responsibility for the bill. The fact that Medicaid payment will not be accepted must be recorded in the recipient's medical record.

1.3.5 As a condition for eligibility for Medicaid benefits, a recipient assigns all rights to recover from any third party or any other source of payment to MEDICAID (42 C.F.R. §433.145 and §22-6-6.1, Code of Alabama 1975). Except as provided by MEDICAID's third-party recovery rules *(Alabama Medicaid Administrative Code*, Chapter 20), Provider agrees to accept the amounts paid under MEDICAID as payment in full for all covered services. (42 C.F.R. §447.15).

1.3.6 Provider must refund to MEDICAID any overpayments, duplicate payments, and erroneous payments which are paid to Provider by MEDICAID as soon as the payment error is discovered.

1.3.7 Provider has an affirmative duty to verify that claims and encounters are received by MEDICAID or its agent and implement an effective method to track submitted claims against payments made by MEDICAID.

1.3.8 MEDICAID'S obligation to make payments hereunder is subject to the availability of State and Federal funds appropriated for MEDICAID purposes. Further, MEDICAID'S obligation to make payments hereunder is and shall be governed by all applicable State and Federal laws and regulations. In no event shall the MEDICAID payment exceed the amount charged to the general public for the same service.

1.3.9 Provider shall not charge MEDICAID for services rendered on a no-cost basis to the general public.

1.3.10 Provider is prohibited from offering incentives (such as discounts, rebates, refunds, or other similar unearned gratuity or gratuities) other than an improvement(s) in the quality of service(s), for the purpose of soliciting the patronage of MEDICAID recipients. Should the Provider give a discount or rebate to the general public, a like amount shall be adjusted to the credit of MEDICAID on the MEDICAID claim form, or such other method as MEDICAID may prescribe. Failure to make a voluntary adjustment by the Provider shall authorize MEDICAID to recover same by then existing administrative recoupment procedures or legal proceedings.

1.3.11 Provider agrees and hereby acknowledges that payments made under this agreement are subject to review, audit adjustment and recoupment action. In the event that Provider acquires or has acquired ownership of another MEDICAID provider through transfer, sale, assignment, merger, replacement or any other method, whether or not a new Agreement is required, Provider shall be responsible for any unrecovered improper MEDICAID payments made to the previous provider. An indemnification agreement between Provider and the previous provider shall not affect MEDICAID'S right to recovery.

1.3.12 Provider agrees to comply with the provisions of the *Alabama Medicaid Provider Manual* regarding the transmission and receipt of electronic claims and eligibility verification data. Provider must verify that all claims submitted to MEDICAID or its agent are received and accepted. Provider is responsible for tracking claims transmissions against claims payments and detection and correcting all claims errors. If Provider contracts with third parties to provide claims and/or eligibility verification data from MEDICAID, the Provider remains responsible for verifying and validating all transactions and claims, and ensuring that the third party adheres to all client data confidentiality requirements.

II. RECIPIENT RIGHTS

2.1. Provider must maintain the recipient's state and federal right of privacy and confidentiality to the medical and personal information contained in Provider's records.

2.2. The recipient must have the right to choose providers unless that right has been restricted by MEDICAID or by waiver of this requirement from CMS. The recipient's acceptance of any service must be voluntary.

2.2.1 The recipient must have the right to choose any qualified provider of family planning services.

III. ADVANCE DIRECTIVES - HOSPITAL, HOME HEALTH, HOSPICE, AND NURSING HOME PROVIDERS

3.1 The provider shall comply with the requirements of §1902(w) of the Social Security Act (42 USC §1396a(w)) as described below:

3.1.1 Maintain written policies and procedures in respect to all adult individuals receiving medical care by or through the provider about patient rights under applicable state law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

3.1.2 Provide written information to all adult individuals on patient policies concerning implementation of such rights;

3.1.3 Document in the patient's medical record whether or not the individual has executed an advance directive;

3.1.4 Not condition the provision of care or otherwise discriminate against a patient based on whether or not he/she has executed an advance directive;

3.1.5 Ensure compliance with requirements of state law (whether statutory or recognized by the courts) concerning advance directives;

3.1.6 Provide (individually or with others) for education for staff and the community on issues concerning advance directives; and

3.1.7 Furnish the written information described above to adult individuals as required by law.

IV. TERM, AMENDMENT, AND TERMINATION

This Agreement will be effective from the date all enrollment documentation has been received and verified until the date the Agreement is terminated by either party. This Agreement may be amended as required, provided such amendment is in writing and signed by both parties concerned. Either party may terminate this Agreement by providing the other party with fifteen (15) days written notice. MEDICAID may immediately terminate the Agreement for cause if the Provider is excluded from the Medicare or Medicaid programs for any reason, loses its licenses or certificates, becomes ineligible for participation in the Medicaid program, fails to comply with the provisions of this Agreement, or if the Provider is or may be placing the health and safety of recipients at risk. MEDICAID may terminate this Agreement without notice if the Provider has not provided services to Medicaid recipients in excess of five (5) claims or $100.00 during the last fiscal year.

Provider Signature _____
(Must be an original signature)

Date _____

Name and Title of Person signing for Provider **(Please print)**

_____

This Agreement must be completed for enrollment purposes. All five pages of the agreement are to be returned with this application. Below is a guide to completing page 1 of the Provider Agreement.

COMPLETION TIPS

- **Information submitted on page 1 of the Provider Agreement, should match that which is indicated in Section I – General Information.**
- **Name of Provider – Indicate the name of the individual or facility you are enrolling using this application.**
- **(Doing Business As) – Indicate the name of the payee as shown in Section I – General Information.**
- **Service Site – Indicate the physical location as shown in Section I – General Information.**
- **Medicare Provider I D – Indicate the Medicare number as shown in Section I – General Information.**
- **Mailing Address – Indicate address to which general mail-outs should be sent. General mail-outs does not include EOPs or paper checks.**

CORPORATE BOARD OF DIRECTORS RESOLUTION

Required for corporations only and **must** be an original, notarized form

For physician groups that operate as corporations, this form must only be filled out once and submitted with the application for the group/payee number.

State of _____

County of_____

On The _____ Day Of_____ , _____ At A Meeting Of The Board

of Directors of _____, A Corporation, Held in The City Of

_____ , In_____ County, With a Quorum Of The Directors

esent, The Following Business Was Conducted:

It Was Duly Moved And Seconded That The Following Resolution Be Adopted:
Be It Resolved That The Board Of Directors Of The Above Corporation Does Hereby Authorize

_____

And His/Her Successors In Office To Negotiate, On Terms And Conditions That He/She May Deem Advisable, A Contract Or Contracts With The Alabama Medicaid Agency, And To Execute Said Contract Or Contracts On Behalf Of The Corporation, And Further We Do Hereby Give Him/Her The Power And Authority To Do All Things Necessary To Implement, Maintain, Amend, Or Renew Said Contract.

The Above Resolution Was Passed By A Majority Of Those Present And Voting In Accordance With The By-Laws And Articles Of Incorporation.

I Certify That The Above Constitutes A True And Correct Copy Of A Part Of The Minutes Of A Meeting Of The Board Of Directors Of_____

Held On The _____Day of _____, _____

_____
Signature Of Secretary of Board

Subscribed And Sworn Before Me, _____, A Notary Public For The

County Of _____, On The _____Day Of _____,_____.

Notary Stamp or Seal (**If stamp or seal does not visibly contain the expiration date of commission, the date must be indicated in the next block.**)

Notary Public, County Of _____

State Of _____

Expiration Date Of Commission: _____,_____

W-9

(Obtain TIN for payments other than interest, dividends, or Form 1099-B gross proceeds)

Taxpayer Identification Number Request

Please complete the following information. We are required by law to obtain information from you when making a reportable payment to you. If you do not provide us with this information, your payments may be subject to 31 percent federal income tax backup withholding. Also, if you do not provide us with this information, you may be subject to a $50 penalty imposed by the Internal Revenue Service under section 6723.

Federal law on backup withholding preempts any state or local law remedies, such as any right to a mechanic's lien. If you do not furnish a valid TIN, or if you are subject to backup withholding, the payor is required to withhold 31 percent of its payment to you. Backup withholding is not a failure to pay you. It is an advance tax payment. You should report all backup withholding as a credit for taxes paid on your federal income tax return.

Instructions:

Complete Part 1 by completing the row of boxes that corresponds to your tax status. Complete Part 2 if you are exempt from Form 1099 reporting. Complete Part 3 to sign and date the form.

Part 1 Tax Status: (complete one row of boxes)

Individuals:	Individual Name:	Individual's Social Security Number (SSN): ___ ___ ___ - ___ ___ - ___ ___ ___ ___

A sole proprietorship may have a 'doing business as' trade name, but the legal name is the name of the business owner.

Sole Proprietor:	Business Owner's Name:	Business Owner's SSN or Employer ID Number: ___ ___ ___ ___ ___ ___ ___ ___ ___	Business or Trade Name

Partnership:	Name of Partnership:	Partnership's Employer ID Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___	Partnership's Name on IRS records (see IRS mailing label)

A corporation may use an abbreviated name or its initials, but its legal name is the name on the articles of incorporation.

Corporation, exempt charity, or other entity:	Name of Corporation or Entity:	Employer Identification Number: ___ ___ - ___ ___ ___ ___ ___ ___ ___

Part 2 Exemption:

If exempt from Form 1099 reporting, check here: ☐
and circle your qualifying exemption reason below

1. Corporation, except there is no exemption for medical and healthcare payments or payments for legal services.
2. Tax Exempt Charity under 501(a), or IRA
3. The United States or any of its agencies or instrumentalities
4. A state, the District of Columbia, a possession of the United States, or any of their political subdivisions.
5. A foreign government or any of its political subdivisions.

Part 3 Signature:

Person completing this form: _____

Signature: _____

Date: _____

Phone: (_____) _____

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Agency Copy *(Return with application)*

CR FORM-2

STATEMENT OF COMPLIANCE

Assurance is hereby given that in accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 70b), the Age Discrimination Act of 1975 (42 U.S.C. 6101, et seq.), the Americans with Disabilities Act of 1990, and the Regulations issued thereunder by the Department of Health and Human Services (45 CFR Parts 80, 84, and 90) no individual shall, on the ground of race, sex, color, creed, national origin, age, or handicap be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or services by this institution.

_____

Signature **(Original signature required)**

_____

Typed or Printed Provider's Name

_____

Date

Provider Copy

(This item should be retained in the Provider's office and must be posted in facility.)

CR FORM

ELECTRONIC FUNDS TRANSFER (EFT) INFORMATION

Electronic Funds Transfer (EFT) is the **required** payment method to deposit funds for claims approved for payment. These funds can be credited to either checking or savings accounts, directly into a provider's bank account, *provided* the bank selected accepts Automated Clearing House (ACH) transactions. EFT also avoids the risks associated with mailing and handling paper checks, **ensuring funds are directly deposited into a specified account.**

The following items are specific to EFT:

- The release of direct deposits depends on the availability of funds. EFT funds are released as directed by the Alabama Medicaid Agency. The earliest date funds are available is Thursday mornings following the checkwrite (Friday in the event of a Monday State holiday).

- Pre-notification to your bank takes place following the application processing. The pre-notification process takes place over a time frame of twenty-one (21) days. Direct deposits when owed to a provider will be made according to the release guidelines in the bullet above. The Explanation of Payment (EOP) Report furnishes the details of individual payments made to the provider's account during the weekly cycle.

- The availability of EOP reports is unaffected by EFT and they typically are received by the end of the week following the checkwrite.

EDS must provide the following notification according to ACH guidelines:

> "Most receiving depository financial institutions receive credit entries on the day before the effective date, and these funds are routinely made available to their depositors as of the opening of business on the effective date.
>
> However, due to geographic factors, some receiving depository financial institutions do not receive their credit entries until the morning of the effective day and the internal records of these financial institutions will not be updated. As a result, tellers, bookkeepers, or automated teller machines (ATM) may not be aware of the deposit and the customer's withdrawal request may be refused. When this occurs, the customer or company should discuss the situation with the ACH coordinator of their institution who, in turn, should work out the best way to serve their customer's needs."
>
> The effective date for EFT under the Alabama Medicaid Program is based on release of funds as directed by the Alabama Medicaid Agency. The earliest effective date is Thursday following the checkwrite (if funds were made available from the Agency for the particular provider).

Complete the attached Electronic Funds Transfer Authorization Agreement. **A voided check or an official letter from the bank must be returned with the agreement to EDS.**

ELECTRONIC FUNDS TRANSFER AUTHORIZATION AGREEMENT

Note: Complete all sections below and **attach a voided check or an official letter for the bank for verification purposes.**
Enter ONE group/payee provider number per form. EFT information is an enrollment requirement.

Type of Authorization _____New _____Change

Provider Name	Group/Payee Provider No.
Payee Address	**Provider Phone No.**

Bank Name	ABA/Transit No.
Bank Phone No.	**Account No.**
Bank Address	
	Checking ☐
	Savings ☐

I (we) hereby authorize Alabama Medicaid Agency to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I (we) am responsible for the validity of the information on this form. If the company erroneously deposits funds into my (our) account, I (we) authorize the company to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay period.

I (we) agree to comply with all certification requirements of the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by the Alabama Medicaid Agency or its fiscal agent. I (we) understand that payment claims will be from federal and state funds, and that any falsification, or concealment of material fact, may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

_____ _____
Authorized Signature **(Original signature required)** Date

_____ _____
Title Internet Address (if applicable)

_____ _____
Contact Name Phone

Input By_____ Date _____