STATE OF TENNESSEE
DEPARTMENT OF FINANCE AND ADMINISTRATION
DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
**BUREAU OF TENNCARE**
310 Great Circle Road
NASHVILLE, TENNESSEE 37243

# MCC
## Instate and Out-Of-State Sole Proprietor

In response to your interest in participating in the Tennessee TennCare/Medicaid Program, we are providing the necessary documents for enrollment. This site includes, but is not limited to enrollment applications for hospitals, hospice, laboratories, and groups.

Tennessee TennCare/Medicaid Providers must have completed applications forms on file before claims can be processed for payment. Please complete all documents and return to

**Department of Finance and Administration**
**Bureau of TennCare**
**Provider Registration Unit**
**310 Great Circle Road**
**Nashville, TN 37243**

All incomplete applications and requested documents not included will be returned to the pay-to address on your application. Original signature is required for all documents.

Tennessee Providers may obtain a copy of their licensure verification from the website of the State of Tennessee, Department of health listed bellow

**http://health.state.tn.us/Licensure/default.aspx**

**Note: Out-of-State Providers must return a claim form with an attached Medicare Remittance for dually-eligible Medicare/Medicaid recipients, or a claim form only if billing for a TennCare recipient.**

Completed Applications will be assign a Tennessee Medicaid Provider Number. You will be notified in writing of your assigned Provider Number. Please file all future claims only after you receive the notification as your provider number must be stated on all claim forms. Providers who have rendered a service to a TennCare only recipient will be required to enroll with the TennCare Manage Care Organization the recipient has chosen to manage his/her healthcare. The state Medicaid ID number assigned by this office should be presented to the MCO upon enrolling. You will be assigned a billing number by the MCO for reimbursement.

Should you have any questions regarding your number assignment please contact:
1-800-852-2683.

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# MCC Checklist

## Instate and Out-Of-State Sole Proprietor

This check list will assist you in completing and returning the correct forms along with this document. Enrollment Packets must include the following

**Note: Please complete all forms in black ink only.**

**Medicaid Provider Number** _____

**NPI Number** _____

**NPI Collection Form (Required)** _____

**No. 1 Sole Proprietor Application** _____

**Disclosure For Provider Person (Required)** _____

**Substitute W-9 Form (Required)** _____

**DEA Certification (If Applicable)** _____

**CLIA Certification (If Applicable)** _____

**Copy of License (If Applicable)** _____

**Copy of Certification (If Applicable)** _____

**Copy of Renewal (If Applicable)** _____

**Claim Form (Out-Of-State Only)** _____

**NOTE: THIS FORM MUST BE RETURNED WITH THE ENROLLMENT PACKET**

**MCC NO 1 SOLE PROPRIETOR APPLICATION**

**Provider Registration**
**310 Great Circle Road**
**Nashville, TN 37243**

# STATE OF TENNESSEE
# DEPARTMENT OF FINANCE AND ADMINISTRATION
# DIVISION OF HEALTH CARE FINANCE AND ADMINISTRATION
# BUREAU OF TENNCARE

www.tn.gov/tenncare/pro-forms2.html

| (Check all that apply) | |
|---|---|
| _____ New Enrollment | _____ Adding Practice/Satellite Location |
| _____ Reactivation | _____ Change of Ownership |
| _____ Revalidation | _____ Tax ID Change |

**Physician / Legal Business Name:** _____
**D/B/A Name:** _____
**Practice Location: (No P.O. Box #)** _____
**City:** _____ **State:** _____ **Zip Code + 4:** _____
**Telephone:** _____ **Fax:** _____ **County:** _____

If the name and address to which checks and remittance advices are to be sent is different from the name and address above, please provide that information below. This pay-to information should match the W-9 form.

**Legal Business Name as reported to the IRS:** _____
**D/B/A Name:** _____
**(Pay-To Address)**
**Street Address or P.O. Box:** _____
**City:** _____ **State:** _____ **Zip Code + 4:** _____
**Telephone No.:** _____ **Fax No.:** _____

**Federal Tax No. (IRS No.):** _____ **State Medicaid No.:** _____

**NPI No.:** _____ **Taxonomy:** _____

**Medical Specialty:** _____

**Briefly describe the services you propose to offer to Medicaid recipients:** _____

_____

**Submit copies of professional and/or business licenses, accreditations, certifications, DEA, CLIA and registrations specifically required to operate as a health care provider.**

**License No:** _____ **Date of Issuance:** _____ **Expiration Date:** _____

**DEA No.:** _____ **Date of Issuance:** _____ **Expiration Date:** _____

Application Surety Statement: **"I certify that the information provided on this application is complete and correct to the best of my knowledge."**

**Signature:** _____ **Date:** _____
**(Original Signature of Administrator, Agent, or Owner)**

**Printed Name:** _____ **Title:** _____

# SUBSTITUTE W-9 FORM

## REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

**1. Please complete general information:**

Taxpayer Name: _____ Phone Number: _____

Business Name (if applicable): _____

Address: _____

City: _____ State: _____ ZIP Code: _____

**2. Circle the most appropriate category below: (please circle only one)**

1) Individual (not an actual business)
2) Joint account (two or more individuals)
3) Custodian account of a minor
4) a. Revocable savings trust (grantor is also trustee)
   b. So-called trust account that is not a legal or valid trust under state law
5) Sole proprietorship (using a social security number for the taxpayer ID)
6) Sole proprietorship (using a federal employer identification number for the taxpayer ID)
7) A valid trust, estate, or pension trust
8) Corporation
9) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 13 below)
10) Partnership
11) A broker or registered nominee
12) Account with the U.S. Department of Agriculture in the name of a public entity that receives agricultural program payments
13) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

**3. Fill in your taxpayer identification number below: (please complete only one)**

1) If you circled number 1-5 above, fill in your Social Security Number

   __ __ __ - __ __ - __ __ __ __

2) If you circled number 6-13 above, fill in your Federal Employer Identification Number (EIN).

   __ __ - __ __ __ __ __ __ __

**Sign and date the form:**

Certification – Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 13 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature: _____ Date: _____

Title (if applicable): _____

# National Provider Identifier (NPI) Collection Form
# (Individual/ Solo Practices)

Any form not containing all required fields will be rejected.

## Section 1 – Provider General Information
## (Please make additional copies if required)

| Provider Last Name | First Name | Middle | Title |
|---|---|---|---|
| | | | |

| Existing Medicaid ID's | SSN | EIN Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Section 2 – NPI Information

**NPI Number** _____

**Taxonomy Codes**

| | | |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

## Section 3 – Primary Practice Location (As Entered on NPPES)

**Address** _____

| City | State | ZIP |
|---|---|---|
| | | |

| Phone Number | Fax Number | Provider e-mail Address |
|---|---|---|
| | | |

## Section 4 – Contact Information

**Name of Individual Completing Form** _____

| Phone Number | Fax Number | Contact e-mail Address |
|---|---|---|
| | | |

**Signature** _____ **Title** _____

**NPI Collection Form Surety Statement:**
**"I certify that the information provided on this application is complete and correct to the best of my knowledge."**

# Instructions
# Individual/Solo Practice

Send the completed NPI Collection Form and a copy of the NPPES confirmation via one of the following means:

| | |
|---|---|
| **Mail** | Provider Enrollment<br>Attn: NPI Collection<br>310 Great Circle Rd.<br>Nashville, TN 37243 |
| **Fax** | (615) 248-4386 or (866) 456-8059 |
| **Field** | **Instruction** |
| **Section 1 – Provider General Information** | |
| Provider Last Name | (Required) Enter the provider's last name. |
| First Name | (Required) Enter the provider's first name. |
| Middle | (Optional) Enter the provider's middle name. |
| Title | (Required) Enter the provider's title. |
| Existing Medicaid ID's | (Required) Enter all currently assigned Medicaid provider numbers. |
| SSN | (Required) for an individual provider. Enter the Social Security Number. |
| EIN Number | (Required) Enter the Employer Identification Number (could be SSN). |
| **Section 2 – NPI Information** | |
| National Provider Identifier | (Required) Enter the National Plan and Provider Enumeration System (NPPES) assigned NPI. |
| Taxonomy Codes | (Required) Enter the Taxonomy codes associated with the assigned NPI. |
| **Section 3 – Primary Practice Location** | |
| Address | (Required) Enter the primary practice location line 1 address of the provider as entered in the NPPES. |
| City | (Required) Enter the primary practice location City of the provider as entered in the NPPES. |
| State | (Required) Enter the primary practice location State of the provider as entered in the NPPES. |
| ZIP | (Required) Enter the primary practice location ZIP of the provider as entered in the NPPES.<br>If known, include the ZIP +4. |
| Phone Number with area code | (Required) Enter the primary practice location phone number of the provider as entered in the NPPES. |
| Fax Number with area code | (Optional) Enter the primary practice location fax number of the provider as entered in the NPPES. |
| Provider e-mail Address | (Optional) Enter the primary practice location e-mail address of the provider as entered in the NPPES. |
| **Section 4 – Contact Information** | |
| Name of Individual Completing Form | (Required) Enter the name of the individual completing this form. |
| Phone Number with area code | (Required) Enter the phone number of the individual completing this form. |
| Fax Number with area code | (Optional) Enter the fax number of the individual completing this form. |
| Contact e-mail Address | (Optional) Enter the e-mail address of the individual completing this form. |
| Signature and Title | Signature and Title of the person who has legally binding authority to provide information to the Bureau of TennCare with regards to the provider identified on the form. |

# DISCLOSURE FORM FOR A PROVIDER PERSON

**Directions:** Use this form if you are trying to get a TennCare/Medicaid provider ID number for a **Provider Person**. If the addition of the **Provider Person** will change the **Ownership** or **Control** structure of the **Provider Entity** that the **Provider Person** is joining (i.e. the new **Provider Person** will also be an owner or high ranking employee of the **Provider Entity**, then you must also fill out a new Disclosure form for the **Provider Entity** to reflect the new **Ownership** or **Control** arrangements.

Please answer all questions as of the current date. If additional space is needed, please note on the form that the answer is being continued, and attach a sheet referencing the item number that is being continued. Return this form to the address on the application packet. Go to the TennCare Program Integrity website for a list of contact information for each MCO. Please retain a copy for your files. Completely answer the applicable questions. If a question is not applicable please respond **N/A** for that question. ***NO QUESTIONS SHOULD BE LEFT BLANK***. Website, and email addresses are not acceptable answers to any of the questions and should not be referenced in this statement.

Social Security Numbers (SSN) must be provided. Tennessee Code Annotated § 4-4-125 creates an exception to the public records act by prohibiting state agencies from disclosing (SSN).

| Name of person completing form | Phone number of person completing form |
|---|---|
| | |

## I. Identifying Information

| Provider Person name | SSN | DOB | NPI number (if you have one, if not indicate if applied for) | TennCare/Medicaid Id number (if you have one, if not indicate if applied for") |
|---|---|---|---|---|
| | | | | |

| Provider Person Home Address | City | State | Zip |
|---|---|---|---|
| | | | |

| Provider Entity name<br><br>(Provider Entity is who the Provider person works for. If you are a sole proprietor you would list yourself as the Provider Entity also.) | Provider Entity DBA<br><br>(If different from provider Entity Name) | Provider Entity Address<br><br>(If you have more than one practice location list all locations) |
|---|---|---|
| | | |

| Provider Entity T.I.N. | Provider N.P.I.<br><br>(if the Entity has one, if not indicate if applied for) | Provider TennCare/Medicaid I.D. number<br><br>(if the Entity has one, if not indicate if applied for) |
|---|---|---|
| | | |

## II. Criminal Offense Attestation

A) Have you ever been **Convicted** of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the CHIP services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pre trial diversion or suspended sentence. **Yes** ☐ **No** ☐

**If 'Yes' is checked, provide the following information:**

| Name on Court records | SSN | Matter of the Offense | Date of the Conviction | Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general( OIG) |
|---|---|---|---|---|
| | | | | |

B) Have you ever been **Debarred** from participation in Federal Government contracts? **"Debarred**" means you are not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes ☐ No ☐

If 'Yes' is checked, provide the following information:

| When you were debarred | Length of Debarment | Reason for Debarment |
|---|---|---|
| | | |

C) Have you ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past? "Excluded" means that a provider or entity has been told by the Department of Health and Human Services, Office of the Inspector General (HHS,OIG) that they may no longer be a provider for any federally funded healthcare program.

Yes ☐ No ☐ If "Yes", please supply the following information:

| Beginning date of exclusion or termination | End date of exclusion or termination | Reason for exclusion or termination |
|---|---|---|
| | | |

D) Have you ever been **Terminated** from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)? **Terminated** means the Provider lost the right to bill a State's Medicaid or SCHIP programs for a cause related to fraud or abuse.

Yes ☐ No ☐ If "Yes", please supply the following information:

| State where practicing when terminated | Reason for termination | Date of termination |
|---|---|---|
| | | |

E) Have you ever had **Civil Monetary Penalties (CMPs)** assessed against you? A CMP is a type of fine assessed against a Provider by a governmental agency that manages a federal healthcare program.

Yes ☐ No ☐ If "Yes", please supply the following information:

| State where practicing when CMP assessed | Reason for CMP | Amount of CMP | Date of CMP |
|---|---|---|---|
| | | | |

## III. Questions for a Sole Proprietor

a) If you are a Sole Proprietor, please give the following information for your **Managing Employees and Agents.** A **Managing Employee** is someone who makes day to day decisions on the running of your business such as an office manager or billing manager**.** An **Agent** is someone besides yourself who can legally act for your business.

| Name of Managing Employee or Agent | SSN | DOB | Home Address | City | State | Zip |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |

b) Has any person listed in 3a been convicted of a criminal offense related to your involvement in any program under Medicare, Medicaid, or the CHIP services program since the inception of those programs? **"Convicted"** means been found guilty by a jury or judge, or pled guilty, nolo contendre, best interest plea or pre trial diversion or suspended sentence. Yes ☐ No ☐. If yes, please provide the following information:

| Name on Court records | SSN | Matter of the Offense | Date of the Conviction | Sanction Period of the Offense if you were sanctioned by Federal Office of the Inspector general( OIG) |
|---|---|---|---|---|
| | | | | |

c) Has anyone on the list in 3a ever been **Debarred** from participation in Federal Government contracts? **"Debarred**" means someone is not allowed to participate in contracts paid for by the Federal government, whether or not those contracts are in the health care area. Yes ☐ No ☐

If 'Yes' is checked, provide the following information:

| When the individual was debarred | Length of Debarment | Reason for Debarment |
|---|---|---|
| | | |

d) Has any person on the list in 3a ever been **Excluded** from participation in Federal health care programs (Medicare, Medicaid, CHIP or Tricare) in the past?

Yes ☐ No ☐ If "Yes", please supply the following information:

| Name of Individual | Beginning date of exclusion or termination | End date of exclusion or termination | Reason for exclusion or termination |
|---|---|---|---|
| | | | |

e) Have anyone on the list in 3a ever been terminated from a State's Medicaid or CHIP programs for reasons having to do with Program Integrity (fraud or abuse)?

Yes ☐ No ☐ If "Yes", please supply the following information:

| State where practicing when terminated | Reason for termination | Date of termination |
|---|---|---|
| | | |

f) Has any person on the list in 3a ever had **Civil Monetary Penalties (CMPs)** assessed against them?

Yes ☐ No ☐ If "Yes", please supply the following information:

| Name Of Individual | State where practicing when CMP assessed | Reason for CMP | Amount of CMP | Date of CMP |
|---|---|---|---|---|
| | | | | |

## IV. Signature

The State or Federal Medicaid agency may refuse to enter into, renew, or terminate an agreement with a Provider if it is determined that a Provider did not fully, accurately, and truthfully make the disclosures required by this statement. Additionally, false statements or representations of the required disclosures may be prosecuted under applicable federal or state laws. 42 C.F.R. § 455.106. The signature below **MUST** be the written signature of the Provider;

| Name of Provider Person (Printed) | Signature of Provider Person | Date |
|---|---|---|
| | | |