STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL CARE PROGRAM
PROVIDER APPLICATION

(Revision Date 5/16/11)

Please fill in the requested information as completely as possible. The following form definitions are provided to help clarify the information requested. Should you have any questions please contact the Provider Enrollment Unit at (410) 767-5340.

NOTE: PLEASE ATTACH A COPY OF ALL REQUESTED DOCUMENTS

1) APPLICATION TYPE

Check the appropriate box. If the request is to change existing data, then you must also include your Medicaid Provider Number. If you have already rendered service please indicate a Requested Enrollment Begin Date.

2) PROVIDER INFORMATION

If you have a business, such as pharmacy or medical supply, or a professional group, enter the company name or corporate group name. All physicians and other individual practitioners should enter last name, first name, middle initial and professional title.

Enter the address, telephone and fax number of your primary practice location, contact person name and their telephone number and the practice email or website address. Enter a "Y" for Yes or a "N" for No if your office is handicap accessible.

Enter the appropriate two-digit code for county of your business or practice location address. A listing of the county codes is provided for your reference at the end of these instructions.

Enter the two-digit code for the appropriate provider type from the listing provided at the end of these instructions. Applicants for the Kidney Disease Program (KDP) must also enter the two-digit KDP code.

Enter the Federal Employer ID Number, National Provider Identification (NPI) and the Social Security Number of the individual, group or business to whom the Medicaid reimbursements will be made.

3) LICENSE/PERMIT INFORMATION

Enter your professional license number, beginning effective date and expiration date for each practice location in which you service Maryland Medicaid recipients. If out of state, attach a copy of the current license certificate. Enter your NABP number if applicable.

Enter your Drug Enforcement Agency number and attach a copy of your DEA certificate. If you do not have a DEA number, this box should be left blank.

Enter your pharmacy permit number, if applicable.

Medical laboratory providers, practitioners and other providers that perform medical laboratory services **MUST COMPLETE** and **SUPPLY** the following:

- Enter Clinical Laboratory Improvement Amendment (CLIA) #
- Attach a copy of CLIA Certificate
- Enter Maryland Laboratory Permit or Letter of Permit Exception #
- Attach copy of Maryland Laboratory Permit or 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.

4) PRACTICE INFORMATION

Enter the appropriate two-digit code for your type of practice. If this does not apply, leave blank. For your reference, a listing of the practice codes is provided at the end of these instructions.

5) SPECIALTY INFORMATION

Enter a "P" to designate the primary specialty. If multiple specialty codes are entered, then you must designate one specialty as the primary specialty.

Physicians, Dentists, and Pharmacies MUST enter the appropriate three-digit code from the specialty code listing provided at the end of these instructions. Enter OTH if you have another specialty not listed. PLEASE SPECIFY.

Enter the date you were certified for your specialty in MMDDYY format.

Enter the number, up to six digits, that was provided to you when you were certified for the associated specialty.

6) SPECIALTY VERIFICATION

Please check the applicable statement and attach the required documentation.

7) GROUP MEMBERSHIP INFORMATION

If you are a MEMBER OF A GROUP PRACTICE, please enter the name, Maryland Medicaid provider number and the effective date you became a member of the group. If you are a GROUP PRACTICE, please list the names of each professional practicing in your group and his/her individual Maryland Medicaid provider number and membership effective date. All rendering practitioners in the group MUST individually be enrolled as a Maryland Medicaid provider.

8) MEDICARE INFORMATION

If you participate in Medicare, please list the fiscal intermediaries with whom you are enrolled (i.e. Blue Cross of Maryland, Traveler's Group Hospital Insurance, etc.) and enter the provider number each has assigned to you.

9) ALTERNATE ADDRESS INFORMATION

Enter the Pay-To-Address address, you want your Medicaid reimbursement checks mailed. If you leave this section blank, your checks will be mailed to the primary practice location entered on the first page of the application.

Enter the Correspondence Address you want all your Medicaid related correspondence and remittance advices mailed. If you leave this area blank, correspondence will be mailed to the primary practice location entered on the first page of the application. Also, please indicate if you would like to receive correspondence electronically. If yes, please include your email address on the first page of the application.

10) OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you serve Maryland Medicaid recipients. Include all group addresses where you are currently practicing. Enter a "Y" for Yes or a "N" for No if your office is handicap accessible.

11) MEDICAID INFORMATION: OTHER STATES

Please indicate if you are a Medicaid provider in another state. Please indicate the state that you are a provider and indicate your number..

12) AUTHORIZATION

Please sign and date the application. No one can sign on your behalf.

PROVIDER TYPE CODES

AC	Acupuncture- Children ONLY	51	EPSDT Therapeutic Intervention- Children ONLY	23	Nurse Practitioner (Indiv. Or Group)
50	ADAA Certified Addictions Outpatient Prog.	52	EPSDT Therapeutic Nursery	24	Nurse Psychotherapist (Indiv. Or Group)
T1	Ambulance Services	72	HealthChoice and PAC Managed Care Organizations	57	Nursing Facility
39	Ambulatory Surgical Center-Must be Medicare Certified			76	Older Adults Waiver Provider
		40	Home and Community Based Services-Autism Waiver	18	Occupational Therapist (Indiv. Or Group)- Children ONLY
AT	Attendant Care Waiver-Living at Home Waiver Provider	41	Home Health Agency- Must be Medicare Certified	63	Oxygen Services
19	Audiology Services Provider- Children ONLY	71	Hospice Provider- Must be Medicare Certified	MH	Partial Hospitalization Program (Mental Health)
		01	Hospital, Acute	44	Personal Care Aid
81	Case Management	03	Hospital, Rehabilitation Acute	45	Personal Care Aid Agency
CC	Certified Professional Counselor	04	Hospital, Rehabilitation Chronic	47	Personal Care Monitor
82	Children's Medical Services (CMS) Provider	05	Hospital, Chronic	RX	Pharmacy
13	Chiropractor- Children ONLY	06	Hospital, Special Pediatric	16	Physical Therapist (Indiv. Or Group)
30	Clinic, Abortion	07	Hospital, Special Psychiatric	20	Physician (Indiv. Or Group)
		55	Intermediate Care Facility-Addiction (ICF-A)- Children ONLY	11	Podiatrist (Indiv. Or Group)
32	Clinic, Drug Abuse (Methadone)			59	Portable X-Ray
				53	Private Duty Nursing-Must be Residential Service Agency
33	Clinic, Family Planning	10	Laboratories, Medical	15	Psychologist (Indiv. Or Group)
34	Clinic, Federally Qualified Health Center	91	Local Education Agencies/ Local Lead Agencies	PR	Psychiatric Rehab. Program
35	Clinic, Local Health Department	72	MCO (HealthChoice and PAC)	87	REM Case Management Providers
36	Clinic, Maryland Qualified Health Centers	42	Medical Day Care, Adult	88	Residential Service Center
		43	Medical Day Care, Children	89	Residential Treatment Waiver Services
38	Clinic, General	MA	Medicare Advantage Plan	92	Prescribing Providers- ONLY
83	Comprehensive Outpatient Rehabilitation Facility (CORF)	CM	Mental Health Case Management Provider	93	Senior Center Plus
90	DDA Services Provider	MC	Mental Health Clinic	94	Social Worker (Indiv. or Group)
14	Dental	27	Mental Health Group Provider (Psychotherapist, Social Worker, Nurse Psychotherapist)	17	Speech/Language Pathologist (Indiv. or Group)
60	Diagnostic Services, Other			95	State Agency
61	Dialysis Facilities	MT	Mobile Treatment (Mental Health)	28	Therapy Group Provider (PT. OT. Speech)
85	Dietician/Nutritionists- Children and Pregnant Women ONLY	21	Nurse Anesthetists (Indiv. Or Group)	86	Traumatic Brain Injury Waiver
62	DME/DMS- Must be Medicare Certified	22	Nurse Midwife (Indiv. Or Group)	08	Urgent Care Centers
				12	Vision Care

KIDNEY DISEASE PROGRAM

K1	Physician	K6	Hospital- Inpatient
K2	Pharmacy	K7	Medical Laboratory
K3	Dialysis Facility	K8	Other (dental, vision)
K5	Hospital-Outpatient		

TYPE OF PRACTICE CODES

35	Group Practice	99	Other
50	HMO	20	Pharmacy, single store
30	Individual Practice	21	Pharmacy chain, 2-10 stores
31	Individual Practice, L/P hospital only	22	Pharmacy chain, 11+ stores
32	Individual Practice, Emerg. Room only	23	Pharmacy, hospital based
33	Individual Practice, O/P or clinic only	24	Pharmacy, nursing home based
10	Nursing Home	25	Pharmacy, tax supported

COUNTY CODES

01	Allegany	07	Cecil	13	Howard	19	Somerset	40	Washington, DC
02	Anne Arundel	08	Charles	14	Kent	20	Talbot	99	Other State
03	Baltimore County	09	Dorchester	15	Montgomery	21	Washington		
04	Calvert	10	Frederick	16	Prince George's	22	Wicomico		
05	Caroline	11	Garrett	17	Queen Anne's	23	Worcester		
06	Carroll	12	Harford	18	St. Mary's	30	Baltimore City		

SPECIALTY CODES

PHYSICIAN SPECIALTY CODES

026	Allergy & Immunology	008	Gynecologic Oncology	019	Pediatric Critical Care Medicine
045	Anatomic & Clinical Pathology	035	Hematology	020	Pediatric Endocrinology
046	Anatomic Pathology	036	Infectious Disease	021	Pediatric Gastroenterology
041	Anesthesiology	030	Internal Medicine	022	Pediatric Hematology- Oncology
031	Cardiovascular Disease	009	Maternal & Fetal Medicine	023	Pediatric Nephrology
053	Child & Adolescent Psychiatry	037	Medical Oncology	024	Pediatric Pulmonology
047	Clinical Pathology	025	Neonatal- Perinatal Medicine	002	Pediatric Surgery
004	Colon& Rectal Surgery	038	Nephrology	016	Pediatric
032	Critical Care Medicine	014	Neurological Surgery	048	Physical Medicine & Rehabilitation
060	Dermatoligcal Immunology/ Diagnostic & Laboratory Immunology	050	Neurology	011	Plastic Surgery
058	Dermatology	051	Neurology with Special Qualification in Child Neurology	052	Psychiatry
059	Dermatopathology	044	Nuclear Medicine	049	Public Health & General Preventive Medicine
017	Diagnostic Lab Immunology	057	Nuclear Radiology	039	Pulmonary Disease
055	Diagnostic Radiology	007	Obstetrics & Gynecology	056	Radiation Oncology
043	Emergency Medicine	015	Opthalmology	054	Radiology
033	Endocrinology & Metabolism	013	Orthopedic Surgery	010	Reproductive Endocrinology
029	Family Practice	183	Osteopath	040	Rheumatology
034	Gastroenterology	012	Otolaryngology	001	Surgery
028	General Practice	186	Pathology	005	Thoracic Surgery
003	General Vascular Surgery	018	Pediatric Cardiology	006	Urology

DENTAL SPECIALTY CODES

113	Dental- Other	181	Oral Surgery
123	Endodontics	182	Orthodontics
057	Nuclear Radiology	187	Pedodontics
131	General Dentistry	188	Periodontics

PHARMACY SPECIALTY CODES

147	Home IV Therapy	184	Other Pharmacy
151	Hospital Outpatient Pharmacy	202	Retail Chain Pharmacy
156	Institutional Pharmacy	204	Retail Single Pharmacy
168	Multi-Specialty Pharmacy		

MEDICAL CARE PROGRAM—PROVIDER APPLICATION

IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION

1) APPLICATION TYPE:

NPI: _____

☐ New Enrollment
☐ Re-Enrollment
☐ Existing Provider/ InformationChange Provider Number: _____

I am applying as a….. Please check one:

Requested Enrollment Begin Date _____

☐ Group of Practitioners
☐ Individual Practitioner- Solo Practitioner or Member of a Group (Please circle type)
☐ Facility/ Institution/ Business/ Agency (Please circle type)

2) PROVIDER INFORMATION

*Please refer to the instructions for the appropriate codes.

Group/Facility/ Business/ Agency Name: _____

Physician/Practitioner Last Name: _____ First Name: _____ Title: _____

Contact Person Name: _____ Phone Number: _____ Email Address: _____

Primary Practice Address: _____ Suite Number: _____

City: _____ State: _____ Zip: _____ Handicap Access: _____

Phone: _____ Fax : _____ County Code: _____ Provider Type Code: _____

Employer Identification Number:_____ Name of EIN Owner: _____ Social Security Number: _____

Medicare Provider Number: _____ Fiscal Year End Date: _____ Date Of Birth: _____

3) LICENSE/PERMIT INFORMATION

License/ Permit Type

Individual:

Professional: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

DEA: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

Good Standing: Yes:☐ No:☐

Institutional:

MDLAB: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

CLIA: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

NABP: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

Pharmacy: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

NCPDP: State Issued:____ License/Permit Number:_____ Date Issued:_____ Expiration Date:_____

Good Standing: Yes:☐ No:☐

4) PRACTICE INFORMATION
***Please refer to instructions for appropriate codes.**

Type of Practice: _____

5) SPECIALTY INFORMATION (IF APPLICABLE)
***Please refer to the instructions for appropriate codes.**

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

Primary / Secondary Specialty: _____ Specialty Code: _____
Certification Date: _____ Certification Number: _____

6) 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 following 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.

If your application is for a group or professional association, each physician/practitioner in the group or association who wishes to be considered a specialist must submit the required verification.

7) GROUP MEMBERSHIP INFORMATION

Group Name: _____ Provider Number: _____ Begin Date: _____

Group Name: _____ Provider Number: _____ Begin Date: _____

Group Name: _____ Provider Number: _____ Begin Date: _____

Group Name: _____ Provider Number: _____ Begin Date: _____

8) MEDICARE INFORMATION

Name: _____ Medicare Number: _____

Name: _____ Medicare Number: _____

Name: _____ Medicare Number: _____

9) ALTERNATIVE ADDRESS INFORMATION

Pay To Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Correspondence Address:

Address: _____

City: _____ State: _____ Zip Code: _____

Would you prefer to receive electronic correspondence, including remittance advices, in lieu of paper, when available?
Yes: ☐ **No:** ☐

10) OTHER PRACTICE LOCATION INFORMATION

Please enter other locations where you provide healthcare services for Maryland Medicaid recipients. Include all group addresses you are currently practicing under, if applicable. *Please refer to the instructions for appropriate codes.

Practice Address #2

Address: _____ Suite Number: _____

City: _____ State: _____ Zip Code: _____ Handicap Access: _____

Phone Number: _____ Country Code: _____

License Number: _____ Expiration Date: _____

Practice Address #3

Address: _____ Suite Number: _____

City: _____ State: _____ Zip Code: _____ Handicap Access: _____

Phone Number: _____ Country Code: _____

License Number: _____ Expiration Date: _____

11) MEDICAID INFORMATION

Name: _____ Medicaid Number: _____
State: _____

Name: _____ Medicaid Number: _____
State: _____

Name: _____ Medicaid Number: _____
State: _____

12)AUTHORIZATION

I, the practitioner, administrator or authorized professional representative of this group, 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.

Date: _____

Type or Print Name of Practitioner, Administrator or
Authorized Professional Responsible for the Quality of Patient Care: _____

Signature of Practitioner, Administrator or
Authorized Professional Responsible for the Quality of Patient Care: _____

Signature of Owner (in the case of a Pharmacy): _____

Please Return Completed Application to: Systems and Operations Administration,
Provider Enrollment
P.O. Box 17030
Baltimore, MD 21203

PROVIDER APPLICATION PRACTITIONER AND GROUP ADDENDUM

PRACTITIONER

If you are participating in a group practice, do you also provide care to Maryland Medicaid recipients in your private practice and wish to be reimbursed directly by the State (your personal tax identification number must appear on this application)?

Yes: ☐ No: ☐

GROUP

If your group 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:

Name of Facility: _____

Address: _____

Title: _____

Duties: _____

Is your group salaried by the above institution? Yes: ☐ No: ☐

If you are a M.D. or D.O. will you be dispensing pharmaceuticals other than samples (as pharmacy)? Yes: ☐ No: ☐

If you are an O. D., are you practicing optometry exclusively? Yes: ☐ No: ☐ or optometry as well as preparing and dispensing eyeglasses (as an optician)? Yes: ☐ No: ☐

Is your group operating a Local Health Department Clinic? Yes: ☐ No: ☐

Is your group operating a Freestanding Clinic? Yes: ☐ No: ☐

NOTE: All practitioners in a group must be enrolled as Medical Care Program rendering providers.

LABORATORY INFORMATION

Completion of this section is required by individual practitioners and groups. 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.

INSTITUTIONAL BED DATA:

Nursing Facility (NF) Number of Beds: _____ Chronic Hospital (CHB) Number of Beds: _____

Acute Inpatient (INP) Number of Beds: _____ Intellectual Disability (ID) Number of Beds: _____

Other (OTH) Number of Beds: _____

DIALYSIS FACILITIES

Medicare Provider Number: _____

Attach a copy of letter with assigned Medicare Provider Number.

Attach a copy of the letter(s) from your intermediary showing all current composite rates.

Note: You will be paid ONLY for the rate(s) appearing in this/these letter(s) in addition to those services provided, but not included in the composite rate.

PORTABLE X-RAY AND OTHER DIAGNOSTIC SERVICES MUST SUPPLY THE FOLLOWING:

Maryland Medical test Unit Permit No.: _____

Do you intend to bill for portability? Yes: ☐ No: ☐

Note: All portable x-ray and other diagnostic service providers located within Maryland or serving patients located within Maryland MUST have a Maryland Test Unit Permit. The only out-of-state portable x-ray and other diagnostic services providers that do not have to have a Maryland Medical Test Unit Permit are those that serve Maryland Medical recipients in the State in which the provider is located and they must provide a Medicare number.

LABORATORY INFORMATION

Completion of this section is required. Reimbursement for medical laboratory services you provide to eligible recipients is dependent on answering the following questions and supplying copies of CLIA Certificate and, when required, a Maryland Laboratory Permits or Letters of Permit Examination. 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 practitioners are required to have a Maryland Laboratory Permit or Letter of Permit Exception Number (§ Health General Article 17-202 and 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.

PROVIDER OWNERSHIP AND DISCLOSURE FORM
(Applicable to all Providers of items or services[1] except for individual practitioners or groups of practitioners[2])

Provider Name : _____

Provider Address: _____

Pursuant to 42 CFR 455.100 et seq., the disclosure of the following is a required portion of the Maryland Medicaid Provider Application. Therefore, please answer the following questions and sign this document affirming that this information is true and complete, and return with your application.

A. Name any person, who, with respect to the Title XIX Provider[3]

1. is an officer or director:

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

2. is a partner:

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

3. has direct or indirect ownership interest[4] of 5% or more:

Name: _____ Address: _____
Date of Birth: _____ Social Security Number: _____

---

[1] "Provider" or "provider" of services means a hospital, a skilled nursing facility, an intermediate care facility, a clinic, a psychiatric facility, a mental institution, an independent clinical laboratory, a health maintenance organization, a pharmacy, and any other entity that furnishes or arranges for the furnishing of services for which payment is claimed under the Medicaid program. It does not include individual practitioners or groups of practitioners.

[2] "Group of practitioners" means two or more health care practitioners who practice their profession at a common location (whether or not they share common facilities, common supporting staff, or common equipment) but who have not formed a partnership or corporation and are not employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice.

[3] Identify any persons named, who are related to others named, as spouse, parent, child or sibling.

[4] 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.

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

4. has a combination of direct or indirect ownership interests equal to 5% or more in the Provider

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

5. is an owner (in whole or in part) of an interest of 5% or more in any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by the Provider or its property or assets if that interest equals at least 5% of the value of the property or assets of the Provider

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Category: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Category: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Category: _____

B. With respect to any subcontractor in which the Title XIX Provider has, directly or indirectly, an ownership or control interest of 5% or more, name any person who falls within Part A. 1-5 above, as applied to the subcontractor and specify which of the above categories he falls within

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Category: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Category: _____

Name: _____ Address: _____

Date of Birth: _____ Social Security Number: _____

Category: _____

C. 1. If any person named in response to Part A. 1-5, above, has any of the relationships described in that Part with any Title XIX Provider of items or services other than the applicant, or with any entity that does not participate in Medicaid but is required to disclose certain ownership and control information because of participation in any of the programs established under Title V, XVII, or XX of the Social Security Act, state the name of the person, the name of the other Provider, and the nature of the relationship.

Name: _____ Provider: _____

Relationship: _____

Name: _____ Provider: _____

Relationship: _____

Name: _____ Provider: _____

Relationship: _____

2. If the answer to Part C. 1. above, contains the names of more than two persons, state whether any of those so reported are related to each other as spouse, parent, child or sibling

Relationship: _____

D. Name any person who has been convicted[5] of a criminal offense related to his involvement with any program operated under Title XVIII, XIX, or XX of the Social Security Act, and who, with regard to the Title XIX Provider, falls within the provisions of A.1-5, above, or is an agent or a managing employee [an individual, including a general manager, administrator and director, who exercises operational or managerial control or who directly or indirectly conducts the day-to-day operations]

Name: _____

Name: _____

Name: _____

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[6], occurring during the 5 year period ending on the date of such request, between the Provider and any wholly-owned supplier[7] or any subcontractor.

AUTHORIZED SIGNATURE: _____ DATE: _____

POSITION: _____

[5] "Convicted" means that a judgment of conviction has been entered by a Federal, State, or local court, irrespective of whether an appeal from that judgment is pending.
[6] "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.
[7] "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).

FOR DHMH USE ONLY

Application Date: _____/ /_____

Eligibility Date: _____/_____/_____

Enrollment Status: [ ] [ ]

Category of Service Codes

Provider Activity Record

Date	Initials	Activity

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

_____

_____

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, 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, statutes, 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 General Service Administration's Excluded Parties List System (EPLS) prior to hiring or contracting with individuals or entities and periodically check the EPLS 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 whom 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;

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

Provider Signature	Date	Department Authorization	Date
Provider Name (Typed)	Date	Assistant Attorney General	Date

Provider Signature Address (Typed)