



Application Checklist for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

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

Della Brown - Phone: (410)-767-5883 - Email: gondella.brown@maryland.gov

A completed application will include the following:

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



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION: PT 76 AGENCY

INSTRUCTIONS FOR COMPLETING MARYLAND MEDICAID ENROLLMENT FORMS FOR FACILITIES/ORGANIZATIONS

Should you have any questions, please contact:

Della Brown - Phone: (410)-767-5883 - Email: gondella.brown@maryland.gov

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

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

FACILITY/ORGANIZATION INFORMATION	
NATIONAL PROVIDER IDENTIFIER (NPI)	DO NOT COMPLETE. This information is not required for this provider type.
MARYLAND MEDICAL ASSISTANCE PROVIDER NUMBER	This is a unique provider number generated by Maryland Medicaid for each facility/organization. If you are a new enrollee, please leave this field blank. If you are an existing Maryland Medicaid facility/organization, please fill in your facility/organization's 9-digit Maryland Medicaid Number.
FACILITY/ORGANIZATION PROVIDER TYPE	Enter the two-digit code for the appropriate provider type from the listing provided at the end of these instructions.
TYPE OF PRACTICE	Enter the two-digit code for the appropriate type of practice from the listing provided at the end of these instructions.
SPECIALTY CODE	DO NOT COMPLETE. This information is not required for this provider type.
COUNTY CODE	Enter the two-digit code for the appropriate county code from the listing provided at the end of these instructions.
FACILITY/ORGANIZATION NAME	Enter the legal name of the facility/organization as it appears on federal tax documents.
DOING BUSINESS AS (NAME)	If the facility/organization operates under a different name than the legal name, enter that name here.
TAX IDENTIFICATION NUMBER	Enter the 9-digit tax identification number of the facility/organization.
NAME OF TAX IDENTIFICATION NUMBER OWNER	Enter the name to which the tax identification number of the facility/organization is assigned.
MEDICARE PROVIDER NUMBER	DO NOT COMPLETE. This information is not required for this provider type.



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION: PT 76 AGENCY

MEDICARE FISCAL YEAR END DATE	DO NOT COMPLETE. This information is not required for this provider type.
TELEPHONE NUMBER	Enter the best number to reach the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.
E-MAIL ADDRESS	Enter the e-mail address of the facility/organization or contact person who can speak on behalf of the facility/organization regarding Maryland Medicaid participation.

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

LICENSE/PERMIT INFORMATION	
If applicable attach a copy of each license or certificate that is listed.	
ASSISTED LIVING FACILITY	DO NOT COMPLETE. This information is not required for this provider type.
CLINICAL LABORATORY IMPROVEMENT AMENDMENT (CLIA) NUMBER*	DO NOT COMPLETE. This information is not required for this provider type.
DRUG ENFORCEMENT AGENCY (DEA)	DO NOT COMPLETE. This information is not required for this provider type.
HOSPITAL FACILITY LICENSE	DO NOT COMPLETE. This information is not required for this provider type.
MARYLAND LABORATORY PERMIT (MDLAB) OR LETTER OF PERMIT EXCEPTION NUMBER*	DO NOT COMPLETE. This information is not required for this provider type.
NATIONAL COUNCIL FOR PRESCRIPTION DRUG PROGRAM (NCPDP)	DO NOT COMPLETE. This information is not required for this provider type.
PHARMACY	DO NOT COMPLETE. This information is not required for this provider type.
RESIDENTIAL SERVICE AGENCY (RSA)	Enter your OHCQ issued license number if applicable.
OTHER	DO NOT COMPLETE. This information is not required for this provider type.
* Medical laboratory providers: Practitioners and other providers that perform medical laboratory services MUST COMPLETE and SUPPLY a copy of their CLIA and MDLAB Permit/Letter of Permit Exception. Out-of-state providers that do not receive specimens originating in Maryland do not have to supply Maryland certification information but do have to state that they do not receive specimens originating in Maryland. Practitioners providing laboratory services to OTHER THAN THEIR OWN PATIENTS MUST enroll as medical laboratory providers.	



Instructions for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION: PT 76 AGENCY

ADDITIONAL INFORMATION	
FACILITY/ORGANIZATION ADDENDUM	DO NOT COMPLETE. This information is not required for this provider type.
LABORATORY INFORMATION	DO NOT COMPLETE. This information is not required for this provider type.
INSTITUTIONAL BED DATA	DO NOT COMPLETE. This information is not required for this provider type.
DIALYSIS FACILITIES	DO NOT COMPLETE. This information is not required for this provider type.
AUTHORIZATION	Please have the administrator or authorized professional representative sign and date the application.
DISCLOSURE OF OWNERSHIP AND CONTROL	Maryland Medicaid is required to obtain disclosures on ownership and control from disclosing entities, fiscal agents, and managed care entities. Please fill out the six (6) sections and sign and date the Disclosure of Ownership and Control addendum. Failure to complete all required sections will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.
PROVIDER AGREEMENT	Failure to complete the provider agreement will result in your enrollment application being returned to you, which may impact the effective date of your enrollment in Maryland Medicaid.

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		



Application for Participation in Maryland Medical Assistance Program FACILITY

<p>IMPORTANT: PLEASE READ ATTACHED INSTRUCTIONS BEFORE COMPLETING APPLICATION</p>	<p>Mail to: The Department of Health and Mental Hygiene Office of Systems and Operations Administration Provider Enrollment P.O. Box 17030 Baltimore, MD 21203</p>
--	--

TYPE OF REQUEST			
Please select one.			
<input type="checkbox"/> NEW ENROLLMENT (Applicant has never enrolled with Maryland Medical Assistance)	<input type="checkbox"/> RE-ENROLLMENT (Provider is currently excluded/terminated from the Maryland Medicaid Program)	<input type="checkbox"/> RE-VALIDATION (Provider is enrolled and required to revalidate)	<input type="checkbox"/> INFORMATION UPDATE (Provider is enrolled and updating information to the provider's file)
Requested Enrollment Begin Date	Application Submitted Date		

FACILITY/ORGANIZATION INFORMATION	
NPI (Organization)	Maryland Medical Assistance Provider Number (If existing provider)
Provider Type (Refer to instructions for appropriate codes.) PT76	Type of Practice (Refer to instructions for appropriate codes.) PT99
Specialty Code (Refer to instructions for appropriate codes.)	County Code (Refer to instructions for appropriate codes.)
Facility/Organization Name	Doing Business As (DBA)
Tax Identification Number	Name of Tax Identification Number Owner
Medicare Provider Number	Medicare Fiscal Year End Date
Telephone Number + extension	E-Mail Address

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



Application for Participation in Maryland Medical Assistance Program FACILITY

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

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

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

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



Application for Participation in Maryland Medical Assistance Program FACILITY

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

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



Application for Participation in Maryland Medical Assistance Program FACILITY

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

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

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



Application for Participation in Maryland Medical Assistance Program FACILITY

DISCLOSURE OF OWNERSHIP AND CONTROL

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

SECTION 1:

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

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

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

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

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

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

C) “Determination of ownership or control percentage”

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

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



Application for Participation in Maryland Medical Assistance Program FACILITY

SECTION 2:

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

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

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

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

SECTION 3:

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

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



Application for Participation in Maryland Medical Assistance Program FACILITY

SECTION 4:

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

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

SECTION 5:

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

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

SECTION 6:

Respond to these questions on behalf of:

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

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

YES NO

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

Name: _____

Name: _____

Name: _____



Application for Participation in Maryland Medical Assistance Program FACILITY

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

YES NO

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

Name: _____

Name: _____

Name: _____

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

YES NO

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

Name: _____

Name: _____

Name: _____

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

YES NO

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

Name: _____

Name: _____

Name: _____



Application for Participation in Maryland Medical Assistance Program FACILITY

SIGNATURE AND AFFIRMATION

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

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

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

Authorized Signature (No Stamps)

Date

Position (Type or Print)

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

³ "Supplier" means an individual, agency, or organization from which a provider purchases goods and services used in carrying out its responsibilities under Medicaid (e.g. a commercial laundry, a manufacturer of hospital bed, or a pharmaceutical firm).

**THIS PAGE INTENTIONALLY LEFT
BLANK**



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, 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.



Provider Agreement for Participation in Maryland Medical Assistance Program

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



Provider Agreement for Participation in Maryland Medical Assistance Program

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



Provider Agreement for Participation in Maryland Medical Assistance Program

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



Provider Agreement for Participation in Maryland Medical Assistance Program

- S. To comply with the Deficit Reduction Act of 2005 (DRA) employee education requirement imposed upon any entity, including any governmental agency, organization, unit, corporation, partnership or other business arrangement (including any Medicaid MCO), whether for profit or not for profit, which receives annual Medicaid Payments of at least \$5,000,000.
- T. For Provider Groups Only: The Provider Group affirms that it has authority to bind all member Providers to this Agreement and that it will provide each member Provider with a copy of this Agreement. The Provider Group also agrees to provide the Department with names and proof of current licensure for each member Provider as well as the name(s) of individual (s) with authority to sign billings on behalf of the group. The Provider Group agrees to be jointly responsible with any member Provider for contractual or administrative sanctions or remedies including, but not limited to reimbursement, withholding, recovery, suspension, termination or exclusion on any claims submitted or payment received. Any false claims, statements or documents, concealment or omission of any material facts may be prosecuted under applicable federal or state laws.
- U. To notify the Department within five (5) working days of any of the following:
1. Any action which may result in the suspension, revocation, condition, limitation, qualification or other material restriction on a Provider's licenses, certifications, permits or staff privileges by any entity under which a Provider is authorized to provide Services including indictment, arrest, felony conviction or any criminal charge;
 2. Change in corporate entity, servicing locations, mailing address or addition to or removal of practitioners or any other information pertinent to the receipt of Department funds; or
 3. Change in ownership including full disclosure of the terms of the sales Agreement. When there is a change in ownership this Agreement is automatically assigned to the new owner, and the new owner shall, as a condition of participation, assume liability, jointly and severally with the prior owner for any and all amounts that may be due, or become due to the Department, and such amounts may be withheld from the payment of claims submitted when determined. (NOTE: Section I.S.3 does not apply to Nursing Home Providers)

II. THE DEPARTMENT AGREES:

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



Provider Agreement for Participation in Maryland Medical Assistance Program

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

III. THE DEPARTMENT AND PROVIDER MUTUALLY AGREE:

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

Provider Signature (No stamps) Date



Department Authorization Date

Provider Name (Type or Print) Date



Assistant Attorney General Date

Provider Address (Type or Print)



STATE OF MARYLAND ACH/DIRECT DEPOSIT AUTHORIZATION FOR VENDOR PAYMENTS

Type of authorization (select one only):

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

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

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

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

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

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

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

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

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

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

ADMINISTRATIVE USE ONLY

GAD Input By: _____
GAD Reviewed By: _____

STO Input By: _____
STO Reviewed By: _____



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

Purpose:

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

Who will use the form?

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

Routing and General Instructions:

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

Submit to:

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

Processing:

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

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



Addendum for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

Should you have any questions regarding completing this addendum, please contact:
Della Brown - Phone: (410)-767-5883 - Email: gondella.brown@maryland.gov

Home and Community-Based Options Waiver, Community First Choice and Medical Assistance Personal Care

I. Check the Service(s) Which you Intend to Provide:

Accessibility Adaptations	Family Training
Assisted Living	Home Delivered Meals
Assistive Technology	Items or Services that Substitute for Human Assistance
Behavioral Health Consultation	Personal Assistance Services (Agency)
Consumer Training	Personal Emergency Response Systems
Dietitian and Nutrition Services	Senior Center Plus
Environmental Assessments	

II. Check the area(s) you intend to serve. You may provide services in multiple jurisdictions.

Allegany	Caroline	Frederick	Montgomery	Talbot
Anne Arundel	Carroll	Garrett	Prince Georges	Washington
Baltimore City	Cecil	Harford	Queen Anne's	Wicomico
Baltimore Co.	Charles	Howard	Somerset	Worcester
Calvert	Dorchester	Kent	St. Mary's	

III. General Conditions for Provider Participation

Provider's initials: **(Initial each line)**

A: To participate as a provider, The Provider Shall:

___ 1. Meet all of the conditions for participation as a Maryland Medical Assistance Program provider as set forth in COMAR 10.09.36, except as otherwise specified in this chapter.

___ 2. Agree to verify the qualification of all individuals who render services on the provider's behalf and provide a copy of the current license or credentials upon request.

___ 3. Agree to implement the reporting and follow-up of incidents and complaints in accordance with the Department's established reportable events policy by reporting incidents and complaints within 24 hours of knowledge of the event by submitting a written report within 7 calendar days on a form designated by the Department and notifying the local department of social services immediately if the provider has a reason to believe that the participant has been subjected to abuse, neglect, self-neglect, or exploitation, in accordance with COMAR 07.02.16

___ 4. Agree to cooperate with required inspections, reviews, and audits by authorized governmental representatives.



Addendum for Participation in Maryland Medical Assistance Program FACILITY/ORGANIZATION

Should you have any questions regarding completing this addendum, please contact:
Della Brown - Phone: (410)-767-5883 - Email: gondella.brown@maryland.gov

- ___5. Agree to provide services, and to subsequently bill the Department in accordance with the reimbursement methodology provided to participants for a period of 6 years, in a manner approved by the Department.
- ___6. Agree to maintain and have available written documentation of services, including dates and hours of services provided to participants for a period of 6 years, in a manner approved by the Department.
- ___7. Agree not to suspend, terminate, increase, or reduce services for an individual without authorization from the Department and with consultation and input from the participant or a participant’s representative when applicable.
- ___8. Agree to submit a transition plan to the case manager or supports planner and participant or participant’s representative when applicable when suspending or terminating services.
- ___9. Agree to demonstrate substantial, sustained compliance with requirements of this chapter for at least 24 months after a cited deficiency which presented serious danger to participants’ health and safety.
- ___10. Agree to verify Medicaid eligibility at the beginning of each month that services will be rendered.
- ___11. Agree to not be a Medicaid provider or principal of a Medicaid provider that has overpayments that remain due to the Department.
- ___12. If the provider renders health-related services, agree to periodically indicate the condition of a participant in accordance with the procedures and forms designated by the Department which shall be shared and discussed at the request of the participant.

B. Agree that within the past 24 months you have not:

- ___ Had a license or certificate suspended or revoked as a health care provider, health care facility or provider of direct care services.
- ___ Been suspended or removed from participating as a Medicaid provider of personal care under COMAR 10.09.20
- ___ Undergone the imposition of sanctions under COMAR 10.09.36.08
- ___ Been subject to disciplinary action, including actions by the licensing board or any provider or principal of any provider agency.
- ___ Been cited by a State agency for deficiencies which affect participants’ health and safety.
- ___ Experienced a termination of a Medicaid provider agreement or been barred from work or participation by a public or private agency due to failure to meet contractual obligations or fraudulent billing practices.

PROVIDER APPLICANT’S SIGNATURE OF AGREEMENT OF GENERAL CONDITIONS FOR PROVIDER PARTICIPATION:

Signature

Date

CFC Division Approval: _____

Date: _____