Addendum Cover Page for Maryland Medical Assistance Program Application FACILITY/ORGANIZATION

PT 03 ACUTE REHAB HOSPITAL

If you have questions, please contact the Provider Enrollment Helpline at **1-844-4MD-PROV (1-844-463-7768)** **Monday – Friday** from **9am – 5pm.**

All providers are required to use the **e**lectronic **P**rovider **R**evalidation and **E**nrollment **P**ortal, or ePREP (eprep.health.maryland.gov) for enrollment, information updates, provider affiliations and revalidations.

Please fill out the information below and upload the completed addendum to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional documents requested within the addendum.

Provider Information

NPI:

Tax ID:

MA Provider Number (required if already enrolled in Maryland Medicaid):

Please visit health.maryland.gov/ePREP for more information about ePREP

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Please upload this form to the "Additional Information" section under "Practice Information" within the ePREP (eprep.health.maryland.gov) "Applications" tab, along with any additional applicable supporting documents requested below.

Section I:

Please upload the following documents to ePREP :

1. A copy of your Commission on Accreditation of Rehabilitation Facilities (CARF) certification
2. A copy of your Joint Commission on Accreditation of Healthcare Organizations (JCAHO) certification or Det Norske Veritas (DNV) National Integrated Accreditation for Healthcare Organizations (NIAHO) certification
3. A copy of your National Council for Prescription Drug Programs (NCPDP) certification, if applicable

Section II:

Please respond to all questions below and upload any applicable documents to ePREP:

1. Will you be rendering x-ray services or other radiology services?

   ☐ YES   ☐ NO

   • If yes, please include a copy of your Radiation Machine Facility Registration and Certification issued by the Maryland Department of Environment or an x-ray certification from the state in which you practice in your upload.

2. Is the facility outside the state of Maryland or the District of Columbia?

   ☐ YES   ☐ NO

   • If yes, please include a copy of your host state's Medicaid reimbursement rates in your upload.