Provider Enrollment General Instructions

Prospective Medicaid Provider:

Thank you for your inquiry concerning participation in the Utah Medicaid program. You may enroll online at https://medicaid.utah.gov/become-medicaid-provider, or you may complete the required forms in their entirety and mail or fax, them along with the fax coversheet to the address below. Online enrollment is encouraged, due to the shorter turn-around time to process an online application, but paper forms are also available.

Address: Medicaid Operations
PO Box 143106
Salt Lake City, Utah 84114-3106

Fax Number: 801-536-0471

The following documents will be required for all provider types:

- Utah Medicaid provider application
- Copy of professional or business license, if applicable
- Proof of Medicare Certification, if applicable
- Copy of IRS Form W-9 with current Taxpayer Identification Number
- Ownership Disclosure information (Section 4 and 5 in the application form), signed and dated
- Utah Medicaid provider agreement, signed and dated
- Direct Deposit Authorization information (Section 7 in the application form), signed and dated, along with a voided check, or letter from the bank, if applicable

If all documentation is complete, you will receive an approval or denial letter. If any documentation is missing, you will receive a letter explaining that your application was discarded, and it will be necessary for you to complete the forms again.

If you have any questions you may contact Provider Enrollment at 801-538-6155 or toll free 1-800-662-9651, menu option 3, then 4.

Thank you,

Utah Medicaid

Filling Instruction by Section

SECTION 1. BASIC INFORMATION

Section 1A. Enrollment Type

Enrollment Type Definition	
Individual	Any provider who is eligible to receive a Type I National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). Providers eligible to receive an NPI are those who deliver medical or health services, as defined under Section 1861(s) of the Social Security Act, 42 U.S.C. 1395x(s). *NOTE: Individual providers associating to a Billing Provider should be enrolled with the Individual Provider's Social Security Number (SSN). Association should be SSN to Billing Provider Federal Employer Identification Number (FEIN). Please use this enrollment type if you intend to enroll as Qualified Medicare Beneficiary (QMB) Only, Ordering/Referring/Prescribing, or Unlicensed/ Exempt/ Student providing services for Mental Health/Substance Use Disorder.
Atypical Individual	Any one provider who is not eligible to receive a National Provider Identifier (NPI) available through the National Plan and Provider Enumeration System (NPPES). Please consult Section 1861(s) of the Social Security Act, 42 U.S.C. 1395x(s) to see if you are eligible for an NPI. Most individuals providing only non-medical Medicaid waiver, attendant care, and personal care services are classified as Atypical Providers and thus do not need an NPI.
Facility/Agency/Organization/Institution	An Inpatient or Outpatient Hospital, Skilled Nursing Facility, Intermediate Care Facility, Clinic (RHC, FQHC, Hospital Based Clinic, Urgent Care), Psychiatric Facility, Mental Institution, Durable Medical Equipment Supplier, Free Standing Ambulatory Surgical Center, Long Term Care Facility, Independent Clinical Laboratory, Free Standing Radiology, Dialysis Center, Pharmacy, Partnership, Corporation, or 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. In addition, you must also be eligible to receive and currently possess, a Type II National Provider Identifier, available through National Plan and Provider Enumeration System (NPPES).
Atypical Facility/Agency/Organization/ Institution	Any entity other than individual who does not deliver medical care or health services and is thus ineligible for a National Provider Identifier (NPI) available through the National Plan and Provider Enumeration System (NPPES). This provider type can include Fiscal Intermediaries, Non-Emergency Transportation, etc.
Group Practice	One or more health care practitioners who practice their profession at a common location and may have multiple locations under one NPI and FEIN (whether or not they share common facilities, common supporting staff, or common equipment) or who have formed a partnership or corporation or are employees of a person, partnership or corporation, or other entity owning or operating the health care facilities at which they practice. These entities have a Type II National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES). NOTE: If you will be enrolling BOTH the Group and the associated providers of the Group, please enroll the Individual Providers first with their SSN. If the provider will only practice with the Group, then the provider should be enrolled as a "Servicing Only" provider. Enroll Group last so you may associate the providers to the Group as this is a mandatory step to complete a Group application. If you have multiple Type II National Provider Identifiers, please enroll separately.
Indian Health Services	Any facility certified by CMS as an IHS or tribal 638 program, to provide services to members of federally recognized tribes who are eligible American Indian or Alaska Native (AI/AN) individuals.

Section 1C. Individual Information

Field Options	
Generational Suffix	II. III. IV. Junior Senior V
Professional Suffix	ACSW ARNP CMHC CTS DDS DMH DO LCSW LMFT LPN M ED MA MD ME DD MHP MS MSN MSW PHD PS PSY D RN

Section 1E. Other Information

Servicing Type Definition	
REG - Regular Billing Provider	An Individual Provider who bills on their own behalf.
SER - Servicing Only	A provider who is either employed or affiliated with the billing provider. Billing Provider will bill on behalf of Servicing Provider.
ORP - Ordering, Referring, and Prescribing Only	This servicing type is for reporting only. Not reimbursable for services rendered.
QMB - QMB Only	QMB Only (Qualified Medicare Beneficiaries) – Non Medicaid Contracted Providers providing services to dual eligible beneficiaries for Medicare and Medicaid.
STU - Students and Other Unlicensed Providers	An unlicensed individual or student exempted from licensure in accordance with State law who provides mental health or substance use disorder services under the supervision of a licensed mental health or substance use disorder professional. Here is the list of Taxonomies you must use to bill Medicaid for these services: • Peer Specialist- 175T00000X • Case Manager/Care Coordinator - 171M00000X • Community Health Worker (Psychosocial Rehabilitative Services-PRS)-172V00000X **Student exempted from licensure in accordance with State law will continue to utilize the Taxonomy received from NPPES.

Servicing Type Options By Enrollment Type	
Individual	Regular Billing Provider Servicing Only Ordering, Referring, and Prescribing Only QMB Only Students and Other Unlicensed Providers
Atypical Individual	Regular Billing Provider Servicing Only
Facility/Agency/Organization/Institution	Regular Billing Provider QMB Only
All Other Enrollment Types	Servicing Type is Not Applicable. Please leave the field blank.

Other Field Options	
W-9 Entity Type	Individual/Sole Proprietor C-Corporation S-Corporation Partnership Trust/estate Limited Liability C-Corporation Limited Liability S-Corporation Limited Liability Partnership Note: Please specify if you have other W-9 Entity Type.
Profit Status	501(c)(3) NON-PROFIT FOR-PROFIT, CLOSELY HELD FOR-PROFIT, PUBLICLY TRADED N/A - Individual Only Practices as Part of a Group OTHER Unknown
Ownership Code	Government - City Government - City-County Government - County Government - Federal Government - Hospital District Government - State N/A - Individual Only Practices as Part of a Group Proprietary - Corporation Proprietary - Individual Proprietary - Other Proprietary - Partnership Voluntary - Non-Profit - Other Voluntary - Non-Profit - Religious Organizations

SECTION 2. BASE LOCATION INFORMATION

Section 2B. Hospital Privileges

Field Options	
Active Privileges	ALTA VIEW HOSPITAL AMERICAN FORK HOSPITAL ASHLEY REGIONAL MED CNTR BEAR LAKE CO MEM HOSP BEAR RIVER VALLEY HOSPITAL BEAVER VALLEY HOSPITAL BLUE MOUNTAIN HOSPITAL BRIGHAM CITY COMM HOSP CACHE VALLEY SPEC HOSP CASTLEVIEW HOSPITAL LLC CENTRAL VALLEY MEDICAL CTR COMMUNITY HOSPITAL DAVIS HOSP MED CNTR PSYCH DAVIS HOSPITAL & MED CNTR DELTA COMMUNITY MED CNTR DIXIE MEDICAL CENTER EVANSTON REGIONAL HOSPITAL FILLMORE HOSPITAL FRANKLIN COUNTY MED CENTER GARFIELD MEMORIAL HOSP GUNNISON VALLEY HOSPITAL HEALTHSOUTH REHAB HOSP HEBER VALLEY MEDICAL CTR IHC RIVERTON HOSPITAL INTERMOUNTAIN MED CNTR REHAB INTERMOUNTAIN MEDICAL CENTER JORDAN VALLEY HOSP LP JORDAN VALLEY MED PSYCH JORDAN VALLEY MED REHAB KANE COUNTY HOSPITAL LAKEVIEW HOSPITAL LANDMARK HOSP SALT LAKE LDS HOSPITAL LDS HOSPITAL-PSYCH LOGAN REGIONAL MED CENTER MCKAY DEE HOSP REHAB UNIT MCKAY DEE HOSPITAL MEMORIAL HOSP SWEETWATER MILFORD VALLEY MEM HOSP MOAB REGIONAL HOSPITAL MONTROSE MEMORIAL HOSP MOUNTAIN VIEW HOSPITAL MOUNTAIN WEST MEDICAL CNTR OGDEN REGIONAL MEDICAL CTR OREM COMMUNITY HOSPITAL ORTHOPEDIC SPECIALTY HOSP PARK CITY MEDICAL CENTER PRIMARY CHILDRENS MED CNTR PRIMARY CHILDRENS REHAB PROMISE HOSP OF SALT LAKE SAINT ELIZABETH REGIONAL SALT LAKE REG MED CNTR SALT LAKE REG MED PSYCH SALT LAKE REG MED REHAB SAN JUAN HOSPITAL SAN JUAN REG REHAB HOSP SAN JUAN REGIONAL MED CTR SANPETE VALLEY HOSPITAL SEVIER VALLEY MEDICAL CNTR SHRINERS HOSP FOR CHILDREN SOUTHWEST HEALTH SYSTEM ST MARKS HOSPITAL ST MARKS HOSPITAL PSYCH ST MARKS REHAB HOSP ST MARYS HOSP & MED CNTR TIMPANOGOS REGIONAL HOSP UINTAH BASIN MEDICAL CNTR UNIVERSITY HOSPITAL PSYCH UNIVERSITY HOSPITAL REHAB UNIVERSITY OF UTAH HOSP UTAH VALLEY HOSP PSYCH UTAH VALLEY REG MED CNTR UTAH VALLEY REHABILITATION UTAH VALLEY SPECIALTY HOSP VALLEY VIEW MEDICAL CTR

Section 2C. Facility Details

Field Options	
Inpatient Unit	None Psych Skilled Nursing (TCC/TCU) Rehabilitation General Acute Care Long Term Acute Care

Section 2D. Pharmacy Details

Field Options	
Pharmacy Type	Retail Retail-Mail Order Retail-Out of State Mail Order Out of State Institutional Pharmacy
Pharmacy Services	All Unit Dose Compounding Specialty TPN DME Cancer General Pharmacy Services

Section 2E. Additional Information for Dental Providers

Field Description	
Services Mobility	Facility Can Provide Services for Children with Mobility Limitations
Sedation	Facility Can Provide Sedation for Children with Complex Medical or Behavioral Conditions
Services Intellectual Disability	Facility Can Provide Services for Children Who May Have Difficulty Communicating or Cooperating Such as Those with Autism, Mental Retardation, or Intellectual Disability
Special Needs	Can Accommodate Special Needs

Section 2G. Specializations

Field Options	
Program	Medicaid Medicaid Autism Waiver Community Supports Waiver Physical Disabilities Waiver New Choices Waiver Aging Waiver Acquired Brain Injury Waiver Tech Dependent Waiver EPAS

Section 2H. License/Certification

Field Options	
License Board/Authority	License/Certification Type
DOPL/Out of State License Board	Professional License
Department of Human Services	State of Utah Department of Human Services License for Mental Health Services Department of Human Service license as an Alcohol & Drug Provider
Business License	Local Business License
Department of Health	DOH License
Medicare	Medicare Certification incl. JCAHO or AOA CLIA Certificate National Supplier Clearinghouse letter FQHC, RHC, CAH Approval from CMS Regional office
Certification	Nurse Practitioner Certification Neonatal Board Certification Pediatric Critical Care Board Certification Approved BC for Sleep Medicine Board Certification The American Diabetes Association course completion Ultrasound Technician or Sonographer Certificate
DMV	Driver's License
DEQ	Department of Environmental Quality Letter
EMS	EMS License

Section 2I. Training/Education

Field Options	
Training/Education Type	Associates Bachelors Doctorate Masters

Section 2J. Identifiers

Field Options		
Identifier Type	NCPDP ID HPID Medicare # DEA Other National Health Plan Identifier Vehicle Policy # Chain Number Parent Organization ID	Payment Center ID OEID Additional NPI Real NPI RX_GROUP RX_BIN RX_PCN RX_ID

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SECTION 3. OTHER SERVICE LOCATIONS

Same as SECTION 2

SECTION 4. OWNERSHIP INFORMATION

Section 4B. Individual Owner Information

Field Options	
Generational Suffix	Same as Section 1C.
Title/Job	Founder Incorporator Member Office Support Staff Owner Shareholder

Section 4E. Owner in Other Program

Field Options	
Plan Type	Medicaid Medicare Part A Medicare Part B Medicare Part C Medicare Part D Other Government

Section 4F. Owner Relationships

Field Options	
Relationship	Child Parent Sibling Spouse Not Related

SECTION 5. MANAGING EMPLOYEE/AGENT INFORMATION

Section 5A. Managing Employee/Agent Information

Field Options	
Generational Suffix	Same as Section 1C.
Title/Job	Administrator Board of directors Board of trustees Chairman Chairperson Chief Business Officer (CBO) Chief Executive Officer (CEO) Chief Financial Officer (CFO) Chief Operating Officer (COO) Director Manager/Agent Officer Other Owner Self Staff Third Party Trustee

Section 5B. Managing Employee/Agent in Other Program

Same as Section 4E.

SECTION 8. HCBS WAIVERS AND EPAS

Field Options	
AAA Locations	Bear River Area Agency on Aging (Box Elder, Cache, Rich) Davis County Health Dept., Family Health and Senior Services Division (Davis) Five-County Area Agency on Aging (Beaver, Garfield, Iron, Kane, Washington) Mountainland Dept. of Aging and Family Services (Summit, Utah, Wasatch) Salt Lake County Aging Services (Salt Lake) San Juan County Area Agency on Aging (San Juan) Six-County Area Agency on Aging (Juab, Millard, Piute, Sanpete, Sevier, Wayne) Southeastern Utah AAA (Carbon, Emery, Grand) Tooele Co. Div. of Aging and Adult Services (Tooele) Uintah Basin Area Agency on Aging (Daggett, Duchesne) Council on Aging – Golden Age Center - (Uintah County PSA) (Uintah County) Weber Area Agency on Aging (Morgan, Weber)
Service Areas	All Counties Beaver County Box Elder County Cache County Carbon County Daggett County Davis County Duchesne County Emery County Garfield County Grand County Iron County Juab County Kane County Millard County Morgan County Piute County Rich County Salt Lake County San Juan County Sanpete County Sevier County Summit County Tooele County Uintah County Utah County Wasatch County Washington County Wayne County Weber County

APPLICATION REASON *(Check one)*

☐ New Enrollment ☐ Modification of Existing Provider Data *(Requires PRISM ID)*

PRISM ID: ___________________________________

Note for Modification Application:

- It is not necessary to complete the entire form. Please update only the data fields that need updating.
- Not all data is allowed to be updated. If you need to change your enrollment type, Federal Tax Identification Number (TIN), or Employer Identification Number (EIN), a new enrollment application is required. The existing provider will be terminated.

SECTION 1: BASIC INFORMATION *(Required)*

A. Enrollment Type * *(Check one)*

☐ Individual
☐ Facility/Agency/Organization/Institution
☐ Group Practice
☐ Atypical Individual
☐ Atypical Facility/Agency/Organization/Institution
☐ Indian Health Services

Note: Enroll Servicing Providers prior to enrolling Group by selecting Individual Enrollment Type.

B. Tax Identifier Type * *(Check one)*

☐ Social Security Number (SSN) ☐ Federal Employer Identification Number (FEIN)

C. Individual Information *(Required only for SSN Tax Identifier Type)*

First Name *	Middle Initial	Last Name *	Social Security Number *

Date of Birth * (MM/DD/YYYY)	Gender *	Generational Suffix (Jr. Sr., etc.)	Professional Suffix (MD., DO., etc.)

D. Organization Information *(Required only for FEIN Tax Identifier Type)*

Organization Name (Legal Business Name) *	FEIN *

Organization Business Name (Doing Business As) *

E. Other Information

NPI * *(Not Required for Atypical Provider)*	Servicing Type * *(See Instruction 3B)*

W-9 Entity Type *	Profit Status*	Ownership Code

Provider Requested Effective Date * (MM/DD/YYYY)	Email Address

Check the applicable ones *

☐ Fee for Service Provider
☐ MCO Network Provider (Required for MCO participation)

SECTION 2: BASE LOCATION INFORMATION *(Required)*

A. Location Details

Location Business Name *	Contact First Name *	Contact Last Name *

Phone Number *	Fax Number *	Cell Phone Number

Email Address	Web Page	Accepting New Patients? * (Yes/No)

Hours/Days of Operation (e.g. Monday – Friday 8AM – 5PM)	Communication Preference (Email, PRISM Notice, Standard Mail)

Provider Language 1 *ENGLISH*	Provider Language 2	Provider Language 3	PHI/Secure Information Contact Details

Minimum Age	Maximum Age	Handicap Accessible? (Yes/No)	TDD? (Yes/No)

*Check the applicable ones **

☐ Fee for Service Provider
☐ MCO Network Provider (Required for MCO participation)

B. Hospital Privileges *(Applicable only for Individual Enrollment Type)*

Active Privileges	Courtesy/Other Privileges

C. Facility Details *(Required only for Inpatient Facility under Facility/Agency/Organization/Institution Enrollment Type)*

Fiscal Year End Date (MM/DD/YYYY)	Accreditation (Yes/No)	Inpatient Unit (See Instruction 2C)
Number of Beds	Number of Medicare Beds	Number of Medicaid Beds
Number of Dually Certified Beds	Number of ICF/ID Beds	Number of Swing Beds

D. Pharmacy Details *(Required only for Pharmacy under Facility/Agency/Organization/Institution Enrollment Type)*

Are you a 340B Provider? (Yes/No)	Will you provide 340B pricing for UT DOH? (Yes/No)	Store Number

Pharmacy Type	Pharmacy Services

E. Additional Information for Dental Providers *(Required only for providers with dental taxonomies)*
(Answer Yes, No or Unknown for each question. See Instruction 2E for description of each question.)

Services Mobility	Sedation	Services Intellectual Disability	Special Needs

SECTION 2: BASE LOCATION INFORMATION *(Required, Continued)*

F1. Physical Address * *(Not required for SER, ORP or STU Servicing Types)*

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

F2. Mailing Address * ☐ Same as Physical Address

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

F3. Pay-To Address * *(Not required for SER, ORP or STU Servicing Types)* ☐ Same as Physical Address

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

F4. OIG Correspondence Address * *(Not required for SER, ORP or STU Servicing Types)*

☐ Same as Physical Address ☐ Same as Mailing Address

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

F5. Finance Correspondence Address * *(Not required for SER, ORP or STU Servicing Types)*

☐ Same as Physical Address ☐ Same as Mailing Address

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

How would you like overpayment recouped? (Check one)

☐ Auto-offset ☐ Send check

SECTION 2: BASE LOCATION INFORMATION *(Required, Continued)*

G. Specializations * *(If you need more space, please attach additional copies of this page.)*

Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)
Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)
Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)
Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)

H. License/Certification *(If you need more space, please attach additional copies of this page.)*

License Board/Authority *	License/Certification Type *	License/Certification # *
Effective Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)	Issued By (State)

License Board/Authority *	License/Certification Type *	License/Certification # *
Effective Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)	Issued By (State)

I. Training/Education *(If you need more space, please attach additional copies of this page.)*

Training/Education Type *	Name of Institution *	
Date Completed * (MM/DD/YYYY)	Unit Type (Credits/Hours)	Unit Value

Training/Education Type *	Name of Institution *	
Date Completed * (MM/DD/YYYY)	Unit Type (Credits/Hours)	Unit Value

J. Identifiers *(If you need more space, please attach additional copies of this page.)*

Identifier Type *	Identifier Value *	Start Date * (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Identifier Type *	Identifier Value *	Start Date * (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Identifier Type *	Identifier Value *	Start Date * (MM/DD/YYYY)	End Date (MM/DD/YYYY)

SECTION 3: OTHER SERVICE LOCATIONS *(Optional. Not applicable for SER, ORP or STU Service Type. Please attach additional copies for each additional location.)*

A. Location Details

Location Business Name *	Contact First Name *	Contact Last Name *

Phone Number *	Fax Number *	Cell Phone Number

Email Address	Web Page	Accepting New Patients? * (Yes/No)

Hours/Days of Operation (e.g. Monday – Friday 8AM – 5PM)	Communication Preference (Email, PRISM Notice, Standard Mail)

Provider Language 1	Provider Language 2	Provider Language 3	PHI/Secure Information Contact Details
ENGLISH			

Minimum Age	Maximum Age	Handicap Accessible? (Yes/No)	TDD? (Yes/No)

Check the applicable ones *

☐ Fee for Service Provider
☐ MCO Network Provider (Required for MCO participation)

B. Hospital Privileges *(Applicable only for Individual Enrollment Type)*

Active Privileges	Courtesy/Other Privileges

C. Facility Details *(Required only for Inpatient Facility under Facility/Agency/Organization/Institution Enrollment Type)*

Fiscal Year End Date (MM/DD/YYYY)	Accreditation (Yes/No)	Inpatient Unit (See Instruction 2C)
Number of Beds	Number of Medicare Beds	Number of Medicaid Beds
Number of Dually Certified Beds	Number of ICF/ID Beds	Number of Swing Beds

D. Pharmacy Details *(Required only for Pharmacy under Facility/Agency/Organization/Institution Enrollment Type)*

Are you a 340B Provider? (Yes/No)	Will you provide 340B pricing for UT DOH? (Yes/No)	Store Number

Pharmacy Type	Pharmacy Services

E. Additional Information for Dental Providers *(Required only for providers with dental taxonomies)*
(Answer Yes, No or Unknown for each question. See Instruction 2E for description of each question.)

Services Mobility	Sedation	Services Intellectual Disability	Special Needs

SECTION 3: OTHER SERVICE LOCATIONS *(Optional, Continued)*

F1. Physical Address * *(Not required for SER, ORP or STU Servicing Types)*

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

F2. Mailing Address * ☐ Same as Physical Address

Address Line 1 *		Address Line 2
Address Line 3		County
City/Town *	State *	Zip Code *

SECTION 3: OTHER SERVICE LOCATIONS *(Optional, Continued)*

G. Specializations * *(If you need more space, please attach additional copies of this page.)*

Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)
Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)
Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)
Program *	Taxonomy Code *	Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)

H. License/Certification *(If you need more space, please attach additional copies of this page.)*

License Board/Authority *	License/Certification Type *	License/Certification # *
Effective Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)	Issued By (State)

License Board/Authority *	License/Certification Type *	License/Certification # *
Effective Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY)	Issued By (State)

I. Training/Education *(If you need more space, please attach additional copies of this page.)*

Training/Education Type *	Name of Institution *	
Date Completed * (MM/DD/YYYY)	Unit Type (Credits/Hours)	Unit Value

Training/Education Type *	Name of Institution *	
Date Completed * (MM/DD/YYYY)	Unit Type (Credits/Hours)	Unit Value

J. Identifiers *(If you need more space, please attach additional copies of this page.)*

Identifier Type *	Identifier Value *	Start Date * (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Identifier Type *	Identifier Value *	Start Date * (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Identifier Type *	Identifier Value *	Start Date * (MM/DD/YYYY)	End Date (MM/DD/YYYY)

SECTION 4: OWNERSHIP INFORMATION *(Required)*

(If there are more than one owners, please attach additional copies of this Section.)

A. Owner Type * *(Check one)*

☐ Individual Ownership ☐ Organization Ownership

B. Individual Owner Information *(Required only for Individual Ownership Type)*

First Name *	Middle Initial	Last Name *	Maiden Name

Social Security Number *	Date of Birth *	Generational Suffix	Title/Job *	U.S. Citizen? * (Yes/No)

C. Organization Owner Information *(Required only for Organization Ownership Type)*

Organization Name *	FEIN *

Doing Business As *

D. Other Owner Information

Ownership Start Date * (MM/DD/YYYY)	Ownership End Date * (MM/DD/YYYY or Open)	Percentage Owned

Phone Number *	Fax Number	Email Address

Address Line 1 *	Address Line 2

Address Line 3	County

City/Town *	State *	Zip Code *

E. Owner in Other Program *(If this owner has ownership or controlling interest in any other entity currently participating in a Federal/State funded healthcare program.)*

Plan Type *	Doing Business As *

Tax ID *	State *	Plan Number *

Plan Type *	Doing Business As *

Tax ID *	State *	Plan Number *

SECTION 4: OWNERSHIP INFORMATION *(Required, Continued)*

F. Owner Relationships

(If this is an Individual owner and is related to another owner or managing employee/agent of this provider. If you need more space, please attach additional copies of this page.)

Other Owner/Managing Employee/Agent Name *	Relationship * (Spouse, Sibling, etc.)	Type * (Owner or Managing Employee/Agent)
Other Owner/Managing Employee/Agent Name *	Relationship * (Spouse, Sibling, etc.)	Type * (Owner or Managing Employee/Agent)
Other Owner/Managing Employee/Agent Name *	Relationship * (Spouse, Sibling, etc.)	Type * (Owner or Managing Employee/Agent)

G. Please answer the below checklist questions

(If you answer "Yes" to any of the questions, please provide explanation in the Remark field.)

1. Have you ever been convicted of a healthcare related felony or any other criminal offense, State or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post-trial motion, a plea of guilty or nolo contendere or participation in a First Offense pardon program?

   ☐ Yes ☐ No

   Remark:

2. Have you ever had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification?

   ☐ Yes ☐ No

   Remark:

3. Have you even been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicaid or other healthcare program(s) in any state or U.S. Territory?

   ☐ Yes ☐ No

   Remark:

4. Are you currently or have you ever been terminated from Medicare?

   ☐ Yes ☐ No

   Remark:

H. Please read below and acknowledge that Ownership Details have been completed accurately.

☐ * I AGREE THAT I HAVE NOT KNOWINGLY OR WILLFULLY MADE FALSE STATEMENTS OR REPRESENTATIONS OF THIS STATEMENT, AND UNDERSTAND I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

_______________________________ _______________________________

Authorized Signature * Printed Name *

SECTION 5: MANAGING EMPLOYEE/AGENT INFORMATION *(Required)*

(If there are more than one managing employee/agent, please attach additional copies of this Section.)

A. Managing Employee/Agent Information

First Name *	Middle Initial	Last Name *	Maiden Name

Social Security Number *	Date of Birth *	Generational Suffix	Title/Job *

Start Date * (MM/DD/YYYY)	End Date * (MM/DD/YYYY or Open)	U.S. Citizen? * (Yes/No)

Management Type* (Agent or Managing Employee)	Phone Number *	Email Address

Address Line 1 *	Address Line 2

Address Line 3	County

City/Town *	State *	Zip Code *

B. Managing Employee/Agent in Other Program

(If this managing employee/agent has ownership or controlling interest in any other entity currently participating in a Federal/State funded healthcare program.)

Plan Type *	Doing Business As *

Tax ID *	State *	Plan Number *

Plan Type *	Doing Business As *

Tax ID *	State *	Plan Number *

Plan Type *	Doing Business As *

Tax ID *	State *	Plan Number *

SECTION 5: MANAGING EMPLOYEE/AGENT INFORMATION *(Required, Continued)*

C. Please answer the below checklist questions

(If you answer "Yes" to any of the questions, please provide explanation in the Remark field.)

1. Have you ever been convicted of a healthcare related felony or any other criminal offense, State or Federal, under this name or any other name in any state or U.S. Territory, regardless of a post-trial motion, a plea of guilty or nolo contendere or participation in a First Offense pardon program?

   ☐ Yes ☐ No

   Remark:

2. Have you ever had any disciplinary action taken against any professional license or certification held in any state or U.S. Territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification?

   ☐ Yes ☐ No

   Remark:

3. Have you even been denied enrollment, suspended, terminated from participation, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicaid or other healthcare program(s) in any state or U.S. Territory, or employed by a corporation, entity/business, or professional association that has ever been denied enrollment, suspended, terminated, excluded, or voluntarily withdrawn to avoid disciplinary action from Medicaid or other healthcare program(s) in any state or U.S. Territory?

   ☐ Yes ☐ No

   Remark:

4. Are you currently or have you ever been terminated from Medicare?

   ☐ Yes ☐ No

   Remark:

D. Please read below and acknowledge that Managing Employee/Agent Details have been completed accurately.

☐ * I AGREE THAT I HAVE NOT KNOWINGLY OR WILLFULLY MADE FALSE STATEMENTS OR REPRESENTATIONS OF THIS STATEMENT, AND UNDERSTAND I MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS. IN ADDITION, KNOWINGLY AND WILLFULLY FAILING TO FULLY AND ACCURATELY DISCLOSE THE INFORMATION REQUESTED MAY RESULT IN DENIAL OF A REQUEST TO PARTICIPATE OR WHERE THE ENTITY ALREADY PARTICIPATES, A TERMINATION OF ITS AGREEMENT OR CONTRACT WITH THE STATE AGENCY OR THE SECRETARY, AS APPROPRIATE.

______________________________________ ______________________________________

Authorized Signature * Printed Name *

SECTION 5: PROVIDER AFFILIATION INFORMATION

A. Servicing Providers *(Applicable only for provider with Group Practice, Facility/Agency/Organization/institution or Atypical Facility/Agency/Organization/Institution Enrollment Type who has Servicing Providers affiliated.)*
(If you need more space, please attach additional copies of this page.)

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

Servicing Provider Name *		SSN/FEIN *	PRISM ID
NPI	Affiliation Start Date * (MM/DD/YYYY)	Affiliation End Date * (MM/DD/YYYY)	

SECTION 5: PROVIDER AFFILIATION INFORMATION *(Continued)*

B. Billing Provider *(Applicable only for servicing provider with Individual or Atypical Individual Enrollment Type who is affiliated to Billing Provider(s) (e.g. A group, clinic, hospital, etc.)*
(If you are affiliated to more than one billing provider, please attach additional copies of this page.)

Billing Provider Name *	PRISM ID/NPI *

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	Title
Address	
Duties	

1. Is your group salaried by the above institution?

   ☐ Yes ☐ No

2. If you are a M.D. or D.O., will you be dispensing pharmaceuticals other than samples (as a pharmacy)?

   ☐ Yes ☐ No

3. If you are an O.D., are you practicing optometry exclusively?

   ☐ Yes ☐ No

4. If you are an O.D., are you practicing optometry as well as preparing and dispensing eyeglasses (as an optician)?

   ☐ Yes ☐ No

5. Is your group operating a Local Health Department Clinic?

   ☐ Yes ☐ No

6. Is your group operating a Freestanding Clinic?

   ☐ Yes ☐ No

SECTION 6: REMITTANCE DETAILS

(Not applicable for SER, ORP or STU Service Type)

A. Electronic Remittance Advice (ERA) Enrollment

<table>
<tr><th colspan="3">Provider Information</th></tr>
<tr><td colspan="3">Provider Name *</td></tr>
<tr><th colspan="3">Provider Identifiers Information</th></tr>
<tr><td>Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *</td><td colspan="2">National Provider Identifier (NPI)</td></tr>
<tr><th colspan="3">Electronic Remittance Advice Information</th></tr>
<tr><td colspan="3">Preference for Aggregation of Remittance Data
☒ National Provider Identifier (NPI)</td></tr>
<tr><td colspan="3">Method of Retrieval
☐ EDI/835 (Delivered Directly to Provider) ☐ Billing Agent/Clearinghouse
Note:
1. PDF version of your RA is retrievable through the provider portal.
2. Selection of 835 HIPAA Transaction is optional.</td></tr>
<tr><th colspan="3">Submission Information</th></tr>
<tr><td>Requested Effective Date</td><td>Reason for Submission
New Enrollment</td><td>Authorized Signature *</td></tr>
</table>

SECTION 7: PROVIDER PAYMENT DETAILS

(Not applicable for SER, ORP or STU Service Type)

A. Payment Method * *(Check one)*

☐ Electronic Funds Transfer (Direct Deposit) ☐ Paper Check

B. Electronic Funds Transfer (EFT) Enrollment *(Required for Electronic Funds Transfer Payment Method)*

<table>
<tr><th colspan="6">Provider Information</th></tr>
<tr><td colspan="6">Provider Name *</td></tr>
<tr><th colspan="6">Provider Identifiers Information</th></tr>
<tr><td colspan="3">Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) *</td><td colspan="3">National Provider Identifier (NPI)</td></tr>
<tr><th colspan="6">Financial Institution Information</th></tr>
<tr><td colspan="4">Financial Institution Name *</td><td colspan="2">Financial Institution Routing Number *</td></tr>
<tr><td colspan="2">Provider's Account Number with Financial Institution *</td><td colspan="2">Type of Account at Financial Institution * (Checking, Savings, etc.)</td><td colspan="2">Payment Notification Preference</td></tr>
<tr><td colspan="4">Preference for Aggregation of Remittance Data

☒ National Provider Identifier (NPI)</td><td colspan="2">Account Number Linkage to Provider Identifier

Same as the National Provider Identifier (NPI) above</td></tr>
<tr><th colspan="6">Submission Information</th></tr>
<tr><td>Requested Effective Date</td><td colspan="2">Reason for Submission

New Enrollment</td><td colspan="3">Authorized Signature *</td></tr>
</table>

SECTION 8: HCBS WAIVERS AND EPAS

A. Medicaid Autism Waiver *(Required if you have chosen Medicaid Autism Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide:

☐ Intensive Individual Support – Consultation Service
☐ Intensive Individual Support – Direct Services
☐ Financial Management Services
☐ Respite Services

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

____________________________________ ____________________________________

Authorized Signature * Printed Name *

B. Community Supports Waiver for Individuals with Intellectual Disabilities & Other Related Conditions *(Required if you have chosen Community Supports Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide:

☐ Behavioral Consultation Services
☐ Chore Services
☐ Companion Services
☐ Day Supports
☐ Environmental Adaptations
☐ Extended Living Supports
☐ Family and Individual Training and Preparation
☐ Financial Management Services
☐ Homemaker Services
☐ Living Start-up Costs
☐ Massage Therapy
☐ Personal Assistance
☐ Personal Budget Assistance
☐ Personal Emergency Response Systems
☐ Personal Medication Monitoring
☐ Residential Habilitation
☐ Respite Care
☐ Specialized Medical Equipment & Supplies
☐ Supported Employment
☐ Supported Living
☐ Transportation
☐ Waiver Support Coordination

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

____________________________________ ____________________________________

Authorized Signature * Printed Name *

SECTION 8: HCBS WAIVERS AND EPAS *(Continued)*

C. Acquired Brain Injury Waiver *(Required if you have chosen Acquired Brain Injury Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide:

☐ ABI Support Coordination
☐ Chore Services
☐ Financial Management Services
☐ Community Living Supports
☐ Community Supported Living
☐ Companion Services
☐ Family Assistance and Support
☐ Habilitation, Day (Structure Day Program)
☐ Homemaker Services
☐ Personal Emergency Response Systems
☐ Respite Care
☐ Specialized Medical Equipment & Supplies
☐ Supported Employment
☐ Transportation

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

______________________________________ ______________________________________

Authorized Signature * Printed Name *

D. Physical Disabilities Waiver *(Required if you have chosen Physical Disabilities Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide:

☐ Attendant Care
☐ Consumer Rep
☐ Financial Management Services
☐ Local Area Support Coordination Liaison
☐ Personal Emergency Response Systems

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

______________________________________ ______________________________________

Authorized Signature * Printed Name *

SECTION 8: HCBS WAIVERS AND EPAS *(Continued)*

E. Waiver for Individuals Age 65 or Older (Aging Waiver) *(Required if you have chosen Aging Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide and specify the AAA location(s) where you propose to provide for each service:

Waiver Service	AAA Location(s)
☐ Adult Companion Services	
☐ Adult Day Health Services	
☐ Chore Services	
☐ Community Transition Services	
☐ Financial Services ☐ Personal Budget Assistance ☐ Financial Management Services	
☐ Home Delivered Supplemental Meals	
☐ Homemaker Services	
☐ Transportation ☐ Non-Medical Transportation Services, One Way Trip ☐ Non-Medical Transportation Services, Stretcher Van, One Way Trip	
☐ Personal Attendant ☐ Personal Attendant Program Training (Consumer Preparation) ☐ Personal Attendant Services-Agency Based ☐ Personal Attendant Services-Participant Employed	
☐ Assistive Technology/Emergency Response Systems/Home Adaptations ☐ Personal Emergency Response System-Installation, Testing, & Removal ☐ Personal Emergency Response System-Response Center Services ☐ Personal Emergency Response System-Purchase, Rental, & Repair ☐ Medication Reminder System ☐ Specialized Medical Equipment/Supplies/Assistive Technology ☐ Environmental Accessibility Adaptations	
☐ Respite ☐ Respite Care - Home Health Aide ☐ Respite Care Services - LTC Facility ☐ Respite Care Services - Unskilled	
☐ Supportive Maintenance - Home Health Aide	
☐ Waiver Case Management	

SECTION 8: HCBS WAIVERS AND EPAS *(Continued)*

E. Waiver for Individuals Age 65 or Older (Aging Waiver) *(Required if you have chosen Aging Waiver Program in Section 2F or 3F) (Continued)*

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

☐ I, the provider, request voluntary reassignment of the billing of Medicaid claims to the local Area Agency on Aging (AAA), and give the AAA permission to use my assigned Medicaid Contract Payment Number. I also acknowledge that by requesting voluntary reassignment of the billing of Medicaid claims to the local AAA, I am authorizing funds to come directly to me and on an annual basis I will receive a form 1099, reportable to the IRS. I understand I am also responsible to submit my Electronic Fund Transfer information to the AAA.

_______________________________________	_______________________________________
Authorized Signature *	Printed Name *

Note:
If you plan to choose Aging Area Agency (AAA) to submit the claims, please contact DOH for the list of AAA Agent ID.

F. Waiver for Technology Dependent, Medically Fragile Individuals (Tech Dependent Waiver) *(Required if you have chosen Tech Dependent Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide:

☐ Extended Private Duty Nursing
☐ Family Directed Support
☐ Family Support Services
☐ Financial Management Services
☐ Home Health Certified Nursing Assistant
☐ In Home Feeding Therapy
☐ Skilled Nursing Respite Care

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

_______________________________________	_______________________________________
Authorized Signature *	Printed Name *

SECTION 8: HCBS WAIVERS AND EPAS *(Continued)*

G. New Choices Waiver *(Required if you have chosen New Choices Waiver Program in Section 2F or 3F)*

Check the Waiver Service(s) which you propose to provide and specify the Service Area(s) where you propose to provide for each service:

Waiver Service	Service Area(s)
☐ Adult Day Care	
☐ Adult Residential Services - Independent Living Facility	
☐ Adult Residential Services - Assisted Living Facility Level I	
☐ Adult Residential Services - Assisted Living Facility Level II	
☐ Adult Residential Services - Certified Residential Care Facility/Secure Alzheimer Unit	
☐ Adult Residential Services - Licensed Community Residential Care Facility	
☐ Assistive Technology	
☐ Attendant Care	
☐ Caregiver Training	
☐ Case Management	
☐ Chore Services	
☐ Consumer Preparation Services	
☐ Community Transition Services	
☐ Environmental Accessibility Adaptations ☐ Home Modifications ☐ Vehicle Modifications	
☐ Financial Management Services	
☐ Habilitation Services	

SECTION 8: HCBS WAIVERS AND EPAS *(Continued)*

G. New Choices Waiver *(Required if you have chosen New Choices Waiver Program in Section 2F or 3F) (Continued)*

Check the Waiver Service(s) which you propose to provide and specify the Service Area(s) where you propose to provide for each service:

Waiver Service *(Continued)*	**Service Area(s)**
☐ Home Delivered Meals	
☐ Homemaker Services	
☐ Medication Administration Assistance Services ☐ Medication Set-up and Administration ☐ Medication Reminder System	
☐ Non-Medical Transportation ☐ Non-Medical Transportation, Per Mile ☐ Non-Medical Transportation, One-way Trip ☐ Non-Medical Transportation, Public Transit Pass	
☐ Personal Budget Assistance	
☐ Personal Emergency Response System (PERS)	
☐ Respite Care ☐ Routine Hourly Respite Care ☐ Daily Respite Care, in the Home ☐ Daily Respite Care, Out of the Home, Room and Board Included	
☐ Specialized Medical Equipment and Supplies ☐ Durable Medical Equipment ☐ Non-Durable Medical Supplies	
☐ Supportive Maintenance	

☐ * I understand and agree that I am requesting enrollment as a Provider of Medicaid 1915(c) HCBS waiver for the services selected in this section and will remain continuously certified/licensed throughout the period of the agreement.

______________________________ ______________________________

Authorized Signature * Printed Name *

SECTION 8: HCBS WAIVERS AND EPAS *(Continued)*

H. Employment-Related Personal Assistance Services (EPAS) *(Required if you have chosen EPAS Program in Section 2F or 3F)*

Check the Service(s) which you propose to provide and specify the Service Area(s) where you propose to provide for the selected service(s):

☐ Service Coordination
☐ Personal Care
☐ Financial Management Services

Service Area(s)

☐ * I understand and agree that I am requesting enrollment as a Provider of Employment-related Personal Assistant Services selected in this section.

______________________	______________________
Authorized Signature *	Printed Name *

SECTION 9: ENROLLMENT CHECKLIST AND SUBMISSION

A. Please answer all the checklist questions below. *

(If you answer "Yes" to any of the questions, please provide explanation in the Remark field.)

1. Have you or any employee ever had an Assessment taken against you? ☐ Yes ☐ No

   Remark:

2. Have you or any employee ever had an Administrative Sanction taken against you? ☐ Yes ☐ No

   Remark:

3. Have you or any employee ever had a Suspension of Payment taken against you? ☐ Yes ☐ No

   Remark:

4. Have you or any employee ever had a Restitution Order taken against you? ☐ Yes ☐ No

   Remark:

5. Have you or any employee ever had a Program Exclusion taken against you? ☐ Yes ☐ No

   Remark:

6. Have you or any employee ever had a Program Debarment taken against you? ☐ Yes ☐ No

   Remark:

7. Have you or any employee ever had a Pending Criminal Judgment taken against you? ☐ Yes ☐ No

   Remark:

8. Have you or any employee ever had a Pending Civil Judgment taken against you? ☐ Yes ☐ No

   Remark:

9. Have you or any employee ever had a Judgment Pending Under False Claims Act taken against you? ☐ Yes ☐ No

   Remark:

10. Have you or any employee ever had a Criminal Fine taken against you? ☐Yes ☐No

    Remark:

11. Have you or any employee ever had a Civil Monetary Penalty taken against you? ☐ Yes ☐ No

    Remark:

12. Has applicant or employees ever been placed on the MED, LEIE, or similar database? ☐ Yes ☐ No

    Remark:

13. Has applicant or employees ever been charged with or convicted of any theft or fraud type crime(s)? ☐ Yes ☐ No

    Remark:

SECTION 9: ENROLLMENT CHECKLIST AND SUBMISSION *(Continued)*

A. Please answer all the checklist questions below. * *(Continued)*

(If you answer "Yes" to any of the questions, please provide explanation in the Remark field.)

14. Has any State or Federal health care program ever taken any type of administrative action against applicant or employees? ☐ Yes ☐ No

    Remark:

15. Has Applicant, or employees, ever been charged with or convicted of any health related crimes? ☐ Yes ☐ No

    Remark:

16. Has Applicant, or employees, ever been charged with or convicted of a crime involving the abuse of a child or an elderly/vulnerable adult? ☐ Yes ☐ No

    Remark:

17. Have you paid an Enrollment Fee to Medicare in the past 3 years? ☐ Yes ☐ No

    Remark:

18. Have you paid an Enrollment Fee to Medicare in the past 5 years? ☐ Yes ☐ No

    Remark:

19. If you have not paid Medicare or Medicaid (out of state or in state) Enrollment Fee, have you obtained a Hardship Waiver? ☐ Yes ☐ No

    Remark:

B. Enrollment Submission Signature

Please review all information entered into the application form to ensure accuracy of the information.

☐ * BY CHECKING THIS BOX, I CERTIFY THAT THE FOREGOING INFORMATION IS TRUE AND COMPLETE.

Knowingly and willfully providing false information may result in prosecution under applicable federal or state laws.

____ ________________________________

Authorized Signature * Date * Printed Name *