



Application Checklist for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

If you are applying to enroll as a facility/organization, please include the items in the following checklist with your enrollment packet. Should you have any questions, please contact:

BHU Enrollment - Phone: (410) 767-9732 - Email: dhmh.BHEnrollment@maryland.gov

A completed application will include the following:

- Completed and signed Facility/Organization Provider Application
- A copy of your facility/organization NPI printout from NPPES
- If you provide services in a state other than Maryland, please include a copy of your board issued license from the state in which you are practicing.
- Include a copy of any certifications that indicate any specialties
- Completed and signed Disclosure of Ownership and Control
- Completed and signed Provider Agreement
- Completed Electronic Funds Transfer (EFT) form if you wish to receive payments via direct deposit. NOTE: this form is to be submitted only to the Comptroller of Maryland at the address indicated at the top of the form. Any EFT forms that are submitted directly to DHMH will not be processed.
- Any additional material including application addenda that may be required by specific programs.



Instructions for Maryland Medical Assistance Program Application HIV TCM FACILITY/ORGANIZATION

MEMORANDUM

TO: Prospective HIV Targeted Case Management Services Providers

FROM: Office of Health Services

SUBJECT: Application for HIV Targeted Case Management Providers

Please read all supporting documents thoroughly before beginning the application process. You must read and agree to adhere to regulations COMAR 10.09.36 (General Medical Assistance Provider Participation) and COMAR 10.09.32 (Targeted Case Management for HIV Infected Individuals).

Be sure to note that there are two phases of HIV case management services: diagnostic evaluation services (DES) and ongoing case management services. COMAR 10.09.32.03 specifies different provider requirements. A provider/entity may choose to apply as a provider for one or both phases of HIV case management. You must submit both a **Medical Assistance Program Provider application** and the appropriate **HIV Targeted Case Management Provider addendum**.

Some helpful hints for completing the **Medical Assistance Program Provider application form**:

- Under “Type of Request” If you do not have a provider number for HIV Diagnostic Evaluation Services (DES) or HIV ongoing case management, check the box for “New Enrollment.” If you are already enrolled as an HIV DES or HIV ongoing case management provider and now wish to provide both services, check the box for “Existing Provider/Change.”
- Under “provider type code”, please enter 81 for case management and specify HIV (i.e., 81 HIV).
- Under Authorization – An original signature is required on all three parts of this application: 1) Provider Application Form (including Practitioner and Group Addendum); 2) Provider Ownership and Control Disclosure Form; and 3) Provider Agreement Form.

The application for HIV Targeted Case Management Services providers, require supporting documentation. If any forms are not completed properly or if supporting documentation is not submitted with the application, you will be notified that your application is incomplete.

After a review of all required forms and supporting documentation, a determination will be made as to whether a provider is qualified to be enrolled as a HIV Targeted Case Management provider. If your application is approved, you will be issued a Medicaid provider number. Notification will be made by mail and will include the provider number and billing instructions.

Thank you for your interest in enrolling as a HIV Targeted Case Management Services provider. If you have any additional questions about HIV Case Management or the application process, please contact Corden Kane at (410) 767-1998 or at corden.kane@maryland.gov.

Please mail **both** the Medical Assistance Program Provider application and the HIV Targeted Case Management Provider application to Provider Enrollment at:

**Systems and Operations Administration,
Provider Enrollment
P.O. Box 17030 Baltimore, MD 21203**

Rev. 8/15



Instructions for Maryland Medical Assistance Program Application HIV TCM FACILITY/ORGANIZATION

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR FACILITIES/ORGANIZATIONS

Should you have any questions, please contact: BHU Enrollment - Phone: (410) 767-9732 - Email: dhmh.BHEnrollment@maryland.gov

GENERAL INSTRUCTIONS	
1. Complete ALL items on the form unless otherwise instructed below. Failure to complete all required fields will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid. 2. Completion of signature fields is required. Initials or stamped signatures will not be accepted. 3. Please attach a copy of all requested documents. 4. These instructions do not need to be submitted with the application.	
MAIL TO	Unless instructed otherwise please mail completed enrollment applications and documentation to: The Department of Health and Mental Hygiene Office of Systems and Operations Administration Provider Enrollment P.O. Box 17030 Baltimore, MD 21203

TYPE OF REQUEST	
NEW ENROLLMENT	The facility/organization attempting to enroll in Maryland Medicaid has never been enrolled with Maryland Medicaid as a Fee for Service Provider.
RE-ENROLLMENT	The facility/organization has previously been enrolled with Maryland Medicaid as a Fee for Service Provider, but the facility/organization has been suspended or terminated from Maryland Medicaid.
RE-VALIDATION	The facility/organization is actively enrolled in Maryland Medicaid Fee for Service, but, due to required law, is verifying their information with Medicaid on or before their five year Maryland Medicaid enrollment anniversary date.
INFORMATION UPDATE	The facility/organization is actively enrolled in Maryland Medicaid and would like to change the information that is currently on file with Maryland Medicaid for the facility/organization.
REQUESTED ENROLLMENT BEGIN DATE	If the facility/organization has already rendered services, please indicate a Requested Enrollment Begin Date.
APPLICATION SUBMITTED DATE	Date filling out the application.

FACILITY/ORGANIZATION INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the unique 10-digit NPI (Entity Type 2 Organization) of the facility/organization who will be providing services to Maryland Medicaid participants. To obtain a NPI, please visit the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do If the facility/organization is an Atypical provider and is not eligible to obtain a NPI, leave this field blank and Maryland Medicaid will assign a NPI to you.
MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER	This is a unique provider number generated by Maryland Medicaid for each facility/organization. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid facility/organization, please fill in your facility/organization's 9-digit Maryland Medicaid Number.
FACILITY/ORGANIZATION PROVIDER TYPE	Enter 81 for case management and specify HIV (i.e., 81 HIV).
TYPE OF PRACTICE	Enter the two-digit code for the appropriate type of practice from the listing provided at the end of these instructions.
SPECIALTY CODE	If applicable enter the two-digit code for the appropriate specialty code from the listing provided at the end of these instructions.
COUNTY CODE	Enter the two-digit code for the appropriate county code from the listing provided at the end of these instructions.
FACILITY/ORGANIZATION NAME	Enter the legal name of the facility/organization as it appears on federal tax documents.
DOING BUSINESS AS (NAME)	If the facility/organization operates under a different name than the legal name, enter that name here.
TAX IDENTIFICATION NUMBER	Enter the 9-digit tax identification number of the facility/organization.
NAME OF TAX IDENTIFICATION NUMBER OWNER	Enter the name to which the tax identification number of the facility/organization is assigned.
MEDICARE PROVIDER NUMBER	If you participate in Medicare, please list the provider number that has been assigned to you.



Instructions for Maryland Medical Assistance Program Application HIV TCM FACILITY/ORGANIZATION

MEDICARE FISCAL YEAR END DATE	Complete this field if the facility/organization is a nursing facility or hospital.
TELEPHONE NUMBER	Enter the best number to reach the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.

CORRESPONDENCE INFORMATION	
CONTACT INFORMATION	If the application is being filled out on behalf of the facility/organization, enter the Name, Position/Title, Telephone and E-Mail address of the contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
FACILITY/ORGANIZATION ADDRESS	Enter the Street Number, Suite, City, State, Zip Code, Telephone number and Fax number of the primary address of the facility/organization.
CORRESPONDENCE ADDRESS	Enter the Street Number, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any letters or correspondence should be sent. This address must be kept up to date. Requests to Re-Validate or Update Information are NOT issued electronically and will be sent to this address.
PAY TO ADDRESS	Enter the Street Number, Suite, City, State, Zip Code, Telephone number and Fax number of the address where any paper checks and paper remittance advices should be sent.
ELECTRONIC CORRESPONDENCE	If you prefer to receive electronic correspondence and Remittance Advice through an established eMedicaid account, check Yes.

LICENSE/PERMIT INFORMATION	
If applicable attach a copy of each license or certificate that is listed.	
CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER*	Enter your CLIA ID Number, beginning effective date, and expiration date.
DRUG ENFORCEMENT ADMINISTRATION (DEA)	Enter your Drug Enforcement Administration number if applicable.
HOSPITAL FACILITY LICENSE	Enter your Office of Health Care Quality (OHCQ) issued hospital license number, beginning effective date, and expiration date.
MARYLAND LABORATORY PERMIT (MDLAB) OR LETTER OF PERMIT EXCEPTION NUMBER*	Enter your Office of Health Care Quality (OHCQ) issued MDLAB Number, beginning effective date, and expiration date. OR enter your OHCQ issued Letter of Permit Exception Number, beginning effective date, and expiration date.
NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP)	Enter your NCPDP number if applicable.
PHARMACY	Enter your state issued license number if applicable.
RESIDENTIAL SERVICE AGENCY (RSA)	Enter your OHCQ issued license number if applicable.
OTHER	Enter any other license information as required.
<p>*Medical laboratory providers: Practitioners and other providers that perform medical laboratory services MUST COMPLETE and SUPPLY a copy of their CLIA and MDLAB Permit/Letter of Permit Exception. Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland. Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.</p>	



Instructions for Maryland Medical Assistance Program Application HIV TCM FACILITY/ORGANIZATION

ADDITIONAL INFORMATION	
FACILITY/ORGANIZATION ADDENDUM	If the facility/organization is affiliated with a healthcare institution or medical school, please fill in the required fields and attach the required documentation.
LABORATORY INFORMATION	Answer the three questions listed in this section.
INSTITUTIONAL BED DATA	Complete all fields as appropriate for your provider type.
DIALYSIS FACILITIES	Complete this section if applicable.
AUTHORIZATION	Please have the administrator or authorized professional representative sign and date the application.
DISCLOSURE OF OWNERSHIP AND CONTROL	Maryland Medicaid is required to obtain disclosures on ownership and control from disclosing entities, fiscal agents, and managed care entities. Please fill out the six (6) sections and sign and date the Disclosure of Ownership and Control addendum. Failure to complete all required sections will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER AGREEMENT	Failure to complete the provider agreement will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
ELECTRONIC FUND TRANSFER (EFT)	If you wish to receive EFT, please complete this form and return to the address listed on this form, separately from the provider application.
PROVIDER ADDENDUM	If applicable to your provider type, please complete the attached addendum.

TYPE OF PRACTICE CODES			
HMO	50	PHARMACY, HOSPITAL BASED	23
NURSING HOME	10	PHARMACY, NURSING HOME BASED	24
PHARMACY, SINGLE STORE	20	PHARMACY, TAX SUPPORTED	25
PHARMACY CHAIN, 2-10 STORES	21	OTHER	99
PHARMACY CHAIN, 11+ STORES	22		

COUNTY CODE					
ALLEGANY	01	DORCHESTER	09	SOMERSET	19
ANNE ARUNDEL	02	FREDERICK	10	ST. MARY'S	18
BALTIMORE CITY	30	GARRETT	11	TALBOT	20
BALTIMORE COUNTY	03	HARFORD	12	WASHINGTON	21
CALVERT	04	HOWARD	13	WASHINGTON, DC	40
CAROLINE	05	KENT	14	WICOMICO	22
CARROLL	06	MONTGOMERY	15	WORCESTER	23
CECIL	07	PRINCE GEORGE'S	16	OTHER STATE	99
CHARLES	08	QUEEN ANNE'S	17		

PHARMACY SPECIALTY CODES		KIDNEY DISEASE PROGRAM	
HOME IV THERAPY	147	DIALYSIS FACILITY	K3
HOSPITAL OUTPATIENT PHARMACY	151	HOSPITAL-INPATIENT	K6
INSTITUTIONAL PHARMACY	156	HOSPITAL-OUTPATIENT	K5
MULTI-SPECIALTY PHARMACY	168	MEDICAL LABORATORY	K7
RETAIL CHAIN PHARMACY	202	PHARMACY	K2
RETAIL SINGLE PHARMACY	204	PHYSICIAN	K1
OTHER PHARMACY	184	OTHER (DENTAL, VISION)	K8

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Billing Instructions for Maryland Medical Assistance Program HIV TCM

BILLING INSTRUCTIONS

These billing instructions are for Medical Assistance (also called Medicaid) services covered under the Targeted Case Management for HIV-Infected Individuals program (the Program). The program is governed by COMAR 10.09.32.

The Maryland Department of Health and Mental Hygiene (DHMH) is the State's lead agency for the Medicaid Program. The Program is administered at DHMH. Billing questions may be directed to the Program at 410-767-1458.

This packet was prepared to provide proper billing instructions for program services. The next section, "Frequently Asked Billing Questions," contains all of the general information you need to know about billing. The "Instructions for Completing the CMS-1500," section gives detailed information about completing the CMS-1500 billing form. Please be sure to read this information carefully so that your claims will be appropriately submitted and paid.



Billing Instructions for Maryland Medical Assistance Program HIV TCM

APPROVAL NOTICE AND BILLING INSTRUCTIONS

Maryland Medical Assistance Program
Maryland Department of Health and Mental Hygiene
Targeted Case Management for HIV-Infected Individuals

Your application to become a Medical Assistance provider for Targeted Case Management for HIV Infected Individuals has been reviewed and approved by the Medical Assistance Program and the Department of Health and Mental Hygiene for the following service(s):

Diagnostic Evaluation Services (DES) provider _____
Ongoing Case Management provider _____

Your new provider number is assigned to a specific procedure code that will allow you to bill only for the service(s), which you provide. This provider number should not be interchanged with any other provider number. Reimbursement for HIV services will begin as of your effective date indicated below.

Provider Name PROVIDER NAME
Your provider number is: PROVIDER NUMBER
The effective date is: EFFECTIVE DATE

These billing instructions are for Medical Assistance (i.e. Medicaid) services covered under COMAR 10.09.32 for providers of Target Case Management for HIV Infected Individuals.

The following conditions must be met for payment of HIV services:

- The provider must be approved as a Medicaid provider and enrolled to provide the type of services billed;
- The Provider must complete the Enrollment form for HIV Ongoing Case Management;
- The recipient must be Medicaid-eligible as of the date of service;
- The services must be rendered in accordance with COMAR 10.09.32, and any other government requirements;
- The services must not exceed any limitations or restrictions specified in COMAR 10.09.32;
- The provider must submit the appropriate billing form in order to be reimbursed by the program.



Billing Instructions for Maryland Medical Assistance Program HIV TCM

FREQUENTLY ASKED BILLING QUESTIONS

This section provides insight into frequently asked questions about the Program. After you read this section, look at the following section “Instructions for Completing CMS-1500” for detailed instructions on paper billing.

Before you render and/or bill for any services, ask yourself these questions:

1. *Is the participant enrolled in Medicaid?*

Each time you provide a service you should:

- Verify the participant’s Medical Assistance eligibility by calling the Eligibility Verification System (EVS) at 1-866-710-1447. EVS is an automated system that you can use 24 hours a day, 7 days a week. To use EVS, you will need your provider number and either the participant’s medical assistance number or the participant’s social security number and the date(s) of service. To retrieve an EVS Brochure call 410-767-6024 to request one or go to the internet at: <https://mmcp.dhmf.maryland.gov/docs/EVS%20Brochure%20March%202013.pdf>.

2. *Determine if the participant is in a Managed Care Organization (MCO)*

- A participant’s MCO status will be clearly indicated through the EVS system and include the MCO with which they are a member, as well as the contact information for that MCO.
- If a participant is in an MCO, the claim should be sent to the appropriate MCO according to their billing protocols.

If the participant is covered by Medicaid, follow the billing instructions below.

3. *How do I submit claims for reimbursement?*

Electronic Billing

Providers may submit claims electronically via eMedicaid. eMedicaid allows providers secure online access to verify participant eligibility, submit claims for reimbursement, and view remittance advices. Additional information regarding eMedicaid can be found at <https://encrypt.emdhealthchoice.org/emedicaid/>

The Department of Health and Mental Hygiene (DHMH) does not provide software for electronic billing. Providers may consult with billing software vendors to learn about electronic billing.



Billing Instructions for Maryland Medical Assistance Program HIV TCM

Paper Billing

Providers may submit paper claims to DHMH for claims processing, but will experience longer processing times. Paper claims are generally paid within 4-6 weeks.

Providers are encouraged to submit claims electronically. Billing electronically has many advantages. Most importantly, your claim is processed quicker with payment within 1-2 weeks of submission.

If you are billing on paper, you must submit all claims for services on the CMS-1500 (08-05), previously called the HCFA-1500. You may purchase these forms from a stationary or office supply store.

Filing Limitations

Claims *must* be received within 12 months following the date of service. The following exceptions apply to the initial claim submission.

- 12 months from the date of the IMA-81 (Notice of Retro-eligibility)
- 60 days from the date of Third Party Liability EOB
- 60 days from the date of Maryland Medicaid Remittance Advice

The Program will not accept computer-generated reports from the provider's office as proof of timely filing. The only documentation that will be accepted is a remittance advice, Medicare/Third-party EOB, IMA-81 (Notice of Retro-eligibility) and/or a returned date stamped claim from the Program.

4. *What can I do to avoid payment delays?*

To avoid payment delays, you should:

- Make sure all information entered on the claim form is correct, including your Provider Number and the Participant's Medical Assistance ID Number.
- If a participant has other insurance besides Medical Assistance, such as Medicare, private insurance, or other health insurance coverage, the participant's other insurance carriers should be contacted to verify if the service is covered.

If the insurer does not cover the service, please indicate "Services not Covered" by inserting Value "K" in Block 11 of the CMS-1500.



Billing Instructions for Maryland Medical Assistance Program HIV TCM

5. *Where do I send the completed CMS-1500?*

Completed claims should be mailed to the following address:

**Maryland Department of Health and Mental Hygiene
Office of Systems, Operations and Pharmacy
Claims Processing Division
P.O. Box 1935 Baltimore, MD 21203**



Billing Instructions for Maryland Medical Assistance Program HIV TCM

SERVICE INSTRUCTIONS

Instructions for Completing the CMS-1500

Program providers are required to complete certain blocks on the CMS-1500 in order to receive payment. The table on the next page shows all blocks that must be completed on the CMS-1500 form to receive payment for services.

Payment Procedures can be found in COMAR 10.09.32.06.

Basic Rules for the Paper CMS-1500:

- Use one CMS-1500 for each recipient.
- Be sure that the information entered on the form is legible.
- Double-check all information on the claim, especially the Provider and Recipient Numbers.
- Enter information with a typewriter or in black ink.
- Only six dates of service can be billed on one CMS-1500 form. If you need to bill additional dates, you must complete a new CMS-1500 form with all the required information filled-in.
- **Claims must be submitted within 12 months of the date of service.**



Billing Instructions for Maryland Medical Assistance Program HIV TCM

Blocks to Complete on CMS-1500 for Billing Targeted Case Management for HIV Services

Block Number	Title	Action
2.	Patient's Name	Enter participant's last name, first name, and middle initial from the Medicaid Assistance Card (e.g., Doe, John A).
9a.	Other Insured's Policy or Group Number [Participant's Medicaid ID number]	Enter the participant's 11-digit Medical Assistance ID number as it appears on the Medical Assistance Card. The Medical Assistance ID number MUST appear here, regardless of whether the participant has other health insurance.
11.	Insured's Policy Group of FECA Number	Insert Value " K " of the Maryland Medicaid Billing Instructions, in Block 11 of the CMS-1500.
24A.	Date(s) of Service From MM DD YY	Enter each separate date of service as a 6-digit numeric date (e.g. 07 01 07) for month, day, and year under the " From " heading. Leave blank the space under the " To " heading. Each date of service must be listed on a separate line. Ranges of dates are not accepted on this form.
24B.	Place of Service	For each waiver service, enter the appropriate place of service code: 11 for provider's office, 12 for participant's residence, or 99 for other facility.
24D.	Procedures, Services or Supplies	Enter the procedure codes: Diagnostic Evaluation Services =S0315 Ongoing Case Management = W0316
24F.	\$ Charges	Enter the total charge billed for the procedure code (not the cost per unit of service). Do not enter the maximum fee unless that amount is your usual and customary charge. If there is more than one unit of service on a line, the charge entered for this block should be the total for all units on this line.
24G.	Days or Units	Enter the units of service.
28	Total Charge	Enter the sum of the charges shown on all lines of Block 24 F.
31	Signature of Provider and Date	The provider's signature is required. The claim date must be in this field in order for the claim to be reimbursed.
33.	Provider's Billing Name, Address, Zip Code, and Phone Number	Enter the name, street, city, and zip code to which the claim may be returned.
33a.	Provider's Medicaid Provider Number [National Provider Identifier]	Your 9-digit provider number to which payment is made MUST be prefixed with a '5' in order for the claim to be reimbursed (e.g., 5012345678).
33b.	Provider's Medicaid Provider Number	Your 9-digit provider number to which payment is made MUST be prefixed with a '1D' in order for the claim to be reimbursed (e.g., 1D012345678).



Billing Instructions for Maryland Medical Assistance Program HIV TCM

A. HIV Diagnostic Evaluation Services (COMAR 10.09.32.04)

Procedure Code	Service	Unit of Service	Maximum Rate Per 12-Month Period
S0315	DES	One unit	\$200.00

Covered Service

Diagnostic evaluation services may not be billed until after the assessment is completed along with a completed plan of care with all required signatures. The fee is all-inclusive and not dependent on the amount of time required.

Limitations

Diagnostic evaluation services may only be billed once per 12-month period.

B. HIV Ongoing Case Management Services (COMAR 10.09.32.04)

Procedure Code	Service	Unit of Service	Maximum Rate
W0316	HIV Ongoing Case Management	One unit is equal to 15 minutes (see below for instructions)	\$17.86

Covered Service

Six units of ongoing case management may be billed prior to completion of the diagnostic evaluation services, for the case manager's role on the multidisciplinary team. A total of 96 units of service for ongoing case management may be billed per year per client after completion of the Diagnostic Evaluation Service.

Limitations

Reimbursement for case management services is for a distinct service event.

- Case management services must be billed in increments of 15-minutes, referred to as a 15-minute unit. Minutes of service and units are to be totaled by day by service.
- A provider may not bill for a service of less than 8 minutes if it is the only service provided that day.
- For multiple units of the same service on the same day, total the actual minutes and round to the nearest 15 minute increment.
- Please see the chart below for additional examples of accurate billing of daily total minutes as 15-minute units of service. The actual minutes billed for any one case manager in a work day may not exceed the work hours of that case manager.

Units	Minutes of Service
1	Greater than or equal to 8 minutes, but less than 23 minutes (8-22 min)
2	Greater than or equal to 23 minutes, but less than 38 minutes (23-37 min)
3	Greater than or equal to 38 minutes, but less than 53 minutes (38-52 min)
4	Greater than or equal to 53 minutes, but less than 68 minutes (53-67 min)
5	Greater than or equal to 68 minutes, but less than 83 minutes (68-82 min)



Billing Instructions for Maryland Medical Assistance Program HIV TCM

6	Greater than or equal to 83 minutes, but less than 98 minutes (83-97 min)
7	Greater than or equal to 98 minutes, but less than 113 minutes(98-112 min)
8	Greater than or equal to 113 minutes, but less than 128 minutes (113-127 min)

Providers must maintain records which fully demonstrate the extent, nature and medical necessity of services provided to Medicaid recipients. The records must support the fee charged or payment sought for the services and items, and demonstrate compliance with all applicable requirements.

Not all activities performed by the provider are considered billable activities.

- Billable case management activities shall be based on the participant's plan of care.
- Examples of billable activities include but are not limited to face-to-face contacts with the applicant/participant, updating of the plan of care, and collateral contact made to persons on behalf of the participant or that relate directly to the management of the participant's services.

Some examples of non-billable services include, but are not limited to:

- Activities that are not allowable under the Federal definition of case management, such as time spent by the provider solely for the purpose of transporting participants.
- Other examples of non-billable activities include:
 - Case Management services of less than seven minutes duration;
 - Telephone contact with the Department or its designated agent for the purpose of requesting or reviewing authorization;
 - Time spent engaged in activities required by a credentialing, certification or oversight entity such as gathering and submitting care plan or service data or other information;
 - Completion of billing documentation;
 - Individual or group supervision, routine case reviews and rounds, ad hoc consultation with supervisors and discussion or consultation among team members;
 - Time spent in staff training, clinical supervision or case reviews including for the purpose of treatment planning;
 - Travel time;
 - Attempted contacts or leaving messages; and
 - Services provided by individuals who do not meet the definition of and minimum qualifications for a case manager (COMAR 10.09.32.02).

Thank you for participating in the Targeted Case Management for HIV Infected Individuals Program. If you have any questions regarding this program please contact D'Nisa Joseph at (410) 767-9732.

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Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION	<u>Unless Instructed Otherwise, Mail to:</u> The Department of Health and Mental Hygiene Office of Systems and Operations Administration Provider Enrollment P.O. Box 17030 Baltimore, MD 21203
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TYPE OF REQUEST			
Please select one.			
<input type="checkbox"/> NEW ENROLLMENT (Applicant has never enrolled with Maryland Medical Assistance)	<input type="checkbox"/> RE-ENROLLMENT (Provider is currently excluded/terminated from the Maryland Medicaid Program)	<input type="checkbox"/> RE-VALIDATION (Provider is enrolled and required to revalidate)	<input type="checkbox"/> INFORMATION UPDATE (Provider is enrolled and updating information to the provider's file)
Requested Enrollment Begin Date		Application Submitted Date	

FACILITY/ORGANIZATION INFORMATION	
NPI (Organization)	Maryland Medical Assistance Provider Number (If existing provider)
Provider Type (Refer to instructions for appropriate codes.)	Type of Practice (Refer to instructions for appropriate codes.)
Specialty Code (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)
Facility/Organization Name	Doing Business As (DBA)
Tax Identification Number	Name of Tax Identification Number Owner
Medicare Provider Number	Medicare Fiscal Year End Date
Telephone Number + extension	E-Mail Address

CONTACT INFORMATION		
The contact name and email relate to the person who can answer questions about the information provided in this packet.		
Contact Name	Position/Title	
Telephone	E-Mail Address	
FACILITY/ORGANIZATION ADDRESS		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

CORRESPONDENCE ADDRESS		
Please indicate where letters and claims forms, if any, should be sent.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

PAY TO ADDRESS		
Please indicate where checks & remittance statements should be sent.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

ELECTRONIC CORRESPONDENCE		
Would you prefer to receive electronic correspondence in lieu of paper when available?	<input type="checkbox"/>	YES
	<input type="checkbox"/>	NO

LICENSE/PERMIT INFORMATION				
A copy of the license or certificate from the appropriate board or authority must be included as an attachment to this application. If more space is needed, please attach additional pages.				
CLIA	State Issued	License Number	Date Issued	Expiration Date
DEA	State Issued	License Number	Date Issued	Expiration Date
Hospital Facility License	State Issued	License Number	Date Issued	Expiration Date
MDLAB	State Issued	License Number	Date Issued	Expiration Date
NCPDP	State Issued	License Number	Date Issued	Expiration Date
Pharmacy	State Issued	License Number	Date Issued	Expiration Date
RSA	State Issued	License Number	Date Issued	Expiration Date
Other	State Issued	License Number	Date Issued	Expiration Date



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

FACILITY/ORGANIZATION ADDENDUM				
If your facility/organization is affiliated with a health care institution or medical school, please enter the name and full address of the institution or school, your title and a brief explanation of your group's duties.			<input type="checkbox"/> NOT APPLICABLE	
Name of Institution				
Title		Duties		
Street Address		Suite/Department/Floor		
City	State	Zip Code (9 Digits)		
Certification Date		Certification Number		
Is your facility/organization salaried by the above institution?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as pharmacy)?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
If you are an O.D., are you practicing optometry exclusively?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
Or optometry as well as preparing and dispensing eyeglasses (as an optician)?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is your facility/organization operating a Local Health Department Clinic?			<input type="checkbox"/> YES	<input type="checkbox"/> NO
Is your facility/organization operating a Freestanding Clinic?			<input type="checkbox"/> YES	<input type="checkbox"/> NO

LABORATORY INFORMATION		
Reimbursement for medical laboratory services you provide to eligible recipients are dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, Maryland Laboratory Permits or Letters of Permit Exception. Practitioner providers cannot be reimbursed for services referred to medical laboratories or other practices. Those laboratories or practices must bill.		
Do you provide medical laboratory services for your own patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you provide medical laboratory services for other than your own patients?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Do you receive specimens that are obtained from other sites located in Maryland?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
All Maryland laboratories are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§Health General Article §17-205, Annotated Code of Maryland) and CLIA Certificate Number (Clinical Laboratory Improvement of 1988 Public Law 100-578) to perform laboratory services. Out-of-state providers are only required to provide their CLIA Certificate Number, if they do not receive specimens that originate in Maryland.		



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

INSTITUTIONAL BED DATA	
Acute Inpatient (INP) Number of Beds	Assisted Living Facilities
Chronic Hospital (CHB) Number of Beds	Intellectual Disability (ID)
Number of Beds Nursing Facility (NF) Number of Beds	Other (OTH) Number of Beds

DIALYSIS FACILITIES
Please attach a copy of letter with assigned Medicare Provider Number and a copy of the letter(s) from your intermediary showing all approved services. You will be paid ONLY for the services that are rendered and appear in this/these letter(s).
Medicare Provider Number

AUTHORIZATION		
<p>I, the administrator or authorized professional representative of this facility/organization, hereby affirm that this information given by me is true and complete to the best of my knowledge and belief. I understand that if I or my facility/organization is salaried by a hospital or other institution for patient care, that I or my group will not bill the Maryland Medical Care Program for those services for which I or my facility/organization is salaried.</p>		
<table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px solid black; width: 80%;">Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps)</td> <td style="border-top: 1px solid black; width: 20%;">Date</td> </tr> </table>	Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps)	Date
Signature of Administrator or Authorized Professional Responsible for the Quality of Patient Care (No stamps)	Date	
<table style="width: 100%; border: none;"> <tr> <td style="border-top: 1px solid black; width: 80%;">Name of Administrator or Authorized Professional Responsible for the Quality of Patient Care (Type or Print)</td> <td style="border-top: 1px solid black; width: 20%;">Date</td> </tr> </table>	Name of Administrator or Authorized Professional Responsible for the Quality of Patient Care (Type or Print)	Date
Name of Administrator or Authorized Professional Responsible for the Quality of Patient Care (Type or Print)	Date	



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

DISCLOSURE OF OWNERSHIP AND CONTROL

Completion is required by 42 CFR Part 455.104. Failure to provide the information requested will cause the application to be returned. Attach additional pages as needed.

SECTION 1:

Disclosing Entity/Applicant (Facility/organization named on page 1 of this application)

Name		NPI (Organization)	
Address – Street	City & State	Zip Code (9 Digits)	
Federal Employer Identification Number (FEIN)			

Ownership in Applicant (Has direct or indirect ownership interest¹ of 5% or more. Include familial relationship to the Applicant and other Owners (spouse, parent, child, sibling), if any. The address for corporate entities must include every business address. See 42 CFR Part 455.104 (b)(1)(i) for more information.)

Name of Individual or Entity	% of Ownership	NPI (Individual)	
Address (Home Address if individual)	City & State	Zip Code (9 Digits)	
SSN (if individual)	Federal Employer Identification Number (if entity)		
Date of Birth (MM/DD/YYYY)	Familial Relationship (if individual, if any)		

¹ A) “Ownership interest” means the possession of equity in the capital of, stock in, or of any interest in the profits of the disclosing entity.

B) “Indirect ownership interest” means any ownership interest in an entity that has ownership interest in the disclosing entity. The term includes an ownership interest in any entity that has an indirect ownership interest in the disclosing entity.

C) “Determination of ownership or control percentage”

1) Indirect ownership interest – the amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity. For example, if A owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the disclosing entity, A’s interest equates to an 8 percent indirect ownership interest in the disclosing entity and must be reported. Conversely, if B owns 80 percent of the stock of a corporation which owns 5 percent of the stock of the disclosing entity, B’s interest equates to a 4 percent indirect ownership interest in the disclosing entity and need not be reported.

2) Person with an ownership or control interest – in order to determine percentage of ownership, mortgage, deed of trust, note, or other obligation, the percentage of the disclosing entity’s assets used to secure the obligation. For example, if A owns 10 percent of a note secured by 60 percent of the provider’s assets, A’s interest in the provider’s assets equates to 6 percent and must be reported. Conversely, if B owns 40 percent of a note secured by 10 percent of the provider’s assets, B’s interest in the provider’s assets equates to 4 percent and need not be reported.



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

SECTION 2:

Agents and Managing Employees (e.g. office manager, administrator, director or other individuals who exercise operational or managerial control over the day to day operations of the provider. If the applicant is a non-profit organization please include all board members, directors, and managers. Include familial relationship to the Applicant (spouse, parent, child, sibling), if any. If additional space is needed, copy form; all entries must be on the form.)

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

Name		Association Type (see instructions)	
Home Address – Street	City & State	Zip Code (9 digits)	
SSN	Date of Birth (MM/DD/YYYY)	Familial Relationship	

SECTION 3:

Ownership in Other Disclosing Entities (ODE) (per 42 CFR, Part 455.104 (b)(3)) – (Complete if any identified in Section 1 has an ownership or control interest in ODE)

Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE
Name (from Section 1)	Name of ODE	NPI or Medicaid ID of ODE



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

SECTION 4:

Ownership in Subcontractors (If the Applicant has an ownership or control interest of 5% or more in a subcontractor and an Owner of the Applicant also has an ownership or control interest in the subcontractor, complete the boxes below. If those identified in this Section have a familial relationship with a person with ownership or control interest in one of these subcontractors, complete Section 4).

Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number
Owner's Name (from Section 1)	Subcontractor's Name	Tax Identification Number

SECTION 5:

Familial Relationship in Subcontractors (Complete if those identified in Section 3 have a familial relationship (parent, child sibling spouse))

Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship
Owner's Name (from Section 1)	Subcontractor's Name	Name & Familial Relationship

SECTION 6:

Respond to these questions on behalf of:

1. The Applicant
2. All individuals and entities identified in Sections 1 & 5.
3. Any entity in which the Applicant has a 5% or more ownership.

1. Have any of the individuals/entities (1,2 and 3) been terminated, denied enrollment, suspended, restricted by Agreement or otherwise sanctioned by the Medicaid Program in Maryland or in any other State, Medicare, or any other governmental or private medical insurance program?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

2. Have any of the individuals/entities (1,2 and 3) ever been convicted of a crime related to the furnishing of, or billing for, medical care or supplies or which is considered an offense involving theft or fraud or an offense against public administration or against public health and morals in any State?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

3. Have any of the individuals/entities (1,2 and 3) ever had their business or professional license or certification, or the license of an entity in which they had an ownership interested over 5% ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any State?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____

4. Is there currently pending any proceedings that could result in the above stated sanctions for the individuals/entities (1, 2 and 3)?

YES NO

If yes, please list the individuals below (attach additional pages if necessary):

Name: _____

Name: _____

Name: _____



Application for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

SIGNATURE AND AFFIRMATION

An application is not considered complete unless the applicant signs below. Failure to provide a signature will cause the application to be returned.

I hereby affirm that this information is true and complete to the best of my knowledge and belief, and that the requested information will be updated as changes occur. I further certify that upon specific request by the Secretary of the Department of Health and Human Services, or the Maryland Department of Health and Mental Hygiene, full and complete information will be supplied within 35 days of the date of the request, concerning:

- A. The ownership of any subcontractor with which the Title XIX Provider has had, during the previous 12 months, business transactions in an aggregate amount in excess of \$25,000.00 and
- B. Any significant business transactions², occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier³ or any subcontractor.

Authorized Signature (No Stamps)

Date

Position (Type or Print)

² "Significant business transaction" means any business transaction or series of transactions that, during any one fiscal year, exceeds the lesser of \$25,000 or 5 percent of the total operating expense of a provider.

³ "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 bed, or a pharmaceutical firm).

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Application for Participation in Maryland Medical Assistance Program HIV TCM ADDENDUM

TO BE COMPLETED BY PROVIDER APPLICANTS

I am applying to participate in Medical Assistance Targeted Case Management for HIV- Infected Individuals as a
(please check all that apply):

- | | |
|--|---|
| <input type="checkbox"/> Diagnostic Evaluation Services (DES) provider | <input type="checkbox"/> Ongoing Case Management provider |
|--|---|

I hereby certify that as a Medical Assistance Targeted Case Management for HIV- Infected Individuals provider, I will meet the provider requirements and render the covered services in accordance with COMAR 10.09.32 and any amendments thereto.

All applicants must submit the following documentation:

- Written policies and procedures for the implementation and provision of DES and/or HIV case management services. Please include the process for the reassessment of participants and case closure.
- A copy of current licenses and resumes of all members of multi-disciplinary teams and/or case managers (i.e., physicians, nurses, social workers). Please see COMAR 10.09.32 for specific requirements.
- A copy of all signed written agreements between your agency and agencies in which referrals for DES or case management services may be given to or accepted from. (If your agency is applying for both services and will not have additional agreements with other agencies, you do not need to submit this form.)

All applicants must agree to the following:

- To be available to participants at least eight hours a day, five days a week, except State holidays.
- To complete and update the plan of care consistent with the requirements of the regulations.
- To present qualified Medicaid recipients with the option of receiving HIV DES and HIV ongoing case management from a choice of providers. The provider acknowledges that the participant's ongoing case manager may participate as a member of the multidisciplinary team.
- Medical Assistance Targeted Case Management services will not be delivered free of charge to non-Medicaid participants. The provider must charge all non-Medicaid recipients for the service according to a fee schedule which may be billed to a participant, either in full or using a sliding fee scale, or directly to a third-party payer.

By signing and submitting this application, the provider agrees to the following, as stated in COMAR 10.09.32:

For DES providers only:

- The provider will bill only upon completion of a multidisciplinary assessment and signature of all multidisciplinary team members on the individualized plan of care.
- The provider will convene a multidisciplinary team for each participant as specified within the regulations. The team will perform a multidisciplinary assessment and revise the plan of care for the participant annually, or more frequently if significant changes occur during the year.
- The assessment will include all of the components in COMAR 10.09.32 using the Department's HIV/AIDS Bio-Psychosocial Assessment Form as a guide.
- The plan of care will include all of the components in COMAR 10.09.32 using the Department's Case Management Plan of Care Form as a guide.
- The provider must have access to specialty physicians experienced and trained in provision of services to HIV-infected individuals, for consultation as necessary concerning a participant's medical assessment and the medical plan of care.

For Ongoing Case Management providers only:

- The provider has established alternatives for managing participants' medical and social crises during off-hours that will be specified in participants' individualized plans of care.
- The provider ensures that case managers are knowledgeable of the eligibility requirements and application procedures for applicable federal, State, and local government assistance programs.
- The provider agrees to maintain a current listing of medical, social, housing, mental health, financial assistance, counseling and other support services available to HIV-infected individuals.
- The provider agrees that case managers will adhere to all provisions in the plan of care and monitor and evaluate the plan appropriately.
- The provider must have a written policy for case closure.



Application for Participation in Maryland Medical Assistance Program HIV TCM ADDENDUM

AGREEMENT OF UNDERSTANDING BETWEEN AN HIV DIAGNOSTIC EVALUATION SERVICES PROVIDER AND AN HIV ONGOING CASE MANAGEMENT PROVIDER

The providers of this agreement of understanding mutually agree that the case manager selected by the client and employed by the HIV Ongoing Case Management provider shall:

- Serve as a member of the client's multidisciplinary team convened by the HIV Diagnostic Evaluation Services provider and participate in the multidisciplinary assessment and development of the client's plan of care;
- Be given access to the client's plan of care for its implementation; and
- Order an assessment of the client and revision to the plan of care by the HIV Diagnostic Evaluation Services provider, as necessary.

Authorized Signature

HIV Diagnostic Evaluation Services Provider

Authorized Signature

HIV Ongoing Case Management Provider

This agreement of understanding *does not* need to be completed if diagnostic evaluation services and case management are being rendered by the same provider.

AUTHORIZATION

I do solemnly declare and affirm under the penalties of perjury that the contents of the foregoing document and of the attachments are true, accurate, and complete. I understand that a provider agreement will not be signed until the application and all required attachments have been received and approved by the Office of Health Services.

Name of Applicant Entry

Authorized Signature

Date



Provider Agreement for Participation in Maryland Medical Assistance Program

This Agreement (the “Agreement”), entered into between the Maryland State Department of Health and Mental Hygiene (the “Department”) and

_____ (Provider Name)

the undersigned Provider or Provider Group and its members or Practitioner(s) (hereinafter called the “Provider”), is made pursuant to Title XIX and Title XXI of the Social Security Act, Health-General, Title 15, Annotated Code of Maryland and state regulations promulgated thereunder to provide medical, healthcare, and home- and community-based services and/or remedial care and services (“Service(s)”) to eligible Maryland Medical Assistance recipients (“Recipient(s)”). On its effective date, this Agreement supersedes and replaces any existing contracts between the parties related to the provision of Services to Recipients.

I. THE PROVIDER AGREES:

- A. To comply with all standards of practice, professional standards and levels of Service as set forth in all applicable federal and state laws, statues, rules and regulations, as well as all administrative policies, procedures, transmittals, and guidelines issued by the Department, including but not limited to, verifying Recipient eligibility, obtaining prior authorizations, submitting accurate, complete and timely claims, and conducting business in such a way the Recipient retains freedom of choice of providers. The Provider acknowledges his, her or its responsibility to become familiar with those requirements as they may differ significantly from those of other third party payor programs;
- B. To maintain adequate medical, financial and administrative records that fully justify and describe the nature and extent of all goods and Services provided to Recipients for a minimum of six years from the date of payment or longer if required by law. The Provider agrees to provide access upon request to its business or facility and all related Recipient information and records, including claims records, to the Department, the Medicaid Fraud Control Unit (MFCU) of the Maryland Attorney General’s Office, the U.S. Department of Health and Human Services, and/or any of their respective employees, designees or authorized representatives. This requirement does not proscribe record requirements by other laws, regulations, or agreements. It is the Provider’s responsibility to obtain any Recipient consent required to provide the Department, its designee, the MFCU, federal employees, and/or designees or authorized representatives with requested information and records or copies of records. Failure to timely submit or failure to retain adequate documentation for services billed to the Department may result in recovery of payments for Services not adequately documented, and may result in the termination or suspension of the Provider from participation as a Medical Assistance provider.



Provider Agreement for Participation in Maryland Medical Assistance Program

1. Original records must be made available upon request during on-site visits by Department personnel or personnel of the Department's designee.
 2. Copies of records must be timely forwarded to the Department upon written request;
- C. To protect the confidentiality of all Recipient information in accordance with the terms, conditions and requirements of the health Insurance Portability and Accountability Act (HIPAA) of 1996, as amended, and regulations adopted thereunder contained in 45 CFR 160, 162 and 164, and the Maryland Confidentiality of Medical Records Act (Md. Ann. Code, Health-General §§4-301 *et seq.*);
- D. To provide services on a non-discriminatory basis and to hold harmless, indemnify and defend the Department from all negligent or intentionally detrimental acts of the Provider, its agents and employees. The Provider will not discriminate on the basis of race, color, national origin, age, religion, sex, disabilities, or sexual orientation;
- E. To provide Services in compliance with the Americans with Disabilities Act of 1990, Section 504 of the Rehabilitation Act of 1973, and their respective accompanying regulations, and ensure that qualified individuals with disabilities are given an opportunity to participate in and benefit from its Services, including providing interpretive services for the deaf and hard of hearing when required;
- F. To check the Federal List of Excluded Individuals/Entities on the Health and Human Services (HHS) Office of Inspector General (OIG) website prior to hiring or contracting with individuals or entities and periodically check the OIG website to determine the participation/exclusion status of current employees and contractors. To check the Federal System for Award Management (SAM) prior to hiring or contracting with individuals or entities and periodically check the SAM website to determine the participation/exclusion status of current employees and contractors. To check the Maryland Medicaid List of Excluded Providers and Entities prior to hiring or contracting with individuals or entities and periodically check the website to determine the participation/exclusion status of current employees and contractors. The Provider further agrees to not knowingly employ, or contract with a person, partnership, company, corporation or any other entity or individual that has been disqualified from providing or supplying services to Medical Assistance Recipients unless the Provider receives prior written approval from the Department;



Provider Agreement for Participation in Maryland Medical Assistance Program

- G. To accept the Department's payments as payment in full for covered Services rendered to a Recipient. The Provider agrees not to bill, retain, or accept any additional payment from any Recipient. If the Department denies payment or requests payment from the Recipient, or if the Department denies payment or requests repayment because an otherwise covered Service was not medically necessary or was not preauthorized (if required), the Provider agrees not to seek payment from the Recipient for that Service. The Provider further agrees to immediately repay the Department in full for any claims where the Provider received payment from another party after being paid by the Department;
- H. With the exception of prenatal care or preventive pediatric care, to seek payment from a Recipient's other insurances and resources of payment before submitting claims to the Department, which includes but is not limited to seeking payment from Medicare, private insurance, medical benefits provided by employers and unions, worker compensation, and any other third party insurance. If payment is made by both the Department and the Recipient's other insurance, the Provider shall refund the Department, within 60 days of receipt, the amount paid by the Department;
- I. To accept responsibility for the validity and accuracy of all claims submitted to the Department, whether submitted on paper, electronically or through a billing service;
- J. That all claims submitted under his, her or its provider number shall be for medically necessary Services that were actually provided as described in the claim. The Provider acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions. This may include his, her or its expulsion from the Maryland Medical Assistance Program and/or referrals by the Department to the HHS OIG for expulsion from the Medicare program;
- K. That if Provider is a physician, he or she will, upon request, submit the name and applicable licensure for each physician extender in his or her employment. The Provider is responsible for knowing and complying with the Maryland Medical Assistance Program's definition of an eligible physician extender and for providing supervision as required by the Maryland Medical Assistance Program;
- L. That in case of a group provider, the individual Provider rendering the service shall include his or her own provider number, as well as the group provider number, on any claim;



Provider Agreement for Participation in Maryland Medical Assistance Program

- M. To furnish the Department, within 35 days of the Department's request, full and complete information about:
1. The ownership of any subcontractor with who the Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request;
 2. Any significant business transaction 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; and
 3. Any ownership interest exceeding 5 percent held by the Provider in any other Medical Assistance Provider;
- N. That before the Department enters into or renews this Agreement, the Provider agrees to disclose the identity of any person who:
1. Has an ownership or control interest in the Provider, or is an agent or managing employee of the Provider; and
 2. Has been convicted of a criminal offense related to that person's involvement in the Medicaid or Medicare programs;
- O. To exhaust all administrative remedies prior to initiating any litigation against the Department;
- P. Upon receipt of notification that the Provider is disqualified through any federal, state and/or Medicaid administrative action, to not submit claims for payment to the Department for Services performed after the disqualification date;
- Q. Any excessive payments to a Provider may be immediately deducted from future Department payments to any payee with the Provider's tax identification number, at the discretion of the Department;
- R. Continuation of this Agreement beyond the current term is subject to and contingent upon sufficient funds being appropriated, budgeted, and otherwise made available by the State legislature and/or federal sources. The Department may terminate this Agreement and the Provider waives any and all claim(s) for damages, effective immediately upon receipt of written notice (or any date specified therein) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;



Provider Agreement for Participation in Maryland Medical Assistance Program

- S. To comply with the Deficit Reduction Act of 2005 (DRA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least \$5,000,000.

- T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual (s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.

- U. To notify the Department within five (5) working days of any of the following:
 - 1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;

 - 2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or

 - 3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership this Agreement is automatically assigned to the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

II. THE DEPARTMENT AGREES:

- A. To reimburse the Provider for medically necessary Services provided to Recipients that are covered by the Maryland Medical Assistance Program. Services will be reimbursed in accordance with all Program regulations and fee schedules as reflected in the Code of Maryland Regulations or other rules, action transmittals or guidance issued by the Department; and



Provider Agreement for Participation in Maryland Medical Assistance Program

- B. To provide notice of changes in Program regulations through publication in the Maryland Register.

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

- A. That except as specifically provided otherwise in applicable law and regulations, either party may terminate this Agreement by giving thirty (30) days notice in writing to the other party. After termination, the Provider shall notify Recipients, before rendering additional Services, that he or she is no longer a Maryland Medical Assistance participating Provider;
- B. That the effective date of this Agreement shall be _____, provided that the Department verifies the information in the Provider's application. This Agreement shall remain in effect until either party terminates the Agreement (as described in Section III A). Following termination of this Agreement, the Provider must continue to retain records and reimburse the Maryland Medical Assistance Program for overpayments as described in this Agreement and as required by law, including but not limited to Maryland Health-General § 4-403;
- C. That no employee of the State of Maryland, whose duties include matters relating to this Provider's Agreement, shall at the same time become an employee of the Provider without the written permission of the Department;
- D. That this Agreement is not transferable or assignable;
- E. That the Provider Enrollment Application submitted and signed by the Provider is incorporated by reference into this Agreement and is a part hereof as though fully set forth herein; and

Provider Signature (No stamps) Date



Department Authorization Date

Provider Name (Type or Print) Date



Assistant Attorney General Date

Provider Address (Type or Print)



STATE OF MARYLAND ACH/DIRECT DEPOSIT AUTHORIZATION FOR VENDOR PAYMENTS

Type of authorization (select one only):

NEW: Enter all banking information requested below and submit this form. *(Complete lines 1-12 and 16-22)*

Note: Student refunds, Lottery payments, DORS payments, Renters tax credits, and Restitution payments are NOT eligible for ACH.

CHANGE: Complete this form by entering changes to the financial institution, account number, or type of account; and submit the completed form. Do not close your old bank account until electronic payments are received in your new account. *(Complete all lines)*

CANCELLATION (Revocation): You may cancel (revoke) your prior Authorization by checking this box and completing and submitting this form. *(Complete lines 1-7, 13-15 and 17-22)*

Please complete all sections of this Enrollment Form and attach either a voided check OR a letter signed by your bank representative, confirming account name, account number, and ABA routing number for ACH payments. Starter checks or counter checks are NOT acceptable. Online credit cards are NOT eligible for ACH transfer.

Send completed form and documentation to: State of Maryland, Comptroller of Maryland, ACH Registration, General Accounting Division, Room 205, P.O. Box 746, Annapolis, Maryland 21404-0746 or fax the form to 410-974-2309. If you have any questions, contact the General Accounting Division at 410-260-7375 or toll free at 888-784-0144.

Please type or print legibly. PAYEE INFORMATION	The number below is: <input type="checkbox"/> Social Security No.(SSN) <input type="checkbox"/> Federal Employer No.(FEIN)
1. Payee Name	2. SSN or FEIN
3. Mailing Address	4. City, State, ZIP Code
5. E-mail address	
6. Contact Name and Title	7. Daytime Telephone Number
NEW – Complete 8-12	
OLD BANK ACCOUNT INFORMATION – Complete 13-15	
8. Financial Institution Name	13. Financial Institution Name
9. ABA/Routing Number	14. ABA/Routing Number
10. Account Number	15. Account Number for Deposit of Electronic Funds Transfer
11. Account Type (Select one only) <input type="checkbox"/> Checking <input type="checkbox"/> Savings	
12. Financial Institution Telephone Number	

16. Level of Detail on Bank Statement Requested (select one only): <input type="checkbox"/> Standard format – CCD+ (DEFAULT) <input type="checkbox"/> Detailed format - CTX* (multiple detail lines) <input type="checkbox"/> Detailed format - EDI* (full detail) Example: “State of Maryland” “State of Maryland and Invoice Information” “State of Maryland and Invoice Information” <i>*Note: You must contact your bank to receive these detailed formats. There may be a charge to you by your bank for detailed formats.</i>

I hereby certify that I am authorized to make the representations contained in this paragraph. I authorize the Comptroller and the Treasurer of Maryland to register the payee for automated clearing house (ACH) using the information contained in this registration form. I agree to receive all vendor payments from the State of Maryland by electronic funds transfer according to the terms of the ACH program. I agree to return to the State of Maryland any ACH payment incorrectly disbursed by the State of Maryland. I agree to hold harmless the State of Maryland and its agencies and departments for any delays or errors caused by inaccurate or outdated registration information or by the financial institution listed above.

17. Print or Type Name of Payee or Payee’s Authorized Signatory	18. Title of Authorized Signatory
19. Signature of Payee or Payee’s Authorized Signatory	20. Date
21. Signature of Secondary Signatory(s) – if applicable	22. Date

ADMINISTRATIVE USE ONLY

GAD Input By: _____
GAD Reviewed By: _____

STO Input By: _____
STO Reviewed By: _____



**STATE OF MARYLAND
ACH/DIRECT DEPOSIT
INSTRUCTION SHEET**

Purpose:

To provide information to the State of Maryland for ACH/Direct Deposit.

Who will use the form?

Vendors that are required to have payments made via ACH/Direct Deposit or other vendors requesting payments via ACH/Direct Deposit.

Routing and General Instructions:

Complete and send the form and documentation to Vendor Services in the General Accounting Division. Please retain a copy of the form for your records.

Submit to:

ACH Registration, General Accounting Division
Room 205, P.O. Box 746
Annapolis, Maryland 21404-0746
(or) Fax to 410-974-2309

Processing:

Allow 30 days from the date of your request for the Comptroller's/Treasurer's office to process your request. Payments will be processed according to payment terms.

Questions: Email to GAD@comp.state.md.us, call 410-260-7375 or toll free at 888-784-0144.