

INTRODUCTION

Thank you for your interest in being a Vermont Healthcare Programs provider. As a state and federal Assisted Healthcare Programs provider, you must be enrolled and certified. If you are required to be licensed in your state, you must attach a copy of your license. If your state does not require a license or certification for the service you provide, certification will be verified through the HP Enterprise Services office.

Enclosed is your Provider Agreement. Please complete ALL of the data sheets in Attachment B. These sheets must be completed and the agreement (page 3) must be signed and dated in order for your agreement to be in effect.

Section 8 of Attachment B addresses controlling interests. Completing this information correctly is a Medicaid Program Integrity requirement and must be provided before you may be enrolled as a provider. If a group practice or a corporation employs you or a facility owns your practice, you must list the name of that entity in section 8. If you have any questions, please contact the HP Enterprise Services Provider Enrollment Unit at (802) 878-7871 or 1-800-925-1706 (toll free if you are calling in Vermont).

ALL PROVIDERS - ATTACH A COPY OF YOUR LICENSE

NEW PROVIDERS please also attach a copy of your NPI letter, mail application and required documentation to:

HP ENTERPRISE SERVICES
ENROLLMENT/RECERTIFICATION
P.O. BOX 888
WILLISTON, VT 05495-0888

HP USE ONLY
Date received _____

PROVIDER IDENTIFICATION RECORD

SECTION 1 - PROVIDER DATA

Name: _____
(Individual - Last name, first name, middle initial title - e.g. Smith, John F. M.D. or group or institution)

UPIN Number: _____ License/Cert #: _____ Exp. Date: _____

Medicare Number: _____ CTP A Cert #: _____ Exp. Date: _____

NABP Number: _____ CLIA Number: _____ Exp. Date: _____

VT Medicaid Number: _____ DEA Number: _____ Fiscal Year End Month: _____

NPI Number: _____ FEIN #: _____
(Attach copy of the official NPI letter) (FEIN for groups/Institutions/"cwcej "eqr { "qh"Y /;)

Taxonomy Codes: _____

Other Cert #: _____
Please provide other certification numbers that gives us authority to pay claims.

SSN: _____ Date of Birth: _____ Gender of Provider (M/F): _____
(SSN for Individuals)

SECTION 2 - CONTACT INFORMATION

CONTACT PERSON REGARDING THIS FORM: _____

PHONE: _____ FAX: _____ E-MAIL: _____

SECTION 3 - PROVIDER ADDRESS INFORMATION-ALL FIELDS ARE MANDATORY

PAY TO (For Remittance Advise)

Name: _____

Address: _____

City: _____

State, Zip Code: _____

Phone: _____

Fax: _____

Email Address: _____

SECTION 3 - PROVIDER ADDRESS INFORMATION (Continued)

This section designates your primary service location. Do not provider a P.O. Box address.
Reprint this page as needed for additional addresses.

Name: _____ **Provider Number:** _____
Address: _____ **Fax Number:** _____
_____ **Office Website:** _____
City: _____ **Email Address:** _____
State, Zip: _____ **Phone Number:** _____

Handicap Accessibility of this service location:

- None
- Partial: At least one building, office and examining room are accessible
- Alternate Methods of Access: The provider’s office is not accessible, but he or she will see you at an alternate site that is accessible
- Totally Accessible

Languages Accommodated at this office:

English; list other(s) (e.g. Bosnian, French, Sign, etc): _____

Patient Age Limits: (Range of patients that you will see-*not the range of your current patients*)

- All ages
- Newborn
- Age Range: ___ youngest ___ oldest

Established patients only? Yes No

(If not accepting new patients check YES, if accepting new patients check NO.)

Are you a Ladies First Provider? Yes No

“Ladies First is a Federally funded breast , cervical & CVD screening program.”

By checking the above yes box, the Ladies First Provider will agree to abide with the following provisions:

- Fees for the Ladies First program are based on the Medicare Part B reimbursement schedule. The provider agrees to accept payment of allowable costs as payment in full and will not bill the patient. However, the provider agrees to show the usual and customary charges on the bill so the difference, if any, can be computed as match for the Ladies First program.
- Provider agrees to comply with the instructions and restrictions regarding billing, third party payment and applicable reporting requirements for the Ladies First Program. The Ladies First Manual and Supplements are available on the web at <http://www.ladiesfirstproviders.vermont.gov/>. The Manual and Supplements are incorporated by reference herein.

Are you a Children w/Special Health Needs (CSHN) Provider? Yes No

Are you a Family Infant Toddler Program (FITP) Provider? Yes No

(Complete if different from above service location information)

Fax Number: _____ **Office Website:** _____

Email Address: _____

SECTION 3 - PROVIDER ADDRESS INFORMATION (Continued)

LEGAL ADDRESS (This is the name & address that will appear on your 1099)	MAIL TO ADDRESS (For correspondence & newsletters)
NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____	NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____
PRIOR AUTHORIZATION ADDRESS (If your service location has no mail receptacle)	BILLING SERVICE
NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____	NAME: _____ ADDRESS: _____ _____ CITY: _____ STATE, ZIP: _____ PHONE: _____ FAX: _____ EMAIL: _____

SECTION 4 - MEDICAL OR CLINICAL SPECIALTIES

SPECIALTY	EFFECTIVE DATE	BOARD CERTIFIED	DATE OF CERTIFICATION
		YES _____ NO _____	
		YES _____ NO _____	
**All applicants who are physicians, nurse practitioners, dentists, doctoral - level psychologists & social workers or individual DME providers (prosthetics) must complete this section if applicable.			

SECTION 5 - APPLICANT'S TYPE OF SERVICES PROVIDED AND TYPE OF BUSINESS

1. List the types of healthcare services you/your agency will provide (such as emergency transportation, psychiatric counseling, physician, pharmacy, personal care, dental, home health, respiratory care services, etc.).

2. Applicant's type of business:

- Individual
- Corporation Non-Profit
- Corporation for Profit
- Partnership
- Sole Proprietor
- Other, specify _____

SECTION 6 - SUSPENSION AND DEBARMENT

Non-federal entities are prohibited by Federal Executive Order from contracting with or making sub-awards under covered transactions to parties that are suspended or debarred or whose principals are suspended or debarred. Covered transactions include procurement contracts for goods or services equal to or in excess of \$100,000 and all non-procurement transactions (sub-awards to sub-recipients). By signing this contract, current Contractor certifies as applicable, that the contracting organization and its principals are not suspended or debarred by the General Services Administration from federal procurement and non-procurement programs. Providers may not knowingly have a relationship with the following:

- a) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No.12549 or under guidelines implementing Executive Order No. 12549.
- b) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above. Every employee and contractor must be checked at: www.oig.hhs.gov.

SECTION 7 - TERMINATION/CONVICTION/SANCTION INFORMATION/DISCLOSURE

42 CFR § 455.106 Disclosure by providers. Have either you, or agents of the provider, or any employee or person in whom you have a controlling interest, or any person having a controlling interest in you, been convicted of a criminal or civil offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs? Yes or No. If yes, supply the identity and all appropriate documentation .

Have either you or any employee been suspended, disciplined or surrendered a license or certification either in this or some other state? Yes or No. If yes, supply the identity and all appropriate documentation.

In accordance with 32 VSA §3113(b) I declare, under the pains and penalties of perjury, that I am in good standing with respect to (or in full compliance with a plan to pay) any and all taxes due. Yes or No. If no, supply explanation.

SECTION 8 - CONTROLLING INTEREST

As defined by 42 CFR § 455.104

Disclosure by providers and fiscal agents: Information on ownership and control. Do you, the applicant, have a controlling interest (see above) in any of the entities listed below, or does any entity listed below have a controlling interest in your practice? A disclosing entity must disclose whether any of the named persons is related to another as a spouse, parent, child or sibling. You must check yes or no to each Type of Entity or your application will be incomplete. If yes, please complete the section(s) on the next page.

Type of Entity	As an employee do you have a controlling interest in the Entity?	Does the Entity have a controlling interest in your practice?
Clinical laboratory services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical therapy services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech and language therapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Occupational therapy services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiology services including MRI and other imaging	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Radiation therapy services and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Durable medical equipment and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Potential and enteral nutrients, supplies or equipment	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prosthetic, orthotics, prosthetic devices and supplies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Home health services of any kind	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Pharmacy or prescription services (e.g., mail order)	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospital services of any kind including outpatient services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Group practice	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physicians Health Organization	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Nursing home	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Assisted Community Care Services	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Enhanced Residential Care	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

Name, Address and Tax ID Number of subcontractors in which the disclosing entity has a direct or indirect ownership of 5% or more.

SECTION 8 – CONTROLLING INTEREST (Continued)

Please indicate employer's name in this section. Any employer is considered to have a controlling interest in the services you provide. (If you are an employee only, please do not fill in "Type and percentage of controlling interest/ownership")

Name _____

Medicaid Provider Number (s) _____ SSN/EIN _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone: Business _____ Home _____

Type and percentage of controlling interest or ownership _____

Are you related to anyone else listed? If so, how (spouse, parent, child, sibling) _____

Name _____

Medicaid Provider Number (s) _____ SSN/EIN _____

Address _____

City _____ State _____ Zip _____ County _____

Telephone: Business _____ Home _____

Type and percentage of controlling interest or ownership _____

Are you related to anyone else listed? If so, how (spouse, parent, child, sibling) _____

Are all of the services provided by you and any special service vendors in which you have a controlling interest billed under a single provider number?

Yes

No

If yes, please enter the number _____

NOTE: If there are additional entries, please copy this page as needed.

SECTION 9 - INSTITUTIONAL INFORMATION

NUMBER OF BEDS: _____ NUMBER OF SWING BEDS: _____

(This information is mandatory for all hospitals.) NUMBER OF LICENSED BEDS: _____

TERMINATION NOTICE

INSTRUCTIONS:

Please complete this termination notice if you wish to terminate your enrollment with Vermont Medicaid. If you are a PCP, you need to notify Vermont Medicaid at least 90 days prior to the effective termination date.

NOTICE OF TERMINATION OF PARTICIPATION IN PC PLUS

All individually participating or group identified PCPs must notify HP, in writing, of their intention to withdraw from participation at least 90 days prior to the termination date. Closure of a practice due to the death of a PCP or sale of an individual practice, a group practice or a clinic will automatically terminate participation in the **PC Plus** plan.

If you are currently an active provider and you no longer wish to participate as a provider in the State of Vermont assisted health care programs, please indicate below. Your provider file will be closed on the date you specify, upon proof of 30 day notification to beneficiaries.

I no longer wish to be a Provider:

_____ CLOSURE DATE _____ PROVIDER _____ NUMBER

_____ SIGNATURE _____ DATE

I am a PCP. YES _____ NO _____

Cancellation- This agreement may be cancelled by either the provider or the state in accordance with applicable state and federal laws and regulations.

This section is to be completed by a PCP provider. Please select one of the following two options:

Transfer My Patients To: _____ (Provider Name)

Move Patients Assigned To Me To: _____ (New Group Name)

New Address Information: _____
_____ a
_____ a
_____ a

New Contact Number: _____ New E-Mail Address: _____

ATTACHMENT A
CONDITIONS OF PARTICIPATION
PROVIDER ENROLLMENT/RECERTIFICATION AGREEMENT

Provider agrees to the following:

1. To conform to all applicable Federal and State laws and regulations including Title VI of the 1964 Civil Rights Act, the Rehabilitation Act of 1973 as amended, the Americans with Disabilities Act, and Vermont Agency of Human Services Policy 1.11.
2. To be licensed, certified or registered with the appropriate state authority.
3. To comply fully with the instructions and restrictions regarding billing and third-party payments set out in the pertinent Provider Manual including its supplements. The Manual and Supplements are available on the web at www.vtmedicaid.com and also in paper form on request to the HP Provider Services Unit. The Manual and Supplements are incorporated by reference herein.
4. To submit information on transactions upon request of the State Agency or HHS secretary for records of any significant business transactions 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, within 35 days. (42 CFR § 455.105)
5. To guard the confidentiality of beneficiary information in a matter consistent with the confidentiality requirements in 45 CFR parts 160 and 164 and as required by state law.
6. To maintain and make available for inspection all medical, case or business records pertaining to the extent of services provided and any other information regarding payments, claimed or received, as they may pertain to the Department of Vermont Health Access programs. Additionally, the provider agrees to furnish these records and the other specified information to the Vermont Agency of Human Services, the U.S. Secretary of Health and Human Services and the Office of the Vermont Attorney General upon request. Such records shall be retained for seven (7) years.
7. To verify the eligibility of each patient prior to providing the service for each date of service, except where EMTALA applies.
8. To file a complete and accurate claim in a timely fashion. The signature of the provider, or the provider's designees, on a paper claim or the signature on the transmittal agreement for electronic claims certifies that the service(s) listed was medically necessary and actually rendered to a state health care program beneficiary. The provider is solely responsible for the accuracy of claims submitted whether in paper or electronic form.
9. To give notice to the Medicaid beneficiary in writing and in advance of providing the service, if the provider will not accept Medicaid payment for a service.
10. To establish and maintain a uniform charge for each item or service provided under this agreement.
11. To accept the state health care program payment for any service or item as payment in full, and to make no additional charge to a beneficiary except as allowed under the Provider Manual or DVHA rules.
12. To receive payment for services through Electronic Funds Transfer (EFT).
13. To comply fully with Title 42: Public Health, Part 455 Program Integrity: Medicaid, Subpart B: Disclosure of Information by Providers and Fiscal Agents.
14. Provider attests that all terms of this agreement are met on the date of service provided to Vermont beneficiaries.
15. Providers are required to do a search every month of the www.oig.hhs.gov Exclusions Database for all employees and contractors, by individual and entity name, to capture exclusions and reinstatements that may have occurred since the last monthly search. Providers will immediately report any exclusion discovery to HP Provider Enrollment.
16. Providers are required to review the member handbook found at www.dvha.vermont.gov/for-consumers for information on enrollee rights, grievances and appeals.

DEPARTMENT OF VERMONT HEALTH ACCESS
PROVIDER ENROLLMENT/RECERTIFICATION AGREEMENT

1. Parties This is an agreement between the State of Vermont Agency of Human Services (“State”) and _____ (“Provider”) doing business as _____
2. Subject Matter The subject matter of this agreement includes provider enrollment requirements and payment for the provision of health services and items to eligible beneficiaries.
3. Payment Amount In consideration of services to be performed by the provider, the State agrees to pay the Provider in accordance with all applicable provisions of the Global Commitment Waiver, Long Term Care (LTC) Waiver, Vermont Medicaid State Plan, Medicaid Rule, and the Provider Manual, including its supplements.
4. Agreement Term The period of this agreement is for one year from the date of signing, at the expiration of the provider’s license and/or certification, or at the suspension or surrender of the provider’s license or certification.
5. Cancellation This agreement may be cancelled by either the provider or the State in accordance with applicable state and federal laws and regulations.
6. Attachments This agreement includes the following attachments which are incorporated herein:
Attachment A – Conditions of Participation
Attachment B – Provider Identification Record
Attachment C –Termination Notice.
7. Additional Provisions Except as may be reasonably necessary in carrying out obligations under this agreement, the Provider shall not release, disclose, or make statements to third parties regarding data, information, files, documents or other materials generated, compiled, or maintained in connection with this agreement concerning beneficiaries, unless the State consents in writing to the disclosure. The exceptions to this prohibition on the release of information are when a court with appropriate jurisdiction orders the release of information or when the recipient of services rendered by the provider consents. In handling all such information, the Provider shall carry out the provisions of this agreement in accordance with applicable federal and state statutes.
8. Covered Programs By enrolling, the provider will be able to bill for services and items provided to beneficiaries in all state/federal assisted healthcare programs including but not limited to Medicaid, Dr Dynasaur, VScript, VHAP, VHAP Pharmacy, VPharm, Ladies First, Children with Special Health Needs(CSHN), Family Infant Toddler Program(FITP) and General Assistance.

9. **Authorized Official Signature**

I have read the contents of this application. My signature legally and financially binds this provider to the laws, regulations, and program instructions of the Vermont Medicaid program and state/federal assisted healthcare programs. If I become aware that any information in this application is not true, correct or complete, I agree to notify HP Enterprise Services of this fact immediately (within 30 days of change) at (802) 878-7871 or (800) 925-1706.

A. Individual Practitioner

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentations or concealment of any information requested in the application may subject me to liability under civil and criminal laws.

Individual Practitioner First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Individual Practitioner Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>) SIGNED			Date (<i>mm/dd/yyyy</i>)

The below section must be completed by a group practice, i.e. Office Manager, Administrator, Director etc.

B. Authorized or Delegated Official

I certify that I have examined the above information and that it is true, accurate and complete. I understand that any misrepresentations or concealment of any information requested in the application may subject me to liability under civil and criminal laws.

First Name	Middle Initial	Last Name	Jr., Sr., M.D., D.O., etc.
Authorized or Delegated Official's Signature (<i>First, Middle, Last Name, Jr., Sr., M.D., D.O., etc.</i>) SIGNED			Date (<i>mm/dd/yyyy</i>)
Title of Authorized Signature			

All signatures must be original and signed in ink. Applications with signatures deemed not original will not be processed. Stamped, faxed or copied signatures will not be accepted.