STATE OF TEXAS MEDICAID PROVIDER SURETY BOND
Instructions

The State of Texas Medicaid Provider Surety Bond form must be completed by the surety company and signed by an authorized power of attorney of the surety company and by an authorized representative of the Texas Medicaid provider. This is the only acceptable form for the submission of a surety bond in compliance with Title 1, Texas Administrative Code (TAC) §352.15. **The use of this form designates the Texas Health and Human Services Commission (HHSC) as the sole obligee of the bond.** Surety bonds that are obtained for the purpose of accreditation in the Medicare program and list the Centers of Medicare & Medicaid Services (CMS) as obligee will **not** fulfill the surety bond requirement for Texas Medicaid.

Important: *Submit the completed bond form with a copy of the Power of Attorney document from the issuing surety company.*

Complete the State of Texas Medicaid Provider Surety Bond form as follows:

Item	Instructions
MEDICAID PROVIDER NUMBER or TAX ID	Enter the Texas Medicaid provider's Texas Provider Identifier (TPI) or the applicant's TAX identification number (TAX ID)
BOND NUMBER	Enter the bond number as determined by the surety company.
Provider's Name	Enter the provider's/applicant's legal name according to the Internal Revenue Service (IRS).
d/b/a	Enter the provider's/applicant's "doing business as" name.
Provider's Physical Address	Enter the physical address of the provider's/applicant's practice location.
City of	Enter the city of the provider's/applicant's physical address.
County of	Enter the county of the provider's/applicant's physical address.
State of	Enter the state of the provider's/applicant's physical address.
Surety Name	Enter the name of the surety company issuing the bond.
State of	Enter the state in which the surety company is incorporated.
Surety Address	Enter the business address of the issuing surety company.
City of	Enter the city of the surety company's business address.
County of	Enter the county of the surety company's business address.
State of	Enter the state of the surety company's business address.
Total Amount of	Enter the total amount of the bond which must be equal to at least $50,000 per location. If the bond will cover more than one enrolled location, attach a list of all locations on a separate page.
This Bond is effective	Enter the date the bond coverage begins. The surety bond submitted must be a continuous bond and for a term of 12 months. The bond must be in effect at the time the provider enrollment application is submitted.
Signed and dated	Enter the date the surety bond is signed and executed by both parties.
Authorized Representative	Enter the printed name of the authorized representative that is signing the bond.
Authorized Representative Signature	This line is for the signature of the authorized representative of the Texas Medicaid provider/applicant.
Title	Enter the business title of the authorized representative of the Texas Medicaid provider/applicant.
Authorized Power of Attorney	Enter the printed name of the authorized power of attorney of the surety company that is signing the bond.
Authorized Power of Attorney Signature	This line is for the signature of the authorized power of attorney of the surety company.
Bond will cover more than one location	Attach a list of all locations to be covered under this bond. The list must include the d/b/a, physical address and provider number (if applicable) for all locations covered.

Proof of Continuation: Upon renewal of the bond every 12 months, proof of continuation must be submitted to TMHP on the surety bond company's form and must include specific information. This State of Texas Medicaid Provider Surety Bond form must **not** be used to submit proof of continuation. Providers can refer to the *Texas Medicaid Provider Procedures Manual* for the proof of continuation requirements.

STATE OF TEXAS
MEDICAID PROVIDER SURETY BOND

MEDICAID PROVIDER NUMBER or **TAX ID: _____ BOND NUMBER: _____**

Know all persons by these presents that subject to the terms, conditions, and limitations of this bond,

_____ d/b/a _____
(Provider's Name)

with its place of business at _____
(Provider's Physical Address)

City of _____, County of _____, State of _____, as principal,

And _____, a corporation organized and existing under the laws of
(Surety Name)

the State of _____, with its principal place of business at _____
(Surety Address)

City of _____, County of _____, State of _____ and authorized to transact a surety business in the State of Texas, as surety, are **held and firmly bound unto the Health and Human Services Commission (HHSC), an agency of the State of Texas, as obligee** in the penal sum of **Fifty Thousand Dollars ($50,000)** for each enrolled location for a total amount of _____, for which payment principal and surety bind themselves, their heirs, executors, administrators, successors and assignees, jointly and severally. (If bond will cover more than one enrolled location, attach a list of all locations on a separate page).

WHEREAS, Principal is enrolled in or seeking to be enrolled in the Texas Medicaid program as a provider.

WHEREAS, pursuant to Title 1 Texas Administrative Code (TAC) § 352.15, the Principal is required to provide a surety bond as a condition of participation in the Medicaid program, and this bond is provided in compliance with the provider's obligations as set forth in this authority.

NOW THEREFORE, the condition of this Bond is that if the Principal shall pay the Obligee any uncollected overpayments (as this term is defined by Title 42 Code of Federal Regulations (CFR) § 433.304), then this Bond shall be null and void, otherwise to remain in full force and effect, subject, however, to the following:

1. Principal and Surety are liable under this Bond for only the amount of any uncollected overpayments for which the Principal is responsible and for which subject to Paragraph 8, are determined during the term of the bond.
2. Surety agrees to pay a claim within 30 days of receiving written notice of the claim and sufficient evidence to establish Surety's liability under this Bond.
3. **HHSC is the sole Obligee of this Bond**, and no action may be brought on it by, or for the use or benefit of, any person or entity other than HHSC, its contractors, or designated agent.
4. Regardless of the number of years this Bond is in effect, the number of premiums paid, or the number of claims made, the Surety's aggregate liability shall not be more than the penal sum of this Bond.
5. The Surety's liability under this Bond shall not be affected, diminished, or concluded by any action by the Principal or the Surety to terminate, reduce, or limit the scope or term of the bond; by any action by the Principal to cease operation, sell or transfer any assets or ownership interest, file for bankruptcy, or fail to pay the Surety; or by the Principal's failure to exercise available appeal rights under Medicaid or CHIP.
6. Subject to Paragraph 8, The Surety's liability under this Bond shall terminate and the Surety shall have no further liability upon the effective date of cancellation or expiration of this Bond by the Surety or Principal in accordance with Paragraph 7 of this Bond.
7. The Surety or Principal may cancel this Bond by providing written notice of such cancellation to the Obligee. Cancellation or expiration shall be effective 30 days after notice of cancellation is sent to the Obligee's contractor provided such notice is actually received.
8. In the event the Principal's participation in the Medicaid program is terminated or this Bond is cancelled or expires, and the Principal fails to submit a new bond to the Obigee, the Surety remains liable for uncollected overpayments that occurred during the term of the bond for 2 years following the effective date of cancellation or expiration of this Bond.

This Bond is effective _____

Signed and dated this _____ day of _____, 20_____.

Provider's Name: _____ Surety Name:_____

Authorized Representative: _____ Authorized Power of Attorney: _____

Signature: _____ Signature:_____

Title: _____