Application Checklist for Maryland Medical Assistance Program Application INDIVIDUAL PROVIDER

If you are applying to enroll as an individual provider, please include the items in the following checklist with your enrollment packet.
Should you have any questions, please contact the Provider Enrollment Unit at (410) 767-5340.

A completed application will include the following:

- ❑ Completed and signed Individual Provider Application
- ❑ A copy of your 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.

INDIVIDUAL

Instructions for Maryland Medical Assistance Program Application INDIVIDUAL PROVIDER

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR INDIVIDUAL PROVIDERS

Should you have any questions, please contact the Provider Enrollment Unit at (410) 767-5340

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 provider attempting to enroll in Maryland Medicaid has never been enrolled with Maryland Medicaid as a Fee for Service Provider.
RE-ENROLLMENT	The provider has previously been enrolled with Maryland Medicaid as a Fee for Service Provider, but the provider has been suspended or terminated from Maryland Medicaid.
RE-VALIDATION	The provider 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 provider is actively enrolled in Maryland Medicaid and would like to change the information that is currently on file with Maryland Medicaid for the provider.
REQUESTED ENROLLMENT BEGIN DATE	If the provider has started rendering services, please indicate a Requested Enrollment Begin Date.
APPLICATION SUBMITTED DATE	Date filling out the application.
PROVIDER INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	Enter the unique 10-digit NPI (Entity Type 1 Individual) of the provider who will be rendering services to Maryland Medicaid recipients. To obtain a NPI, please visit the following website: https://nppes.cms.hhs.gov/NPPES/Welcome.do. Please attach a printout from the previous website that lists the NPI information. If you are an Atypical provider and are 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 provider. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid provider, please fill in your 9-digit Maryland Medicaid Number.
PROVIDER TYPE	Enter the two-digit code for the appropriate provider type 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.
MEDICARE PROVIDER NUMBER	If you participate in Medicare, please list the provider number that has been assigned to you.
PROVIDER NAME	Individual practitioners should enter last, name, first name and middle initial.
DATE OF BIRTH	Enter the date of birth of the provider.
SOCIAL SECURITY NUMBER (SSN)	Enter the SSN of the individual to whom the Medicaid reimbursements will be made.
TELEPHONE NUMBER	Enter the best number to reach the provider or contact person who can speak on behalf of the provider regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the provider or contact person who can speak on behalf of the provider regarding Maryland Medicaid participation.

INDIVIDUAL INSTRUCTIONS

Instructions for Maryland Medical Assistance Program Application INDIVIDUAL PROVIDER

CORRESPONDENCE INFORMATION	
CONTACT INFORMATION	If the application is being filled out on behalf of the provider, enter the Name, Position/Title, Telephone and E-Mail address of the contact person who can speak on behalf of the provider regarding Maryland Medicaid participation.
PRACTICE ADDRESS	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the primary address in which the individual provider will be rendering services.
PRACTICE ADDRESS #2	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of the secondary address in which the individual provider will be rendering services.
PRACTICE ADDRESS #3	Enter the Street Number, Street Name, Suite, City, State, Zip Code, Telephone number and Fax number of any additional addresses in which the individual provider will be rendering services.
CORRESPONDENCE ADDRESS	Enter the Street Number, Street Name, 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, Street Name, 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.	
PROFESSIONAL	Enter your professional license number, the State that issued the license, beginning effective date, and expiration date for each practice location in which you service Maryland Medicaid participants.
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.
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.
OTHER	Enter any other license information as required.

***Medical laboratory providers:** Practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** a copy of 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.

ADDITIONAL INFORMATION	
SPECIALTY INFORMATION	Physicians MUST enter the appropriate three-digit code from the specialty code listing provided at the end of these instructions. Please specify if you have another specialty not listed. Enter the primary specialty, specialty code (if physician), the date you were certified for your specialty in MMDDYY format, and the number, up to six digits, that was provided to you when you were certified for the associated specialty. Attach additional pages if more space is needed.
SPECIALTY VERIFICATION	Check the applicable statement and attach the required documentation.
LABORATORY INFORMATION	Answer the three questions listed in this section.
GROUP AFFILIATION	If you are a member of a group practice, please enter the name, organizational NPI, Maryland Medicaid number, and the effective date you became a member of the group. All rendering practitioners of a group must individually be enrolled as a Maryland Medicaid provider.
AUTHORIZATION	Please sign and date the application. No one can sign on the applicant's behalf.

INDIVIDUAL INSTRUCTIONS

Instructions for Maryland Medical Assistance Program Application INDIVIDUAL PROVIDER

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. If a section is not applicable, please indicate this by checking the box at the end of each section and including the provider's signature.
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.

PROVIDER TYPE CODES			
ACUPUNCTURE	AC	PERSONAL CARE AIDE	44
AUDIOLOGY PROVIDERS	19	PHYSICAL THERAPIST	16
CERTIFIED PROFESSIONAL COUNSELOR	CC	PHYSICIAN	20
CHIROPRACTOR	13	PHYSICIAN ASSISTANT	80
DIETICIAN/NUTRITIONIST	85	PODIATRY PROVIDERS	11
NURSE ANESTHETISTS	21	PRESCRIBING PROVIDERS	92
NURSE MIDWIVES	22	PSYCHOLOGIST	15
NURSE PRACTITIONERS	23	SOCIAL WORKER	94
NURSE PSYCHOTHERAPISTS	24	SPEECH/LANGUAGE PATHOLOGIST	17
OCCUPATIONAL THERAPIST	18	VISION CARE PROVIDERS	12

TYPE OF PRACTICE CODES	
INDIVIDUAL PRACTICE	30
INDIVIDUAL PRACTICE, L/P HOSPITAL ONLY	31
INDIVIDUAL PRACTICE, EMERG. ROOM ONLY	32
INDIVIDUAL PRACTICE, O/P OR CLINIC ONLY	33

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		

PHYSICIAN SPECIALTY CODES					
ALLERGY & IMMUNOLOGY	026	GYNECOLOGIC ONCOLOGY	008	PEDIATRIC CRITICAL CARE MEDICINE	019
ANATOMIC & CLINICAL PATHOLOGY	045	HEMATOLOGY	035	PEDIATRIC ENDOCRINOLOGY	020
ANATOMIC PATHOLOGY	046	INFECTIOUS DISEASE	036	PEDIATRIC GASTROENTEROLOGY	021
ANESTHESIOLOGY	041	INTERNAL MEDICINE	030	PEDIATRIC HEMATOLOGY - ONCOLOGY	022
CARDIOVASCULAR DISEASE	031	MATERNAL & FETAL MEDICINE	009	PEDIATRIC NEPHROLOGY	023
CHILD & ADOLESCENT PSYCHIATRY	053	MEDICAL ONCOLOGY	037	PEDIATRIC PULMONOLOGY	024
CLINICAL PATHOLOGY	047	NEONATAL - PERINATAL MEDICINE	025	PEDIATRIC SURGERY	002
COLON & RECTAL SURGERY	004	NEPHROLOGY	038	PEDIATRIC	016
CRITICAL CARE MEDICINE	032	NEUROLOGICAL SURGERY	014	PHYSICAL MEDICINE & REHABILITATION	048
DERMATOLOGICAL IMMUNOLOGY/DIAGNOSTIC & LABORATORY IMMUNOLOGY	060	NEUROLOGY	050	PLASTIC SURGERY	011
DERMATOLOGY	058	NEUROLOGY WITH SPECIAL QUALIFICATION IN CHILD NEUROLOGY	051	PSYCHIATRY	052
DERMATOPATHOLOGY	059	NUCLEAR MEDICINE	044	PUB HEALTH & GEN PREVENTIVE MEDICINE	049
DIAGNOSTIC LAB IMMUNOLOGY	017	NUCLEAR RADIOLOGY	057	PULMONARY DISEASE	039
DIAGNOSTIC RADIOLOGY	055	OBSTETRICS & GYNECOLOGY	007	RADIATION ONCOLOGY	056
EMERGENCY MEDICINE	043	OPHTHALMOLOGY	015	RADIOLOGY	054
ENDOCRINOLOGY & METABOLISM	033	ORTHOPEDIC SURGERY	013	REPRODUCTIVE ENDOCRINOLOGY	010
FAMILY PRACTICE	029	OSTEOPATH	189	RHEUMATOLOGY	040
GASTROENTEROLOGY	034	OTOLARYNGOLOGY	012	SURGERY	001
GENERAL PRACTICE	028	PATHOLOGY	186	THORACIC SURGERY	005
GENERAL VASCULAR SURGERY	003	PEDIATRIC CARDIOLOGY	018	UROLOGY	006

INDIVIDUAL INSTRUCTIONS

Application for Participation in Maryland Medical Assistance Program
INDIVIDUAL PROVIDER

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION	**Unless Instructed Otherwise, Mail 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 Please select one.			
☐ **NEW ENROLLMENT** (Applicant has never enrolled with Maryland Medical Assistance)	☐ **RE-ENROLLMENT** (Provider is currently excluded/terminated from the Maryland Medicaid Program)	☐ **RE-VALIDATION** (Provider is enrolled and required to revalidate)	☐ **INFORMATION UPDATE** (Provider is enrolled and updating information to the provider's file)
Requested Enrollment Begin Date		Application Submitted Date	

PROVIDER INFORMATION		
NPI (Individual)	Maryland Medical Assistance Provider Number (If existing provider)	
Provider Type (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)	
Medicare Provider Number		
Provider Last Name	First Name	MI
Date of Birth (MM/DD/YYYY)	Social Security Number (SSN)	
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

PRACTICE 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
INDIVIDUAL PROVIDER

PRACTICE ADDRESS # 2 Please enter other locations where you provide healthcare services for Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. If additional space is needed, please attach additional pages.		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

PRACTICE ADDRESS # 3		
Street Address	Suite/Department/Floor	
City	State	Zip Code (9 Digit)
Telephone Number + extension	Fax Number	

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?	☐ YES	☐ NO

Application for Participation in Maryland Medical Assistance Program
INDIVIDUAL PROVIDER

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.				
Professional	State Issued	License Number	Date Issued	Expiration Date
CLIA	State Issued	License Number	Date Issued	Expiration Date
DEA	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
Other	State Issued	License Number	Date Issued	Expiration Date

SPECIALTY INFORMATION If more space is needed, please attach additional pages.	
Primary Specialty	Specialty Code
Certification Date	Certification Number
Secondary Specialty	Specialty Code
Certification Date	Certification Number
Secondary Specialty	Specialty Code
Certification Date	Certification Number
Secondary Specialty	Specialty Code
Certification Date	Certification Number

Application for Participation in Maryland Medical Assistance Program
INDIVIDUAL PROVIDER

SPECIALTY VERIFICATION
(Please check the applicable statement and attach the required documentation. Pursuant to the Physicians Services Regulations (COMAR 10.09.02), the Medical Assistance Program defines a Consultant-Specialist as a licensed physician who meets one of the criteria.)
☐ I have been declared board certified by a member of the American Board of Medical Specialists and currently retain that status. A photocopy of my specialty board certificate is attached.
☐ I have satisfactorily completed a residency program accredited by the Liaison Committee for Graduate Medical Education or by the appropriate residency review committee of the American Medical Association. Attached is a letter of verification from the chairman of the department where I completed my residency or where I am now working. This letter includes the name of the hospital where I completed my residency, length of my residency, by whom the program is accredited and the completion date of my residency.
☐ I have been declared board certified by a specialty board approved by the Advisory Board of Osteopathic Specialists and the Board of Trustees of the American Osteopathic Association. A photocopy of my specialty board certificate is attached.
☐ I have been declared board eligible by a specialty board approved by the Advisory Board of Osteopathic Specialists. Verification from my specialty board that I am board eligible is attached.
☐ I have completed a residency program in a foreign country. My qualifications and training are acceptable for admission in the examination system of the appropriate American Specialty Board. A letter of my specialty board verifying this is attached.

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?	☐ YES	☐ NO
Do you provide medical laboratory services for other than your own patients?	☐ YES	☐ NO
Do you receive specimens that are obtained from other sites located in Maryland?	☐ YES	☐ 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
INDIVIDUAL PROVIDER

GROUP AFFILIATION INFORMATION If additional space is needed, please attach additional pages.			
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date
Group Name	NPI (Group)	Maryland Medical Assistance Number	Begin Date

AUTHORIZATION

I, the practitioner, 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 group 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 group is salaried.

Provider Signature (No stamps) **Date**

Provider Name (Type or Print) **Date**

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 (Individual named on page 1 of this application)

Name	NPI (Individual)	
Home Address – Street	City & State	Zip Code (9 Digits)
Social Security Number (SSN)	Date of Birth (MM/DD/YYYY)	

Ownership in Applicant (Has direct or indirect ownership interest[1] 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
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)	
☐ NOT APPLICABLE	Signature Required if Not Applicable	

[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.

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. 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
☐ NOT APPLICABLE	Signature Required if Not Applicable	

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
☐ NOT APPLICABLE	Signature Required if Not Applicable	

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
☐ NOT APPLICABLE	Signature Required if Not Applicable	

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
☐ NOT APPLICABLE	Signature Required if Not Applicable	

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: _____

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: _____

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 transactions[2], occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier[3] 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).

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.

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;

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;

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 therin) if for any reason the Department's funding from State and/or federal sources is not appropriated or is withdrawn, limited or impaired;

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

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

		Susan J Tucker	
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: ☐ Social Security No.(SSN) ☐ 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) ☐Checking ☐Savings	
12. Financial Institution Telephone Number	

16. **Level of Detail on Bank Statement Requested** (select one only)**:**

☐ Standard format – CCD+ **(DEFAULT)** ☐ Detailed format - CTX* (multiple detail lines) ☐ Detailed format - EDI* (full detail)
Example: "State of Maryland" **"State of Maryland and Invoice Information"** **"State of Maryland and Invoice Information"**
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 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: _____ STO Input By: _____
GAD Reviewed 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.

Contact Information for Maryland Medical Assistance Program Application
INDIVIDUAL PROVIDER

Additional documentation may be required to enroll as this provider type.

To obtain additional application materials, or if you have any questions, please contact program staff at:

Provider Enrollment - Phone: (410)767-5340

INDIVIDUAL CONTACT