

TO: ALL PROSPECTIVE MEDICAID PROVIDERS

Thank you for your inquiry concerning participation in the Utah Medicaid Program. This package outlines procedures for enrolling as a Utah Medicaid provider.

Providers who wish to enroll as Utah Medicaid providers must fill out each required document in its entirety and mail or fax to the address below. You will be notified of the results of your application.

- X Utah Medicaid provider application (please retain a copy for your records)
- X Copy of professional or business license (see page 2)
- X Proof of Medicare Certification (see page 2) and one of the following to show current participation:
 - Current letter of accreditation (JCAHO or AOA)
 - Letter from HHS, CMS, or Medicare intermediary showing current enrollment
 - National Supplier Clearinghouse letter with current service address
- X Copy of IRS Form W-9 with current Taxpayer Identification Number (see page 2, Box 8)
- X Ownership Disclosure information
- X Utah Medicaid provider agreement, signed and dated
- X Direct Deposit Authorization Form for EFT

Click here to access the online [Utah Medicaid Provider Manuals](#). The manuals contain information on general policy, limitations of coverage, and reimbursement policy for your specific type of service. The Provider Manuals also include instructions for completing claim forms, an example and explanation of the remittance statement, and a description of Medicaid's automated payment system.

Thank you for your interest in the Utah Medicaid program.

Sincerely,

PROVIDER ENROLLMENT
Bureau of Medicaid Operations

LICENSE REQUIREMENTS

| If license is for: | License required is: |
|--|--|
| Individual (Professional) | State Professional License (for physical location of service) |
| Pharmacy | State Retail Pharmacy License (if mail order, requires Utah license, also) |
| Laboratory | CLIA Certification - Registration, Waiver, PPMP, or Accreditation |
| Medical Supplier Optical Supplier | Local Business License as a Medical Supplier & National Supplier Clearinghouse ltr Local Business License as an Optical Supplier |
| Alcohol & Drug Center Mental Health Center Day Treatment Center Residential Treatment Facility Support Coordination Agency | License from Utah Department of Human Services Contact Division of Services for People with Disabilities |
| Ambulance Air Ambulance | State Ambulance Services Operation License State Ambulance Services Operation License and FAA Certification |
| Home Health Agency | License from Utah Department of Health (for personal care services only), Approval from CMS for Medicare Participation (full services) |
| General Hospital Mental Hospital (Utah only) Nursing Home General Chronic Disease Hospital Instit Mental Disease (Utah only) State Training School (Utah only) Rural Health Clinic | Certification & Transmittal from Medicare/Medicaid Program Certification & Resident Assessment or proof of Medicare Certification and most recent letter of Accreditation Same as General Hospital plus approval from Medicare/Medicaid Program Certification & Resident Assessment Certification & Transmittal from Medicare/Medicaid Program Certification & Resident Assessment Certification & Transmittal from Medicare/Medicaid Program Certification & Resident Assessment or proof of Medicare certification and most recent letter of Accreditation Certification & Transmittal and approval from Medicare/Medicaid Program Certification & Resident Assessment RHC approval letter from CMS Regional Office |

INSTRUCTIONS FOR COMPLETING THE MEDICAID PROVIDER APPLICATION

Please **do not** enter information into the right area. These fields are for State Office use only. **Please keep Medicaid informed of any address changes. Returned mail could result in your provider contract being closed.**

Box 1. Name. Enter your first name, middle initial, last name and title (i.e., John J. Jones, M.D.) if you are an individual provider. Otherwise, enter your group name as you wish it to appear on your check.

Box 2. Area – Telephone. Enter the area code and telephone number we may use for billing inquiries.

Pay-To Address – These fields identify where your Medicaid Reimbursement and Remittance Statements will be mailed (Boxes 3-8).

Box 3. Suite. Enter the suite number of your “Pay-To” office.

Box 4. Fax Number. Enter your fax number.

Box 5. Street or PO Box Number. Enter the address you want Checks and Remittance Statements mailed.

Box 6. City/State. Enter your Pay-To City and State.

Box 7. 9-Digit Zip Code. Enter your nine-digit zip code.

Box 8. W-9 Name (DBA Name). Enter the name that appears on your IRS W-9 Form. Attach a copy of your IRS W-9 form to the application. This form may be obtained from your local library, US Post Office, by calling the IRS “Need a Tax Form” number at 800 829-3676 or by visiting their Internet web site at www.irs.gov/forms_pubs/formpub.html.

Physical Location. – If your Physical Office Location is different than your “Pay-To” Address (Boxes 9-12). If this information is the same as “Pay-To” skip to next section.

Box 9. Street. Enter the “Physical” location of your office. Include your suite number (no P.O. Boxes).

Box 10. City/State. Enter your City and State.

Box 11. 9-Digit Zip Code. Enter your nine-digit zip code.

Box 12. County. Enter the county which your physical site is located within.

Mailing Address (Formerly MIB Address – the State no longer sends out paper MIBs). To access our online MIBs go to <http://health.utah.gov/medicaid/manuals/directory.php>. or send an e-mail to medicaidops@utah.gov to subscribe to an e-mail list server and receive notices of program changes, announcements of MIBs, and other information. Unsubscribe at any time.

Box 13. Enter your e-mail address.

Box 14. Attention. If you want MIBs sent to a person’s particular attention, enter that information here.

Box 15. Street. Enter the mailing address.

Box 16. Suite. Enter the suite number.

Box 17. City/State. Enter the mailing City and State.

Box 18. 9-Digit Zip Code. Enter your nine-digit zip code.

Provider Information – Enter only when applicable (Boxes 19-37).

Box 19. License Number. (Applicable to Professionals and Corporations licensed by the Utah Department of Commerce). Enter your professional license number and attach a copy of your Professional/Business license. Refer to table of Licensure Requirements for proper credential information (page 2).

Box 20. EDI Trading Partner Number. (Applicable to providers sending electronic claims). For inquiries contract UHIN 801 466-7705). Enter your EDI Trading Partner Number.

Box 21. DEA Number. (Applicable to pharmacies and providers with prescriptive practices) – Enter your DEA License Number.

Box 22. CLIA Number. (Applicable to those who bill for lab procedures.) Enter your 10-digit CLIA Certificate number.

Box 23. UPIN Number. Enter your UPIN number for referral purposes. Obtain a UPIN number from Medicare. Medicare Number. Enter your Medicare number.

Box 24. National Provider Identifier (NPI). Enter your 10 digit NPI number.

Boxes 25-26.

Social Security Number. All individuals enrolling must supply their personal social security number, Medicaid payments will be reported as income to the individual's Employer Identification Number (EIN) if shown in Box 26. A social security number is not required for corporate entities, namely, Medical Suppliers, Pharmacies, Home Health Agencies, Ambulances, etc.

Individuals who are employees of, or contract with, a corporate provider must give **both** their social security number **and** their employer's Employer Identification Number (EIN).

Employer Identification Number. To assure proper IRS 1099 reporting, all corporate providers must supply their Employer Identification Number (EIN).

Note: The number selected for IRS reporting must coordinate with the name being used in Box 8 (Tax Name or DBA Name) or Box 1 (Name).

- Box 27. Group Practice NPI (Applicable to Groups already established by Utah Medicaid). If you are an established group practice with Utah Medicaid, enter your group NPI in this field. If you are requesting a group practice, or affiliation to a non-established group practice, this field should remain blank.
- Box 28. Name of Group Affiliation. (Applicable to all individuals requesting affiliation to a new or previously established Group Practice). Enter the name of the Group or Clinic which you wish to be affiliated to. Also, see page 5 for instructions on establishing a Group Practice.
- Box 29. Provider Type. (Applicable to All) - Specify the one Provider Type you are applying for (see following list of Provider Types recognized by Utah Medicaid).

| | | |
|--|---|---|
| Adult Day Care | Hospital, General | Physician |
| Agency | Hospital, Mental | Podiatrist |
| Alcohol and Drug Center | ICF/MR Day Treatment | Psychologist |
| Ambulance | Independent Lab and/or X-Ray | PT/OT Rehabilitation Center |
| Ambulatory Surg Cntr, Free Standing | Licensed Child Placement Agency | Public Health Department |
| Audiologist | Licensed Day Treatment Facility | QMB (Crossover Only)* |
| Birthing Center, Free Standing | Licensed Home Health Services | Registered Nurse ⁺ |
| Certified Nurse Midwife | Licensed Practical Nurse ⁺ | Rural Health Clinic (RHC) |
| Certified Social Worker ⁺ | Licensed Res Treatment Facility | Social Service Worker (SSW) ⁺ |
| Clinical Social Worker (LCSW)* ⁺ | Licensed Residential & Day Treatment Facility | Speech Pathologist |
| Dentist | Marriage/Family Therapist ⁺ | |
| Diabetes Self Management Educator | Medical Supplier (Includes DME & non-DME) | Key to Abbreviations |
| Dialysis Center | Mental Health Center | |
| Dietician ⁺ | Non-Medical Transportation | * May only bill for Medicare Crossover |
| Emergency Response System | Nurse Anesthetist | |
| Federally Qualified Health Center (FQHC) | Nurse Practitioner [⊙] | + <i>Baby-Your-Baby Services</i> |
| Fixed Wing Aircraft | Nursing Home, General | |
| Group Practice | Occupational Therapist | ⊙ Requires American Academy of Nurse Practitioners (AANP) Certification as a Family Nurse Practitioner, or American Nurses Credentialing Center (ANCC) Certification as a Family or Pediatric Nurse Practitioner. |
| Health Educator (Childbirth Educator) ⁺ | Optical Supplier | |
| Helicopter | Optometrist | |
| HMO | Oral Surgeon | |
| Home Delivered Meals | Osteopath | |
| Home Health Agency | Personal Waiver service Agent | |
| Hospice | Pharmacy | |
| Hospital, Chronic Disease | Physical Therapist | |

Box 30. Begin Date. Specify the Date you wish to have your Medicaid Provider number activated. You may request a Retro-Active date, however, it must be within the scope of your Professional/Business Licensure dates.

Box 31. Categories of Service. (Applicable to All) – Specify the Categories of Service you are applying for (see following list of Categories of Service recognized by Utah Medicaid).

| | | |
|----------------------------------|---|----------------------------------|
| Ambulatory Surgical Center Svcs | Lab and Radiology | Rural Health Services |
| Aging Waiver Services | Medical Supplies | Speech and Hearing |
| Alcohol & Drug Treatment Svcs | Medical Transportation | SNF1 |
| Case Management/Lock In Fee | Nursing Anesthetist - Midwife | SNF2 |
| Clinic Services, Mental | Nutritional Assessment/Counseling + | Targeted Case Management |
| Contract Physician | Occupational Therapy | Vision Care |
| Dental Services | Optical Supplies | Well Child Care (CHEC/EPSTDT) |
| DSS Prepaid Health Plan | Osteopathic Services | |
| Group Pre/Postnatal Education + | Pediatric/Family Nurse Practitioner | + <i>Baby-Your-Baby Services</i> |
| Health Maintenance Org. Services | Perinatal Care Coordination + | |
| Home and Community Based Svcs | Personal Care Services | |
| Home Health Service | Pharmacy | |
| ICF1 | Physical Therapy | |
| ICF2 | Physician Services | |
| ICF/MR1 | Podiatrist Services | |
| ICF/MR2 | Pre/Postnatal Home Visits + | |
| ICF/MR3 | Pre/Postnatal Psychosocial Counseling + | |
| Day Treatment Services | Private Duty Nursing | |
| Kidney Dialysis | Psychologist Services | |
| Hospital, Inpatient General | QMB Only (Crossover Services) | |
| Hospital, Outpatient General | | |

Boxes 32-33. American Board of Medical Specialty Certificate. (Applicable to Physicians and Osteopaths only) – If you are a Physician or Osteopath, enter your American Board of Medical Specialties (see page 6 for specialty list).

Box 34. Taxonomy Code – Enter your taxonomy code that corresponds with your provider type and speciality. Taxonomy codes can be found at www.wpc-edi.com.

Remittance Statement Control Information. These fields control the format of your Remittance Statements.

Box 35. Remit Type (Suspended Claims Information). Check one box.

Once* = Print Suspended Claims Only Once (When claims suspend in the Medicaid system, a Remittance Statement will be sent to you one time notifying you of the suspended claim).

All = Print All Suspended Claims (When claims suspend in the Medicaid system, a Remittance Statement will be sent to you weekly, until the claims are properly adjudicated).

None = Do not print Suspended Claims (You will not receive a Remittance Statement for Suspended Claims).

Box 36. Remit Print Sequence. Check one box.

This indicator controls the order in which your Remittance Statements will print (e.g., If you select Recipient ID, all of your claims will begin with the Recipient ID, then the claim information).

Recipient Name*

Recipient ID

Provider Number

Medical Record Number

Invoice (Pharmacies Only).

Box 37. Reserved for future use.

Box 38. Reserved for future use.

Box 39. Name, Date, Title, and Phone number of the person completing the application. This field is for reference and contact purposes.

Completing the Utah Medicaid Provider Agreement.

Enter the name and address of the provider on Page 1, sign and date Page 8 of the Agreement.

Who must sign the Provider Agreement?

Professional providers. (i.e., physicians, osteopaths, physical therapists, etc.) – The agreement must be signed by the Licensed Professional.

Corporations / Institutions. (i.e., home health agencies, pharmacies, ambulances, etc.) – The agreement must be signed by a corporate manager, officer, administrator, business owner, etc.

Group Practices and FQHCs. – A separate agreement must be signed by the person in charge of the group or FQHC (i.e., corporate officer, sponsoring physician, an affiliate, etc.). Each affiliate **will** need to sign their own agreement as part of their individual application which affiliates them to the group or FQHC.

Establishing a Group Practice.

Enrollment of a group practice requires the following:

1. Application and agreement for the group practice.
2. Application(s), agreement(s) and professional license(s) for each individual with the group (Note: A minimum of one (1) affiliate is required for the establishment of a group practice).

Out-of-State Provider Numbers.

Out of state provider numbers are only eligible for reimbursement until the expiration date of the most current license we have on file. In order to stay current, you **MUST** send us a copy of your license each time it is renewed.

| GENERAL SPECIALTY CERTIFICATES | | SUB-SPECIALTY CERTIFICATES | |
|--------------------------------|--|-----------------------------|----------------------------------|
| ALLERGY & IMMUNOLOGY | | | DIAGNOSTIC LABORATORY IMMUNOLOGY |
| ANESTHESIOLOGY | | | CRITICAL CARE MEDICINE |
| | | | PAIN MANAGEMENT |
| COLON & RECTAL SURGERY | | | |
| DERMATOLOGY | | | DERMATOPATHOLOGY |
| | | | DERM IMMUN/DIAG LAB IMMUN |
| EMERGENCY MEDICINE | | | PEDIATRIC EMERGENCY MEDICINE |
| FAMILY PRACTICE | | | GERIATRIC MEDICINE |
| | | | SPORTS MEDICINE |
| INTERNAL MEDICINE | | | CARDIAC ELECTROPHYSIOLOGY |
| | | | CARDIOVASCULAR DISEASE |
| | | | CRITICAL CARE MEDICINE |
| | | | DIAGNOSTIC LABORATORY IMMUNOLOGY |
| | | | ENDOCRINOLOGY & METABOLISM |
| | | | GASTROENTEROLOGY |
| | | | GERIATRIC MEDICINE |
| | | | HEMATOLOGY |
| | | | INFECTIOUS DISEASE |
| | | | MEDICAL ONCOLOGY |
| | | | NEPHROLOGY |
| | | | PULMONARY DISEASE |
| | | | RHEUMATOLOGY |
| NEUROLOGICAL SURGERY | | | CRITICAL CARE MEDICINE |
| NUCLEAR MEDICINE | | | NUCLEAR RADIOLOGY (W/ABR) |
| | | | RADIOISOTOPIC PATHOLOGY (W/ABPA) |
| OBSTETRICS & GYNECOLOGY | | | CRITICAL CARE MEDICINE |
| | | | GYNECOLOGIC ONCOLOGY |
| | | | MATERNAL & FETAL MEDICINE |
| | | | REPRODUCTIVE ENDOCRINOLOGY |
| OPHTHALMOLOGY | | | |
| ORTHOPAEDIC SURGERY | | | HAND SURGERY |
| OTOLARYNGOLOGY | | | |
| ANATOMIC & CLINICAL PATHOLOGY | | | BLOOD BANKING |
| ANATOMIC PATHOLOGY | | | CHEMICAL PATHOLOGY |
| CLINICAL PATHOLOGY | | | CYTOPATHOLOGY |
| | | | DERMATOPATHOLOGY |
| | | | FORENSIC PATHOLOGY |
| | | | HEMATOLOGY |
| | | | IMMUNOPATHOLOGY |
| | | | MEDICAL MICROBIOLOGY |
| | | | NEUROPATHOLOGY |
| | | | PEDIATRIC PATHOLOGY |
| | | RADIOISOTOPIC PATHOLOGY | |
| PEDIATRICS | | | ADOLESCENT MEDICINE |
| | | | PEDIATRIC CARDIOLOGY |
| | | | PEDIATRIC CRITICAL CARE MEDICINE |
| | | | DIAGNOSTIC LABORATORY IMMUNOLOGY |
| | | | PEDIATRIC GASTROENTEROLOGY |
| | | | PEDIATRIC INFECTIOUS DISEASE |
| | | | PEDIATRIC ENDOCRINOLOGY |
| | | | PEDIATRIC HEMATOLOGY-ONCOLOGY |
| | | | PEDIATRIC NEPHROLOGY |
| | | | PEDIATRIC EMERGENCY MEDICINE |
| | | | PEDIATRIC PULMONOLOGY |
| | | NEONATAL-PERINATAL MEDICINE | |

| | | |
|--|---|---------------------------------|
| | | RHEUMATOLOGY |
| | PHYSICAL MEDICINE & REHABILITATION | |
| | PLASTIC SURGERY | HAND SURGERY |
| | AEROSPACE MEDICINE | UNDERSEAS MEDICINE |
| | OCCUPATIONAL MEDICINE | |
| | PUBLIC HEALTH & GENERAL PREVENTATIVE MEDICINE | |
| | PSYCHIATRY | CHILD AND ADOLESCENT PSYCHIATRY |
| | NEUROLOGY | GERIATRIC PSYCHIATRY |
| | NEUROLOGY W/SPECIAL QUALIFICATIONS IN CHILD NEUROLOGY | NEUROPHYSIOLOGY |
| | RADIOLOGY | NUCLEAR RADIOLOGY |
| | DIAGNOSTIC RADIOLOGY | |
| | RADIOLOGY ONCOLOGY | |
| | THERAPEUTIC RADIOLOGY | |
| | RADIOLOGICAL PHYSICS | |
| | SURGERY | GENERAL VASCULAR SURGERY |
| | | HAND SURGERY |
| | | PEDIATRIC SURGERY |
| | | SURGICAL CRITICAL CARE |
| | THORACIC SURGERY | |
| | UROLOGY | |