

**INSTRUCTIONS FOR COMPLETION OF PENNSYLVANIA PROMISe™
PROVIDER ENROLLMENT FQHC/RHC APPLICATION**

**Applications must be typed or completed in black ink, or they will not be accepted.
All sections must be completed in full; if left blank, application will be rejected.
Applications will be scanned - please do NOT staple.**

Note: Out-of-State providers must submit proof of participation in your State's Medicaid Program.

1. Enter the complete name of the clinic.
- 2a. Check the appropriate boxes for the action(s) you request.
- 2b. If this is a revalidation, please complete the entire application. If you have additional service locations for revalidation, please complete Page 13.
- 2c. If you are reactivating a provider number, indicate the PROMISe™ **13 digit** provider number you wish to have reactivated and complete the application as an initial enrollment.
3. **Enter your National Provider Identifier (NPI) Number and taxonomy(s). If you have more than 4 taxonomy codes, please attach an additional sheet noting the additional codes. Include a legible copy of the NPPES Confirmation letter that shows the NPI Number and Taxonomy(s) assigned to the healthcare provider applying for enrollment. Refer to:**
<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/nationalprovideridentifiernpiinformation>
4. Enter the requested effective date for your action request.
5. Enter your provider type number and description (e.g., provider type 31, Physician).
6. Enter your **primary** specialty name and code number. **See the requirements for your provider type.**
7. Enter your specialty name(s) and code number(s), if applicable. **See the requirements for your provider type.**
8. Enter your sub-specialty name(s) and code number(s), if applicable. **See the requirements for your provider type.**
9. Enter your Tax Identification Number (TIN). **A copy of the TIN label or document generated by the Federal IRS containing the name and IRS number of the entity applying for enrollment must accompany this application. A W-9 form will not be accepted. If completing #10, do not complete #9.**
10. Enter your legal name as it is filed with the IRS and as it appears on IRS generated documents.
11. Indicate whether the clinic provides medical and/or dental services.
- 12a. Indicate whether or not you participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs).
- 12b. Enter the names of any Pennsylvania Medicaid Managed Care Organizations with which you participate.
- 13a. Indicate whether the provider operates under a fictitious business/doing-business as (d/b/a) name.

- 13b. If applicable, enter the statement/permit number and the name. **Attach a legible copy of the recorded/stamped fictitious business name statement/permit.**
- 14a. Enter your IRS address. This address is where your 1099 tax documents will be sent.
- 14b-f. Enter the contact information for the IRS address.
15. Check the appropriate box for the business type of the individual or facility applying for enrollment. Check 1 box only. Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- 16a-d. Enter your license number (if applicable), issuing state, issue date, and expiration date.
***A copy of your license must be included with the application.**
17. Enter your Drug Enforcement Agency (DEA) Number (if applicable).
*** A copy of your DEA certificate must be included with the application.**
18. If you have a CLIA certificate and a Dept. of Health Laboratory Permit associated with this service location.
***A copy of both documents must be included with the application.**
19. Enter your CMS number.
20. Enter a valid service location address. **The address must be a physical location, not a post office box. The zip code must contain 9 digits and the phone number must be for the service location. Refer to block #27 of the application to list an additional address (es) for Pay-to, Mail-to, and/or Home Office locations if different from the Service Location address entered in Block 23a.**
Please indicate if the physical address is handicap accessible
Please indicate if the physical address is an FQHC or RHC location
Please indicate if the physical address has been screened by one of the listed entities
NOTE* you can sign up for the Electronic Funds Transfer Direct Deposit Option by following the link below:
<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation>
21. Answer question, if yes, enter your E-mail Address. If no, follow directions to access the bulletin information yourself. If you require paper bulletins or RA's please call the phone number listed.
22. If you wish Medicare claims to crossover to this service location check this box. **Note: This crossover can be added to only one service location.**
- 23a-d. Enter contact information.
- 24a. Indicate whether you or your staff is able to communicate with patients in any language other than English.
- 24b. If applicable, list the additional languages in which you or your staff can communicate.
25. Enter the appropriate Provider Eligibility Program(s) (PEP(s)). **Refer to the PEP Descriptions and the requirements for your provider type.**

26a-e. The individual applying for enrollment OR the representative of the facility applying for enrollment must complete ALL confidential information questions, A through E.

If you answer “Yes” to any of the questions, you must provide a detailed explanation (on a separate piece of paper) and attach it to your application. (Refer to the Confidential Information sheet).

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

28. This page, beginning with block #28, may be used to add a mail-to, pay-to, and/or home office address to the **previously defined** service location address listed in 20. **This sheet cannot be used to add a service location.**

28a. Enter the corresponding mail-to, pay-to, and/or home office address for the service location.

28b. Indicate whether you are adding a mail-to, pay-to, and/or home office address.

28c. Enter the e-mail address of the contact person for this address.

28d-g. Enter the contact information for this address.

- **Facilities must complete a new base application to add additional service locations to their file.**
- **The representative of the facility applying for enrollment must complete the Provider Agreement included with the application.**

When completed, review the “Did You Remember...” Checklist included with the application.

Submit your application and other documentation to :

**DHS Provider Enrollment
PO Box 8045
Harrisburg, PA 17105-8045
- or -
Fax: (717) 265-8284
- or -
Email: RA-ProvApp@pa.gov**

Provider Eligibility Program (PEP) Descriptions

A Provider Eligibility Program code identifies a program for which a provider may apply. A provider must be approved in that program to be reimbursed for services to beneficiaries of that program. Providers should use the following PEP codes when enrolling in Medical Assistance (MA). Providers should use the descriptions in this document to determine which PEP code to use when enrolling in MA.

Consolidated Community Reporting Initiative Performance Outcome Management System (EPOMS)

Office of Mental Health and Substance Abuse Services - (800) 433-4459

This PEP is used to identify providers who are approved to serve county based-funded mental health recipients.

Eligibility:

- Recipients are non-Medicaid - county funded only;
- Providers do not receive payment through the MMIS (encounter data reporting only);
- The PEP can be added to an independent service location; in conjunction with a Beh Hlth HC or FFS PEP;
- Provider must contract with the County Mental Health Office;
- Licensed/certified/service description and approved by the County Mental Health Office;
- Requires written pre-requisite documentation from the County Mental Health Office;
- Used exclusively by OMHSAS

Services:

- All county funded providers must enroll at the appropriate service location for the county rendered service;
- Contact contracted County Mental Health Office for definition of services

Fee-for-Service

Office of Medical Assistance Programs - (800) 537-8862

The traditional delivery system of the Medical Assistance (MA) program which provides payment on a per-service basis for health care providers who render services to eligible MA recipients.

Eligibility:

All MA Recipients.

Services:

- Behavioral health services
- Inpatient services
- Outpatient services
- Physical health services

Healthy Beginnings Plus

Office of Medical Assistance Programs - (800) 537-8862

Healthy Beginnings Plus is Pennsylvania's effort to assist low-income pregnant women, who are eligible for Medical Assistance (MA). Healthy Beginnings Plus expands the scope of maternity services that can be reimbursed by the MA Program. Care coordination, early intervention, and continuity of care as well as medical/obstetric care are important features of the Healthy Beginnings Plus program.

Eligibility:

Pregnant women who elect to participate in Healthy Beginnings Plus.

Services:

- Childbirth and parenting classes
- Home health services
- Nutritional and psychosocial counseling
- Other individualized client services
- Smoking cessation counseling

PROMISE™ PROVIDER ENROLLMENT FQHC/RHC APPLICATION

1. Enter Name of Clinic:

2. Action Request: Check Boxes that Apply:

- a. Initial Enrollment
b. Revalidation
c. Check here if previously enrolled in Medical Assistance (MA).

Enter Provider Number (if known): _____ (13 digits)
(Complete the application as an initial enrollment.)

3. National Provider Identifier Number: _____ (10 digits)

Taxonomy(s): _____ (10 digits) _____ (10 digits)

Taxonomy(s): _____ (10 digits) _____ (10 digits)

4. Requested Effective Date:
yyyy / mm / dd – (2004/07/31)

____/____/____

5. Provider Type Number and Description:

Number: _____ (2 digits)

Description: _____

6. Primary Specialty and Code

Primary Specialty: _____

Code Number: _____ (3 digits)

7. Specialty(s) and Code(s)

Specialty(s): N/A _____

Code Number(s): N/A _____ / N/A _____ (3 digits)

8. Sub-specialty(s) and Codes(s) Sub-Specialty(s): N/A _____ Code Number(s): N/A _____

9. Federal Tax ID Number:

_____ (9 digits)

***A copy of a document generated by the Federal IRS with your name and IRS number must accompany this application.**

10. Legal Name Shown on Attached Document:

11. This clinic will provide the following services:

- Medical Services Only Dental Services Only Medical **and** Dental Services

<p>12a. Do you intend to participate with any Pennsylvania Medicaid Managed Care Organizations (MCOs)?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>12b. If so, list the MCO(s):</p> <p>_____</p> <p>_____</p>	
<p>13a. Does the provider operate under a fictitious business/doing business as (d/b/a) name?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13b. If yes, list the Statement/Permit number and the name:</p> <p>Number: _____</p> <p>Name: _____</p> <p>*A legible copy of the recorded/stamped fictitious business name statement/permit is required for your application to be processed.</p>	
<p>14a. IRS Address: Note: This is the address where your 1099 tax document will be sent.</p> <p>Street: _____ Room/Suite: _____</p> <p>City: _____ State: _____ Zip: _____ (9 digits)</p>		
<p>14b. Contact Name/Title:</p> <p>Name: _____</p> <p>Title: _____</p>	<p>14c. Contact E-Mail Address:</p>	
<p>14d. Contact Phone:</p> <p>()</p>	<p>14e. Contact Toll-Free Phone:</p> <p>()</p>	<p>14f. Contact Fax Number:</p> <p>()</p>
<p>15. Business Type: (Check 1 Box Only)</p> <p><input type="checkbox"/> Business Corporation, For Profit <input type="checkbox"/> Not For Profit <input type="checkbox"/> Sole Proprietorship</p> <p><input type="checkbox"/> Estate/Trust <input type="checkbox"/> Partnership</p> <p><input type="checkbox"/> Government Owned <input type="checkbox"/> Public Service Corporation</p>		
<p>16. a. License Number: _____ b. Issuing State: _____</p> <p>c. Issue Date: _____ d. Expiration Date: _____</p> <p>*A copy of your license is required for your application to be processed.</p>		
<p>17. Drug Enforcement Agency (DEA) Number: _____</p> <p>*If you have a DEA number, a copy of your DEA certificate is required for your application to be processed.</p>		
<p>18. Is a CLIA certificate and a Dept of Health Lab Permit associated with this Service Location? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>*if YES please provide a copy of both with this application</p>		
<p>19. CMS Certification number: _____</p>		
<p>07/01/2015</p>		

20. Service Location Address: (A POST OFFICE BOX IS NOT A VALID SERVICE LOCATION. THE ADDRESS MUST BE A PHYSICAL LOCATION.)

Street: _____ Room/Suite: _____

City: _____ State: _____ Zip: _____ - _____ (9 digits) County: _____

Business Phone: () _____ - _____ Fax Number: () _____ - _____

- (1) Does the office have exterior or interior steps leading to the main entrance doorway?
Yes No Exterior Interior
- (2) If the answer to (1) is yes, does the office have a permanent or portable wheelchair ramp?
Yes No Permanent Portable
- (3) If the answer to (1) is yes, is there an alternate entrance that has no exterior or interior steps or has a wheelchair ramp?
Yes No
No exterior steps No interior steps
Permanent ramp Portable ramp

Is this address an active Rural Health Clinic or FQHC? Yes No

Do you bill for a mobile unit from this location? Yes No

Mobile Medical Unit? Yes No

Mobile Dental Unit? Yes No

Has the provider named in Block 1 been screened for this location within the last 12 months by:

Medicare? Yes No

Children's Health Insurance Program (CHIP)? Yes (Complete below) No

Another state's Medicaid program? Yes (Complete below) No

Screening State

Screening Contact Phone Number

Screening contact email address

Check all applicable boxes. This service location is also a: Pay-to Mail-to Home Office

If Pay-to, Mail-to, and/or Home Office are different from above address, refer to block #21.

If you wish to utilize the **Electronic Funds Transfer Direct Deposit Option** please follow link for further information:

<http://www.dhs.state.pa.us/provider/doingbusinesswithdhs/electronicfundstransferdirectdepositinformation>

21. Would you like to receive E-Mail notification of new bulletins? Yes *No

E-Mail address is **required if answered YES** to receive notification of MA bulletins: _____

*By answering **NO** you are agreeing to be responsible to check for new MABs on your own by visiting the following website:

<http://www.dhs.state.pa.us/publications/bulletinsearch> OR by signing up to receive notifications of new MABs through the [MA Electronic Bulletins Listserv](#)

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

Once enrolled, you can retrieve RAs from PROMISE™ online. If you require paper RAs, please call 1.800.537.8862 option 1 to see if you meet the requirements.

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

23a. Contact Name: _____ Contact Phone: _____

Title: _____

23b. Contact Toll-Free Phone:

()

23c. Contact Fax Number:

()

23d. Contact E-Mail address:

24a. In addition to English do you or your staff communicate with patients in another language?
Yes No

24b. If "Yes", list language(s):

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

a. _____ b. _____ c. _____

26. CONFIDENTIAL INFORMATION

Have you, any agent, or managing employee ever:

A. Been terminated, excluded, precluded, suspended, debarred from or had their participation in any federal or state health care program limited in any way, including voluntary withdrawal from a program for an agreed to definite or indefinite period of time?

Yes

No

B. Been the subject of a disciplinary proceeding by any licensing or certifying agency, had his/her license limited in any way, or surrendered a license in anticipation of or after the commencement of a formal disciplinary proceeding before a licensing or certifying authority (e.g., license revocations, suspensions, or other loss of license or any limitation on the right to apply for or renew license or surrender of a license related to a formal disciplinary proceeding)?

Yes

No

C. Had a controlled drug license withdrawn?

Yes

No

D. Been convicted of a criminal offense related to Medicare or Medicaid; practice of the provider's profession; unlawful manufacture, distribution, prescription or dispensing of a controlled substance; or interference with or obstruction of any investigation?

Yes

No

E. In connection with the delivery of a health care item or service, been convicted of a criminal offense relating to neglect or abuse of patients or fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct?

Yes

No

If you answered "Yes" to any of the questions listed above, you MUST provide a detailed explanation (on a separate piece of paper) and submit three (3) statements from professional associates or peer review bodies giving factual evidence of why they believe the violation(s) will not be repeated and attach it to your application. Include the following information as applicable to the situation:

- | | |
|--|---|
| 1. Name and title of individual | 8. Disposition/State |
| 2. Name of federal or state health care program | 9. Date license was surrendered |
| 3. Name of licensing/certifying agency taking the action | 10. Name of court |
| 4. Date of action | 11. Date of conviction |
| 5. Type of action taken | 12. Offense(s) convicted of |
| 6. Length of action | 13. Sentence(s) |
| 7. Basis for action | 14. Categorization of offense
(e.g. felony, misdemeanor) |

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

Title

Printed Name

Original Signature

Date

Mail-To/Pay-To/Home Office Information For The Service Location Entered In 20

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

28a. **Address:** Street Suite/Box City State Zip (9-digits) County

b. This address is a:
 Mail-to Pay-to
 Home Office

c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
()

f. Toll-Free Phone
()

g. Fax Number:
()

a. **Address:** Street Suite/Box City State Zip (9-digits) County

b. This address is a:
 Mail-to Pay-to
 Home Office

c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
()

f. Toll-Free Phone
()

g. Fax Number:
()

a. **Address:** Street Suite/Box City State Zip (9-digits) County

b. This address is a:
 Mail-to Pay-to
 Home Office

c. E-Mail address:

d. Contact Name/Title:

Name: _____ Title: _____

e. Business Phone:
()

f. Toll-Free Phone
()

g. Fax Number:
()

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HUMAN SERVICES
OFFICE MEDICAL ASSISTANCE PROGRAM**

Federally Qualified Healthcare Provider Agreement

This Agreement, made by and between the Department of Human Services (hereinafter the "Department") and

(hereinafter the "Provider") sets forth the terms and conditions governing participation in the Medical Assistance Program. The parties to this Agreement, intending to be legally bound, agree as follows:

1. The Provider agrees to comply with all applicable State and Federal laws, regulations and policies which pertain to participation in the Pennsylvania Medical Assistance Program.
2. The provider agrees to keep any records necessary to disclose the extent of services the Provider furnishes to recipients.
3. The provider agrees upon request, furnish to the Department, the United States Department of Health and Human Services, the Medicaid Fraud Control Unit and any other authorized governmental agencies, and the designee of any of the foregoing, any information maintained under paragraph (A) above and any information regarding payments claimed by the provider for furnishing services under the Pennsylvania Medical Assistance Program.
4. The provider agrees to comply with the disclosure requirements specified in 42 C.F.R. Part 455, Subpart B (42 C.F.R § 455.100 *et seq.*) (relating to Disclosure of Information by Providers and Fiscal Agents).
5. The provider agrees to comply with the advance directives requirements for hospitals, nursing facilities, providers of home health care and personal care services, hospices, and HMO's specified in 42 C.F.R. Part 489, Subpart I, (42 C.F.R. § 489.100 *et seq.*) and 42 C.F.R. § 417.436(d).
6. The provider agrees to comply with the attached Reimbursement Guidelines currently in effect, or as may be modified from time to time by the Department.
7. The provider agrees that it will submit within 35 days of the date of request by the Department or the United States Department of Health and Human Services Secretary full and complete information about the following:
 - A. the ownership of any subcontractor with whom the provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request; and
 - B. any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.
8. The provider agrees that it will allow the Centers for Medicare and Medicaid Services, its agents and its contractor and the Department to conduct unannounced on-site inspections of any and all of its locations, including locations where services are provided.
9. The provider agrees that it will consent to criminal background checks, including fingerprinting, of individuals with an ownership interest in the provider, and will provide to the Department any information needed for the Department to conduct a background check of the provider and its owners.

10. The provider agrees that upon written request from the Department it will disclose the identity of any person who has an ownership or control interest in the provider or is an agent or managing employee of the provider that has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, Title XX, or Title XXI (CHIP).
11. The provider agrees that if there is any change in the ownership or control of the provider, it will submit updated disclosure information to the Department within 35 days of the change in ownership or control of the provider.
12. The Department may impose the following sanctions for non-compliance by Provider with any of the requirements listed above:
 - A. Require the submission and compliance with a corrective action plan;
 - B. Impose a monetary sanction of \$1,000.00 per day for each day of non-compliance; or
 - C. Suspend payments until Provider is in compliance with the terms of this Agreement.
13. This Agreement shall continue in effect unless and until it is terminated by either the Provider or the Department. Either the Provider or the Department may terminate this agreement, without cause, upon thirty (30) days prior written notice to the other. The Provider's participation in the Pennsylvania Medical Assistance Program may also be terminated by the Department, with cause, as set forth in applicable Federal and State law and regulation.

PROVIDER ELIGIBILITY AGREEMENT

I have reviewed the information in this enrollment application and affirm on behalf of the provider seeking to enroll in the Pennsylvania Medical Assistance Program that the information submitted in or with this application is true, accurate and complete.

I understand that the provider is responsible for notifying the Department of Human Services if any information included in this enrollment application changes or if the provider becomes aware that any of the information is not true, accurate or complete.

I understand that any false statements or omissions may be subject to prosecution under applicable state or federal law, including 18 Pa. C.S. § 4904, relating to any unsworn falsifications to authorities

I understand that knowingly and willfully providing incomplete or false information in this application may result in the denial of enrollment or termination of the provider from the Pennsylvania Medical Assistance Program.

 (Provider – Original Signature)
 (Owner or Authorized Agent)

 (Date)

 (Name – Please Type or Print)

Pennsylvania Provider Reimbursement and Operations Management Information System electronic (PROMISE™) Medicaid Management Information System (MMIS) is a HIPAA compliant database.

Provider Disclosure Statement Definitions

The definitions below are designed to clarify certain questions on the following Ownership and Control Disclosure Forms. The full text of the regulations governing the disclosure of information by providers and fiscal agents can be found in [42 CFR Part 455 Subpart B](#).

Agent means any person who has been delegated the authority to obligate or act on behalf of a provider.

Disclosing entity means a Medicaid provider (other than an individual practitioner or a group of practitioners), or a fiscal agent.

Other Disclosing entity means any entity that does not participate in Medicaid, but is required to disclose certain ownership and control information because of participation in any of the programs established under title V, XVIII, or XX of the Act. This includes:

- a. Any hospital, skilled nursing facility, home health agency, independent clinical laboratory, renal disease facility, rural health clinic, or health maintenance organization that participates in Medicare (title XVIII);
- b. Any Medicare intermediary or carrier; and
- c. Any entity (other than an individual practitioner or group of practitioners) that furnishes, or arranges for the furnishing of, health-related services for which it claims payment under any plan or program established under title V or title XX of the Act.

Fiscal agent means a contractor that processes or pays vendor claims on behalf of the Medicaid agency.

Group of practitioners means two or more health care practitioners who practice their profession at a common location (whether or not the share common facilities, common supporting staff, or common equipment).

Indirect ownership interest means an ownership interest in an entity that has an ownership interest in the disclosing entity.

Note: The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example:

If you own 10 percent of the stock in Corporation A, which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

If you own 20 percent of the stock in Corporation A, which owns 50 percent of the stock in Corporation B which owns 80 percent of the stock of the disclosing entity, you would have an 8 percent indirect ownership interest in the disclosing entity.

Managing employee means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts the day-to-day operation of an institution, organization or agency.

Ownership interest means the possession of equity in the capital, the stock, or the profits of the disclosing entity.

Person with an ownership or control interest means a person or corporation that:

- a. Has an ownership interest totaling 5 percent or more in a disclosing entity.
- b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity.
- c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity.
- d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

Note: The percentage of ownership of a mortgage, deed of trust, note, or other obligation is determined by multiplying the percentage of interest owned in the obligation by the percentage of the disclosing entity's assets used to secure the obligation. For example:

If you own 10 percent of a note secured by 60 percent of the disclosing entity's assets, you would have a 6 percent interest in the disclosing entity's assets.

- e. Is an officer or director of a disclosing entity that is organized as a corporation; or,
- f. Is a partner in the disclosing entity that is organized as a partnership.

Significant business transaction means any business transaction or series of transactions that, during any one fiscal year, exceed the lesser of \$25,000 and 5 percent of a provider's total operating expenses.

Subcontractor means:

- a. An individual, agency, or organization to which a disclosing entity has contracted or delegated some of its management functions or responsibilities of providing medical care to its patients; or
- b. An individual, agency, or organization with which a fiscal agent has entered into a contract, agreement, purchase order, or lease (or leases of real property) to obtain space, supplies, equipment, or services provided under the Medicaid agreement.

Supplier means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g., a commercial laundry, a manufacturer of hospital beds, or a pharmaceutical firm).

Wholly owned supplier means a supplier whose total ownership interest is held by a provider or by a person, persons, or other entity with an ownership or control interest in a provider.

Section II: Ownership and Control

If the provider is organized as a corporation, partnership, estate trust or is a government entity that is organized as a corporation, complete this section.

In completing this section, an individual with at least 5% direct or indirect ownership interest includes individuals that have a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity and individuals who own an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity.

INDIVIDUALS WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

A. Please enter the full name, social security number, date of birth, and address of individuals with an ownership or control interest in the disclosing entity and all officers, partners, and directors.

Name: _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

(City) (State) (Zip Code) (+4)

1. a. If the individual listed above has an ownership interest in the disclosing entity, please enter the percentage and ownership type that the individual listed above has in the disclosing entity.

Direct: _____% **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. If the individual listed above is an officer or director, what position does the individual hold?

<input type="checkbox"/> President	<input type="checkbox"/> Chairman	<input type="checkbox"/> Member
<input type="checkbox"/> Vice President	<input type="checkbox"/> Vice Chairman	
<input type="checkbox"/> Secretary	<input type="checkbox"/> Director	
<input type="checkbox"/> Treasurer	<input type="checkbox"/> Officer	

2. a. Is the individual listed above the spouse, parent, child, or sibling of any other individual with at least 5% direct or indirect ownership or a control interest in the disclosing entity?

Yes (Provide details below) **No**

Name: _____ Relationship: _____

Attach separate sheet, if necessary

Section II: (cont.)

b. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

Yes (Provide details below) **No**

Name: _____ Relationship: _____
Attach separate sheet, if necessary

3. Does the individual listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

Yes (Provide details below) **No**

Name: _____

Address: _____ Suite/Apt: _____

(City) (State) (Zip Code) (+4)

Attach separate sheet, if necessary

4. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

Yes (Provide details below) **No**

5. Description of Offense: _____

Attach separate sheet, if necessary

****COPY SECTION II A TO ADD ADDITIONAL INDIVIDUALS****

Section II: (cont.)

CORPORATE ENTITIES WITH AN OWNERSHIP OR CONTROL INTEREST IN THE DISCLOSING ENTITY

B. Please enter the full name, tax identification number, and primary business address of corporate entities that have at least 5% direct or indirect ownership interest in the disclosing entity.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

(City)

(State)

(Zip Code)

(+4)

1. Please enter the percentage and ownership type that the corporate entity listed above has in the disclosing entity.

Direct: _____%
(Percent of Ownership)

Indirect: _____%
(Percent of Ownership)

(Name of Entity Owned)

2. Please enter any additional business locations and PO Boxes for the corporate entity listed above.

Address: _____ Suite/Apt: _____

(City)

(State)

(Zip Code)

(+4)

Attach separate sheet, if necessary

3. Does the corporate entity listed above have an ownership or control interest in other Medicare or Medicaid providers, fiscal agents, managed care entities, or any "other disclosing entities"?

Yes (Provide details below) **No**

Name: _____

Address: _____ Suite/Apt: _____

(City)

(State)

(Zip Code)

(+4)

Attach separate sheet, if necessary

****COPY SECTION II B TO ADD ADDITIONAL CORPORATE ENTITIES****

Section II: (cont.)

OWNERSHIP OR CONTROL INTEREST IN SUBCONTRACTORS

C. Please enter the full name, date of birth, and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

(City) (State) (Zip Code) (+4)

1. a. Name of Subcontractor: _____

Federal Tax ID of Subcontractor: _____

b. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

Direct: _____% **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

c. Please enter the percentage and ownership type that the individual listed above has in the subcontractor.

Direct: _____% **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

d. Is the individual listed above the spouse, parent, child, or sibling of any other individuals with at least 5% direct or indirect ownership or control interest in the disclosing entity?

Yes (Provide details below) **No**

Name: _____ Relationship: _____

e. Is the individual listed above the spouse, parent, child or sibling of any other individuals with at least 5% direct or indirect ownership or a control interest in any subcontractor of the disclosing entity?

Yes (Provide details below) **No**

Name: _____ Relationship: _____

Section II: (cont.)

f. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XXI (CHIP), or a state health care program?

Yes (Provide details below) **No**

g. Description of Offense: _____

Attach separate sheet, if necessary

****COPY SECTION II C TO ADD ADDITIONAL INDIVIDUALS****

D. Please enter the full name, tax identification number, and primary business address of any corporate entity with an ownership or control interest in any subcontractor which the disclosing entity has a direct or indirect ownership interest of 5% or more.

Name: _____

Federal Tax ID: _____

Address: _____ Suite/Apt: _____

(City)

(State)

(Zip Code)

(+4)

1. a. Please enter the percentage and ownership type that the disclosing entity has in the subcontractor.

Direct: _____% **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

b. Please enter the percentage and ownership type that the corporate entity listed above has in the subcontractor.

Direct: _____% **Indirect:** _____% _____
(Percent of Ownership) (Percent of Ownership) (Name of Entity Owned)

****COPY SECTION II D TO ADD ADDITIONAL CORPORATE ENTITIES****

Section III: Non-Profit Organization Disclosure (Not Organized as a Corporation)

If the disclosing entity is a non-profit organized as a corporation, please complete Section II

- A. Please enter the full name, address, social security number, and date of birth of any person who is a director (board member) or officer of the disclosing entity.

Name: _____
(First Name) (Middle Name) (Last Name)

Social Security Number: _____ Date of Birth: _____

Address: _____ Suite/Apt: _____

(City) (State) (Zip Code) (+4)

1. What position is held by the individual listed above?

- | | | |
|--|---|--|
| <input type="checkbox"/> President | <input type="checkbox"/> Chairman | <input type="checkbox"/> Member |
| <input type="checkbox"/> Vice President | <input type="checkbox"/> Vice Chairman | |
| <input type="checkbox"/> Secretary | <input type="checkbox"/> Director | |
| <input type="checkbox"/> Treasurer | <input type="checkbox"/> Officer | |

2. Has the individual listed above been convicted of a criminal offense related to that person's involvement in Medicare, Medicaid, Title XX, Title XX (CHIP), or a state health care program?

3. **Yes (Provide details below)** **No**

Description of Offense: _____

Attach separate sheet, if necessary

****COPY SECTION III TO ADD ADDITIONAL INDIVIDUALS****

The following checklist contains the most common reasons Pennsylvania Medicaid Program enrollment applications are returned. Please complete this checklist and **submit it with your application**. Incomplete applications will be returned.

Please remember applications will be scanned - do not staple.

Did you remember to....

- USE BLACK INK or TYPEWRITE. Application must be typed or printed in black ink.**
- Complete all spaces** as required on the application with either your correct information or N/A.
- Ensure that you have entered the **correct number of digits** where specified.
- If you have more than 4 taxonomy codes, please attach a separate sheet listing the additional codes.
- Indicate **one primary** provider type, provider specialty and sub-specialty(s), as applicable.
- Include a copy of your **Social Security card, W-2 or any document generated by the Federal IRS** showing your name and SS number. If the Social Security card states "Valid for work only with INS authorization", please submit the paperwork generated by the INS or Department of Homeland Security that shows proof of authorization to work in the United States.
- Include **documentation generated by the Federal IRS** showing the name associated with the FEIN. Remember, a **W-9 is not permissible**.
- Include corporation papers from the Department of State Corporation Bureau or a copy of your business partnership agreement, if applicable.
- If applicable, **include a copy** of your:
 - Professional license
 - CLIA certificate and Dept. of Health Lab Permit if applicable.
 - Mammography certificate, including the list of mammography certified members and their PROMiSe™ 13 digit provider numbers.
 - Permit from the Department of Health.
 - Any other certification, license, or permit that applies.
- Include a legible copy of your **DEA certificate**, if applicable.
- Include a legible copy of the **NPPES Confirmation letter** that shows the NPI Number and Taxonomy(s) assigned to the entity applying for enrollment.
- Enter **at least 1** Provider Eligibility Program (PEP).
- Show proof of home state Medicaid participation (out of state providers only).
- Only the **person applying for enrollment or a representative of the facility applying for enrollment** can sign and date the **Confidential Information Sheet and Provider Agreement**. Signature stamp not accepted.

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

Then return your application and other documentation **TO THE ADDRESS LISTED ON THE REQUIREMENTS FOR YOUR SPECIFIC PROVIDER TYPE**. If no address is listed on the requirements for your specific provider type/specialty, please mail to:

DHS Enrollment Unit
PO Box 8045
Harrisburg, PA 17105-8045
- or -
Fax: (717) 265-8284
- or -
Email: RA-ProvApp@pa.gov